

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

36290 State of Idaho
BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 36290
 Registered No. 1

1. PLACE OF DEATH

County of Ada
 City of Marion

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 8

Primary Registration District No. 2508
 (No. 3 miles West of Boise St.)

2. FULL NAME

Demaris May Fry

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
 (Write the word.)

6. DATE OF BIRTH

Dec 20 1987
 (Month) (Day) (Year)

7. AGE

49 Yrs. 0 Mos. 17 ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

At Home

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Nathaniel Lewis

11. BIRTHPLACE OF FATHER

(State or Country)

Illinois

12. MAIDEN NAME OF MOTHER

Lucenia Jones

13. BIRTHPLACE OF MOTHER

(State or Country)

Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ascor E. Fry

(Address)

R. F. H. 2, Boise, Id.

Filed January 9, 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 7 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 7 1922 to Jan 7 1922
 that I last saw him alive on Jan 7 1922

and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

Attending Physician was out of the State at time of death

Contributory
 (Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas. E. Summers, Coroner

1-8 1922 (Address) Boise, Id.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Morris Hill Cemetery

DATE OF BURIAL

Jan 10 1922

20. UNDERTAKER

ADDRESS

Summers & Sons Boise, Id.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada
City of Near Boise

Registration District No.

Primary Registration District No.

(No. 3 West of Boise St.)File No. 36290Registered No. 2

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nathaniel Lewis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDM.WhiteMarried

(Write the word.)

6. DATE OF BIRTH

Dec 201872

(Month)

(Day)

(Year)

7. AGE

49

Yrs.

0

Mos.

17

ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

at home

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

Nathaniel Lewis

11. BIRTHPLACE OF FATHER

(State or Country)

Illinois

12. MAIDEN NAME OF MOTHER

Lucerna Ames

13. BIRTHPLACE OF MOTHER

(State or Country)

Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Osceola C. Fry

(Address)

R.D. 2 Boise

15.

Filed Jan 10 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan71922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I saw deceased fromJan1922

to

19

that I last saw h..... alive on..... 19

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

cor. of Strunk
attending physician was out of
state at time of death ds.Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

Clyde E. Sumner1/8 1922 (Address)Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mountain ViewJan 10 1922

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

Stewart

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada Registration District No. 2
City of Boss Primary Registration District No. 1004
STATISTICS 1114 D. 11 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Rosea C. GillumFile No. 36291
Registered No. 3

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

M White Married
(Write the word.)

6. DATE OF BIRTH

August 10 1892
(Month) (Day) (Year)

7. AGE

29 Yrs. 4 Mos. 24 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

Electrician

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Mack Gillum

11. BIRTHPLACE OF FATHER

(State or Country)

Indiana

12. MAIDEN NAME OF MOTHER

Altha Blowing

13. BIRTHPLACE OF MOTHER

(State or Country)

Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mack Gillum

(Address)

1217 Grand Ave

15.

Filed

Jan 7 1922N. H. P. R. A. T.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 5 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Oct 19 1922 to 19that I last saw him alive on 19 and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Coronary Arteriosclerosis(Duration) Yrs. 8 mos. 5 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

James H. Stewart M. D.

(Address)

Boss, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Marshall's Cemetery Jan 6 1922

20. UNDERTAKER

ADDRESS

Summers & Krebs Boss, Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of AdaCity of MeridianRECEIVED
JAN 10 1922
BUREAU OF VITAL
STATISTICS

Registration District No.

County Registration District No.

(No.)

St.)

File No. 36296Registered No. 25

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Kathryn Louise Sims

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

April
(Month)22
(Day)1914
(Year)

7. AGE

7 Yrs.8 Mos.11 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

School Girl

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Elmer E. Sims

11. BIRTHPLACE OF FATHER

(State or Country)

Illinois

12. MAIDEN NAME OF MOTHER

Grace L. Daly

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Elmer E. Sims

(Address)

Meridian Idaho

15.

Filed 1-419 22H. F. Neal

Local Registrar

16. DATE OF DEATH

(Month)

(Day)

19 22
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec. 619 21to Jan 219 22that I last saw him alive on Jan 2 19 22

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

pneumonia & Pericarditis

(Duration)

Yrs. 1 mos. 19 ds.Contributory
(Secondary)

(Duration)

Yrs. mos. ds.

(Signed)

H. F. Neal

M. D.

1-4 1922

(Address)

Meridian

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

MeridianJan 4 19 22

20. UNDERTAKER

ADDRESS

W. B. Mather Meridian

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36355
Registered No. 133

1. PLACE OF DEATH
County of Bonneville
City of South Lee
Registration District No. 73
Primary Registration District No. 215-0
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Archie Anderson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH Oct 31 1879
(Month) (Day) (Year)

7. AGE 43 Yrs. 7 Mos. 3 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION Farming
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE Utah
(State or Country)

10. NAME OF FATHER A. C. Anderson

11. BIRTHPLACE OF FATHER Denmark
(State or Country)

12. MAIDEN NAME OF MOTHER Eliza Curtis

13. BIRTHPLACE OF MOTHER Utah
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. Anderson
(Address) South Lee

15. Filled 1/4 1922 W. Anderson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 3 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 28 1921 to Jan 3 1922
that I last saw him alive on Jan 3 1922
and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:
Typhoid Fever

(Duration) Yrs. mos. 21 ds.
Contributory (Secondary) Typhoid
(Duration) yrs. mos. ds.
(Signed) H. H. Harker M. D.
19 (Address) Idaho Falls, Id.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Idaho Falls
DATE OF BURIAL 1-5-22

20. UNDERTAKER B. L. Woodward
ADDRESS Idaho Falls

Dr. Jackson

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

36378

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Benevolence
City of DesmetRegistration District No. 31

Primary Registration District No. _____

(No. _____ St.)

File No. 1Registered No. 46

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Andrew Timothy

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

IndianMarried

6. DATE OF BIRTH.

(Month)

(Day)

1873

(Year)

7. AGE

48

Yrs.

Mos.

ds.

IF LESS than 1 day
how many hrs. or
..... min. 2]

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).....None

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Not known

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) _____

(Address) _____

15.

Filed

Jan 71922J. L. Bihan

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

Jan 5 1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191

to

191that I last saw him alive on 191and that death occurred on the date stated above, at 11 A. M.

The CAUSE OF DEATH* was as follows:

Methyl alcohol poisoning

(Duration)

Yrs.

mos.

1 ds.Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

Thos. Barton

M. D.

JAN 7 1922 (Address)

Desmet, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death.....yrs.....mos.....days State.....yrs.....mos.....days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

DesmetJan 7 1922

20. UNDERTAKER

ADDRESS

J. FalconDesmet

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Gem*
City of *Emmett*

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No. *6*

(No. St.)

File No. *36433*

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Dorothy Mae Chaney

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *female* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED *child*
(Write the word.)

6. DATE OF BIRTH

June 21 19*22*
(Month) (Day) (Year)

7. AGE

8 Yrs. *6* Mos. *10* ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

child

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

F. L. Chaney

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Ora Fuller

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

F. L. Chaney

(Address)

Emmett Idaho

15.

Filed *1/3/22* 19.....

J. L. Reynolds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 1 19*22*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Dec 23 19*21*, to *Jan 1* 19*22*
that I last saw h. *alive* on *Dec 31* 19*21*,
and that death occurred on the date stated above, at *6:30 A.*
The CAUSE OF DEATH* was as follows:

diphtheria(Duration) Yrs. mos. *8* ds.Contributory (Secondary) *Post diphtheritic Paralysis*

(Duration) yrs. mos. ds.

(Signed) *A. G. Byrd* M. D.

19..... (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Emmett Idaho* DATE OF BURIAL *Jan 2* 19*22*

20. UNDERTAKER *C. D. Buckner* ADDRESS *Emmett Idaho*

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED

JAN 10 1922

BUREAU OF VITAL STATISTICS

Registration District No.

Registration District No.

St.)

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw her alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate. In plain terms, so that it may be properly classified.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Jerome
City of Jerome

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 23
Primary Registration District No. 1017-2017
(No. St.)

File No. 36449
Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William C. Godfrey

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-OWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH July fourth 18
(Month) (Day) (Year)

7. AGE 54 Yrs. 5 Mos. 27 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION Farmer
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE Deerfield, Illinois
(State or Country)

10. NAME OF FATHER William H. Godfrey

11. BIRTHPLACE OF FATHER New York State
(State or Country)

12. MAIDEN NAME OF MOTHER Edith Leatrice Duggan

13. BIRTHPLACE OF MOTHER New York City
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm. C. Godfrey
(Address) Jerome Idaho

15. Filed Jan 3 1922 E. D. Piper Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 2 22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 24 1921, to Jan 2 1922
that I last saw him alive on Jan 2 1922
and that death occurred on the date stated above, at 49 M.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(Duration) Yrs. mos. 8 ds.
Contributory Chronic Bronchitis
(Secondary)

(Duration) 10 yrs. mos. ds.
(Signed) E. D. Piper M. D.
Jan 3 1922 (Address) Jerome Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Jerome Cemetery DATE OF BURIAL Jan 3 1922
20. UNDERTAKER Ed Emerson ADDRESS Jerome Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED
JAN 11 1922
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Salah
City of Pothatch
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

REGISTRATION DISTRICT No. 65
PRIMARY REGISTRATION DISTRICT No. 2145

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36462
Registered No.

2. FULL NAME Mary T. Arnold

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widowed
(Write the word.)

6. DATE OF BIRTH June 4 1987
(Month) (Day) (Year)

7. AGE 64 Yrs. 7 Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Housewife
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) New Jersey

10. NAME OF FATHER Coplin

11. BIRTHPLACE OF FATHER
(State or Country) Illinois

12. MAIDEN NAME OF MOTHER Edsall

13. BIRTHPLACE OF MOTHER
(State or Country) New Jersey

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charles Arnold
(Address) Palouse Wash.

15. Filed Jan 5 1922 D. W. Thompson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 4 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 19 1921, to Jan 1 1922
that I last saw her alive on Jan 1 1922
and that death occurred on the date stated above, at 12 A.M.
The CAUSE OF DEATH* was as follows:

Septic Infection & Nemia

(Duration) Yrs. mos. 22 ds.
Contributory Bright's Disease & Arterio
(Secondary) Sclerosis (Duration) Yrs. mos. ds.
(Signed) E. K. Volk M. D.
1/5 1922 (Address) Palouse Wash.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?

19. PLACE OF BURIAL OR REMOVAL Palouse DATE OF BURIAL Jan 6 1922
20. UNDERTAKER C. M. Lewis ADDRESS Palouse

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

RECEIVED

Registration District No. 16

County of Lincoln

JAN 11

Primary Registration District No. 1016

City of Shashone

BUREAU
STAT

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mrs Pearl Nelson

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36472

Registered No. 22

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDmarried
(Write the word.)

6. DATE OF BIRTH

Oct-26 1896

(Month)

(Day)

(Year)

7. AGE

25

IF LESS than 1 day

how many hrs.

or min.?

25

Yrs.

Mos.

8

ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Oregon

10. NAME OF FATHER

H A Lerner

11. BIRTHPLACE OF FATHER

(State or Country)

Ills

12. MAIDEN NAME OF MOTHER

unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

II

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs Elmer Ford

(Address)

Shashone Idaho

15.

Filed

Jan 4th 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 4

(Month)

(Day)

1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 2 1922 to Jan 4 1922

that I last saw him alive on Jan 4 1922

and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Eclampsia

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

Pregnancy

(Duration)

Yrs.

mos.

ds.

(Signed)

C. D. Dieg

M. D.

Jan 4 1922

(Address)

Shashone

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

Yrs.

mos.

days

In the

State

Yrs.

mos.

days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Shashone

DATE OF BURIAL

Jan 5 1922

20. UNDERTAKER

O. J. Munnaw Shashone

ADDRESS

CERTIFICATE OF DEATH

3652 ✓

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada
City of BoiseRegistration District No. 2
Primary Registration District No. 1004
(No. 414 / Resseguie St.)File No. _____
Registered No. 8If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Samuel Floyd RussellIf death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH

July 5 - 1839
(Month) (Day) (Year)

7. AGE

82 Yrs. 7 Mos. 4 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)Fruit grower

9. BIRTHPLACE

(State or Country)

Penn10. NAME OF
FATHERAlexander Russell11. BIRTHPLACE
OF FATHER

(State or Country)

Penn12. MAIDEN NAME &
OF MOTHERElizabeth Russell13. BIRTHPLACE
OF MOTHER

(State or Country)

Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Cora B. Russell

(Address)

414 Resseguie

15.

Filed

Jan 11 19 22R. H. Pratt

Local Registrar

16. DATE OF DEATH

1 9 19 22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 1921, to 1/9 1922
that I last saw h. in alive on 1/9 1922
and that death occurred on the date stated above, at 10:20 M.

The CAUSE OF DEATH* was as follows:

Similar Libitation
Heart Bloc

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

Frederic A. Tupper M. D.1/10 1922 (Address) Boise Idaho*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery Jan. 11, 1922

20. UNDERTAKER

ADDRESS

Summers & Krebs Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH
in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Registration District No.

Primary Registration District No.

File No.

Registered No.

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF
FATHER11. BIRTHPLACE
OF FATHER

(State or Country)

12. MAIDEN NAME
OF MOTHER13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

19

Local Registrar

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at 1-AM.

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Signed)

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)At place of death..... In the
of death..... yrs..... mos..... days. State..... yrs..... mos..... daysWhere was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH
in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36326

Registered No. 1

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PLACE OF DEATH

County of Ada Registration District No. 9-10
City of Star Registration District No. 4 St.)

If death occurs away from usual residence, give facts called for under special information.

BUREAU OF VITAL STATISTICS

2. FULL NAME

William D Ware

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

maleWhiteMarried
(Write the word.)

6. DATE OF BIRTH.

(Month)

(Day)

(Year)

7. AGE

52 Yrs.

Mos.

6 ds.

IF LESS than 1 day
how many hrs. or
..... min. >]

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

Farmer

9. BIRTHPLACE

(State or Country)

Kentucky

10. NAME OF FATHER

David Ware

11. BIRTHPLACE OF FATHER

(State or Country)

Kentucky

12. MAIDEN NAME OF MOTHER

Elizabeth Ware

13. BIRTHPLACE OF MOTHER

(State or Country)

Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Bart Scrivener

(Address)

Meridian

15.

Filed

Jan 8

191

Willie Jackson

Local Registrar

Eagle Idaho

16. DATE OF DEATH

(Month)

(Day)

(Year)

Jan71922

17. I HEREBY CERTIFY, That I attended deceased from

June 29 1921 to Jan 7 1922that I last saw him alive on Jan 7 1922and that death occurred on the date stated above, at 9:30 M.

The CAUSE OF DEATH* was as follows:

Pulmonary T.B.(Duration) 13.14 Yrs. mos. ds.

Contributory (Secondary)

(Duration) 13.14 Yrs. mos. ds.(Signed) J. H. Neal M. D.1-8-1922 (Address) Meridian Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Star CemeteryJan 8 1922

20. UNDERTAKER

ADDRESS

Summers & KrebsBoise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-22

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH *Adrian, Idaho* Registration District No. *9-10*
County of *Adair* Primary Registration District No. *1*
City of *Star Line* (No. *1* St.)

File No. *36527*

Registered No. *1*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Emma Harriet Baldwin*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *FM* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Widow*
(Write the word.)

6. DATE OF BIRTH *July 14 1859*
(Month) (Day) (Year)

7. AGE *70 yrs. 11 mos. 22 ds.*
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION *Housewife*
(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE *West Virginia*
(State or Country)

10. NAME OF FATHER *Daniel*

11. BIRTHPLACE OF FATHER *Unknown*
(State or Country)

12. MAIDEN NAME OF MOTHER *Haines*

13. BIRTHPLACE OF MOTHER *West Virginia*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Hattie Baldwin*
(Address) *Star Line*

15. Filed *Jan 6 191* Local Registrar *W. C. Bailey*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *January 6 1922*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Jan 3 1922* to *Jan 6 1922*
that I last saw her alive on *Jan 5 1922*
and that death occurred on the date stated above, at *59 M.*

The CAUSE OF DEATH* was as follows:

Senility

(Duration) *10 yrs. 10 mos. 10 ds.*
Contributory (Secondary) *Arteriosclerosis*

(Duration) *10 yrs. 10 mos. 10 ds.*
(Signed) *W. C. Bailey* M. D.
19 (Address) *Star Line*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL *Masonic Cemetery* DATE OF BURIAL *4/8 1922*

20. UNDERTAKER *Schreiber & Sidenfaden* ADDRESS *Boise, Idaho*

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 30528
Registered No. 1-7

1. PLACE OF DEATH

County of *Ada* Registration District No. *2*
City of *Boise* Primary Registration District No. *1404*
St. *Idaho*

If death occurs away from usual residence, give facts called for under special information.

BUREAU OF VITAL STATISTICS

2. FULL NAME

Addie Boyd Clark

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *F.* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*

6. DATE OF BIRTH

Dec 28 19*14*
(Month) (Day) (Year)

7. AGE

72 Yrs. — Mos. *1* ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

At Home

9. BIRTHPLACE

(State or Country)

Illinois

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Joe Butler
927 Main St Boise, Id.

15.

Filed *Jan 3* 19*22* *R. N. Pratt*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 1 19*22*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Apr 12 1914 to *Jan 1 1922*
that I last saw him alive on *Jan 1 1922*
and that death occurred on the date stated above, at *2 P.* M.
The CAUSE OF DEATH* was as follows:*Carcinoma Uterus*(Duration) *3* Yrs. *2* mos. — ds.Contributory (Secondary) *Genital Sepsis*(Duration) *7* yrs. — mos. — ds.(Signed) *Dr. H. H. H. H. H.* M. D.19*22*. (Address) *Empire Bldg*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs mos days In the State yrs mos days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Marion Bliss Cemetery

DATE OF BURIAL

Jan 7 1922

20. UNDERTAKER

Sumner & Co.

ADDRESS

Boise Id.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **36529**
Registered No. **2112**

1. PLACE OF DEATH

County of **Ada**Registration District No. **2**City of **Payson**Primary Registration District No. **1004**(No. **410**)

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Virgie Fry

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

F

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WID-

OWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

March**4****1898**
(Month) (Day) (Year)

7. AGE

22

Yrs.

10

Mos.

1

ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

J. H. Hardman

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Mary Yancy

13. BIRTHPLACE OF MOTHER

(State or Country)

Miss.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. H. Hardman

(Address)

15.

Filed

Jan 9 1922

Local Registrar

16. DATE OF DEATH

January**5****1922**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec. 10**1921**

to

Jan 5 1922that I last saw him alive on **Jan 5 1922**and that death occurred on the date stated above, at **2:30 AM.**

The CAUSE OF DEATH* was as follows:

exophthalmic goiter(Duration) **2** Yrs. mos. ds.Contributory **Operation, excision of goiter**
(Secondary)

(Duration) yrs. mos. ds.

(Signed) **Harold W. Stone** M. D.**Jan 5 1922** (Address) **410 Overland Bldg**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

Hayesman Ida

19. PLACE OF BURIAL OR REMOVAL

Gooding Ida

DATE OF BURIAL

1/5 1922

20. UNDERTAKER

Schubert & Hidenfaden

ADDRESS

Bonnie

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Ada, Idaho
County of Ada
City of Boise
Registration District No. 1004
Registration District No. 608 Washington St.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Rachel Peterson

File No. 36530
Registered No. 4

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED widow
(Write the word.)6. DATE OF BIRTH Dec 16th 1844
(Month) (Day) (Year)7. AGE 79 Yrs. 18 Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Retired

9. BIRTHPLACE

(State or Country)

Hanover, Germany

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

Frederick Berghark

Germany

12. MAIDEN NAME OF MOTHER

not obtainable

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

R. H. Rath
608 Washington St Boise

15.

Filed

Jan 9 1922

R. H. Rath
Local Registrar

16. DATE OF DEATH

Jan 3rd 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 29 1921, to Jan 3 1922

that I last saw him alive on Jan 3 1922,

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

apoplexy

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Geo. A. Smith M. D.

19 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery 16 1922

20. UNDERTAKER

ADDRESS

Schreiber & Hedebrandt Boise

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 36531
Registered No. 5

1. PLACE OF DEATH

Registration District No. 2
County of Ada FLS-1922
Primary Registration District No. 1094
City of Boise St. Alphonsus Hospital

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

M. E. Mills

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

June 1, 1865
(Month) (Day) (Year)

7. AGE

56 Yrs. 7 Mos. 5 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Cigar Maker

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Oregon.

10. NAME OF FATHER

Genier

11. BIRTHPLACE OF FATHER

(State or Country)

Don't know

12. MAIDEN NAME OF MOTHER

4 4

13. BIRTHPLACE OF MOTHER

(State or Country)

" "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. McBratney

(Address)

Boise, Idaho.

15.

Filed

Jan. 4 1922H. H. Pratt

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan. 6 - 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov. 14 1921 to Jan 6th 1922that I last saw him alive on Jan. 6th 1922.and that death occurred on the date stated above, at 11:45 M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach(Duration) Yrs. 6 mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Joe R. Chambers

M. D.

1/6 1922 (Address) Boise Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Morris Hill Cemetery

DATE OF BURIAL

1/7 - 1922

20. UNDERTAKER

W. McBratney

ADDRESS

Boise, Idaho.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of AdaCity of BoiseRegistration District No. 2Primary Registration District No. 1002(No. 410 State St.)File No. 36532Registered No. 6

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Henry Boyer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widower
(Write the word.)

6. DATE OF BIRTH

Oct 18th 1849
(Month) (Day) (Year)

7. AGE

72 Yrs.

Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Farmer

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Erie Co. Ohio

10. NAME OF FATHER

Don't Know

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Don't Know

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ed Boyer

(Address)

15.

Filed

221922W. H. Hatt

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 6th 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 30 1921 to Jan 6 1922that I last saw him alive on Jan 6 1922and that death occurred on the date stated above, at 7:15 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma gall bladder and liver(Duration) 2 Yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

A. H. Higgs

M. D.

1922 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

Ada County Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Nampa Idaho 1/9 1922

20. UNDERTAKER

ADDRESS

Schreiber & SidenfadenA. H. Higgs

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 2
 County of Ada Primary Registration District No. 1004
 City of Boise (No. 110) and Boise (St.)

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Marian Elise Gooding

File No. 36533
 Registered No. 7

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH May 31st 1921
(Month) (Day) (Year)

7. AGE 7 Yrs. 10 Mos. 10 ds.
IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work none
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE Boise Idaho
(State or Country)

10. NAME OF FATHER R.H. Gooding, Jr.

11. BIRTHPLACE OF FATHER Idaho
(State or Country)

12. MAIDEN NAME OF MOTHER Ester M. Bennett

13. BIRTHPLACE OF MOTHER Neb.
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) R.H. Gooding Jr.
(Address) Shoshone Ida

15. Filed Jan 11 19 22

R.H. Gooding Jr.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 10 19 22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Jan 8 19 22, to Jan 10 19 22,
that I last saw h. ex alive on Jan 9 19 22,
and that death occurred on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Streptococcus Infection

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) M. D.

10 19 22 (Address) Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
if not at place of death?

Former or usual residence Shoshone Ida

19. PLACE OF BURIAL OR REMOVAL Shoshone Idaho DATE OF BURIAL 19

20. UNDERTAKER Schreiber & Hidenfaden ADDRESS Boise Ida

Dr. W. F. Smith

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH
 in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 2
County of Ada FEB 3 - 1922
Primary Registration District No. 1004
City of Boise No. H14 Pessier St.)

File No. 36534
Registered No. 8

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Samuel Floyd Russell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH

July 5 1889
(Month) (Day) (Year)

7. AGE

32 Yrs. 7 Mos. 4 ds. IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Fruit grower

9. BIRTHPLACE

(State or Country)

Penn

10. NAME OF FATHER

Alexander Russell

11. BIRTHPLACE OF FATHER

(State or Country)

Penn

12. MAIDEN NAME OF MOTHER

Elizabeth Dunn

13. BIRTHPLACE OF MOTHER

(State or Country)

Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Lara B. Russell

(Address)

H. 17 Pessier

15.

Filed

Jan 11 1922

R. H. Rath

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 9 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 1921 to 1/9 1921
that I last saw him alive on 1/9 1921
and that death occurred on the date stated above, at 11:20 A.M.

The CAUSE OF DEATH* was as follows:

Valvular Stenosis

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Frederic A. Pittenger M. D.

1410 1922 (Address) Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery Jan. 11 1922

20. UNDERTAKER

ADDRESS

Summer Grebe Boise, Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.

County of Ada

Primary Registration District No.

City of BoiseNo. 1324 1/2 State

St.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Russ. H. Boland

File No.

36535

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDM. WhiteMarried
(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

(Year)

Jan 7 1894

7. AGE

IF LESS than 1 day
how many hrs.
or min. ?31 Yrs. 0 Mos. 3 ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

At Home

9. BIRTHPLACE

(State or Country)

Wisconsin

10. NAME OF FATHER

J. W. Morgan

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Lana Uhres

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

R. H. Boland

(Address)

1324 1/2 State St.

15.

Filed 1-12 19 22R. H. Boland
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

(Year)

January 10 1922

17. I HEREBY CERTIFY, That I attended deceased from

Jan 4 1922 to Jan 10 1922that I last saw him alive on Jan 10 1922and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Tubercular Meningitis

(Duration)

Yrs.

mos. 17 ds.Contributory
(Secondary)Respiratory paralysis

(Duration)

Yrs.

mos. 5 hrs.

(Signed)

T. M. Brahan M. D.Jan 2 1922 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

Yrs.

mos.

days.

In the

State

Yrs.

mos.

days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Marion Hill CemeteryJan 14 1922

20. UNDERTAKER

ADDRESS

Jummers & KrebsBoise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36536

Registered No. 10

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

Registration District No.

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Roderick Matheson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single (Widow.)

6. DATE OF BIRTH

1873
(Month) (Day) (Year)

7. AGE

49

Yrs. — Mos. — ds.

IF LESS than 1 day
how many — hrs.
or — min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Clerk.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Scotland.

10. NAME OF FATHER

Angus Matheson

11. BIRTHPLACE OF FATHER

(State or Country)

Scotland.

12. MAIDEN NAME OF MOTHER

Anne McDonald

13. BIRTHPLACE OF MOTHER

(State or Country)

Scotland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Kenneth Matheson

(Address) Rockville Oregon

15.

Filed 1-14 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 16 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 1, 1922 to Jan 16, 1922
that I last saw him alive on Jan 10, 1922
and that death occurred on the date stated above, at 3 A. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bowels

(Duration) Yrs. 6 mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

Jan 14, 1922 (Address) P. P. French Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Morris Hill Cemetery

DATE OF BURIAL

Dec 15, 1922

20. UNDERTAKER

Summers & Co.

ADDRESS

Boise, Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada Registration District No. 103 1/2 South 102
City of Boise Primary Registration District No. 103 1/2 South 102 St.)

If death occurs away from usual residence, give facts called for under special information.

File No. 36537
Registered No. 11

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Henry Arthur Grossman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH

September 15 1872
(Month) (Day) (Year)

7. AGE

49 Yrs. 3 Mos. 26 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Eye Specialist
(b) General nature of industry, business or establishment in which employed (or employer) Optical Office

9. BIRTHPLACE

(State or Country) Austria - Hungary

10. NAME OF FATHER

Wm. Moritz Grossman

11. BIRTHPLACE OF FATHER

(State or Country) Austria Hungary

12. MAIDEN NAME OF MOTHER

Theresa Rosenfield

13. BIRTHPLACE OF MOTHER

(State or Country) Austria - Hungary

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Miss G. Fay Grossman
(Address) Boise, Idaho

15.

Filed 1-14 1922 R. J. Cat
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 10 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Jan 10th 1922, to Jan 10th 1922, that I last saw him alive on Jan 10th 1922, and that death occurred on the date stated above, at 5 P. M.. The CAUSE OF DEATH* was as follows:Cardiac Arrest(Duration) 3 Yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Joe R. Chambers M. D.
1/13/1922 (Address) Boise, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Los Angeles Calif 4/15/1922

20. UNDERTAKER

ADDRESS

Schuber & Widemeyer Boise, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36538
Registered No. 12

1. PLACE OF DEATH *St. Albans Hospital*
County of *Boise* Registration District No. *1*
City of *Boise* Primary Registration District No. *1*
STATISTICS (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Robert Alvero Chamberlan*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED
(Write the word.)

6. DATE OF BIRTH *Jan 9 1922*
(Month) (Day) (Year)

7. AGE *5 days*
IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE *Boise*
(State or Country)

10. NAME OF FATHER *L D Chamberlan*

11. BIRTHPLACE OF FATHER *Trar Iowa*
(State or Country)

12. MAIDEN NAME OF MOTHER *Elsie J Byers*

13. BIRTHPLACE OF MOTHER *Weiser Idaho*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) _____
(Address) _____

15. Filed *1-14 1922* *R. H. Rath*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *Jan 17 1922*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *1/9 1922* to *1/13 1922*
that I last saw *him* alive on *1/13 1922*
and that death occurred on the date stated above, at *4 A. M.*

The CAUSE OF DEATH* was as follows:
Septicemia

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) *Edw. A. Fung* M. D.
1/4 1922 (Address) *Boise*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL *19*

20. UNDERTAKER *Wm McBratney* ADDRESS _____

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36539

Registered No. 13

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH St. Luke's Hospital Registration District No. _____
 County of Boise Primary Registration District No. _____
 City of Boise (No. _____) St. _____

If death occurs away from usual residence, give first called for under special information.

2. FULL NAME

Veneta J. Martin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED _____

(Write the word.)

6. DATE OF BIRTH

July 26 1907
 (Month) (Day) (Year)

7. AGE

14 Yrs. 5 Mos. 18 ds.

IF LESS than 1 day
 how many _____ hrs.
 or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work _____
 (b) General nature of industry, business or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country)

Camp Idaho

10. NAME OF FATHER

Wheeler & Martin

11. BIRTHPLACE OF FATHER

(State or Country)

Bichanan Michigan

12. MAIDEN NAME OF MOTHER

Lavola Lee Eagle

13. BIRTHPLACE OF MOTHER

(State or Country)

Stella Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(Address) _____

15.

Filed 1-14 1924

R. H. Rath
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 13 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 5 1922 to Jan 13 1922

that I last saw him alive on

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) 3 yrs. _____ mos. _____ ds.

(Signed)

Jan 14 1922 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

Wm. E. Bratney

Arthur V
CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
 Bureau of Vital Statistics

1. PLACE OF DEATH *RECEIVED*
 County of *Ada* *FEB 3 - 1922*
 City of *Boise* *STATISTICAL*
 Registration District No. *13*
 Primary Registration District No. *St.*

File No. *36540*
 Registered No. *14*

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME *Larry E. Bower.*

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *M.* **4. COLOR OR RACE** *White* **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** *Married*

6. DATE OF BIRTH

May 7 19*84*
 (Month) (Day) (Year)

7. AGE

73 Yrs. *8* Mos. *8* ds.
 IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

at home

9. BIRTHPLACE

(State or Country) *Indiana*

10. NAME OF FATHER

Leob Manuel

11. BIRTHPLACE OF FATHER

(State or Country) *Unknown*

12. MAIDEN NAME OF MOTHER

Frances Mayers

13. BIRTHPLACE OF MOTHER

(State or Country) *Indiana*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Nancy Toeb.*
 (Address) *Boise, Idaho.*

15.

Filed *Jan. 16* 19*22* *H. H. Platt*
 Local Registrar

16. DATE OF DEATH

Jan 15 19*22*
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
April 19*21*, to *Jan 15* 19*22*,
 that I last saw him alive on *Jan 15* 19*22*,
 and that death occurred on the date stated above, at *4 P.* M.
 The CAUSE OF DEATH* was as follows:

Dilatation of heart

(Duration) *5* Yrs. *5* mos. *5* ds.
 Contributory (Secondary) *Mitral lesion*

(Duration) *5* Yrs. *5* mos. *5* ds.

(Signed) *Dr. Packer* M. D.

1/15/1922 (Address) *City*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death... yrs... mos... days. In the State... yrs... mos... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Masonic Cemetery *Jan 17* 19*22*

20. UNDERTAKER

Summers & Toeb. *Boise Idaho*

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
 N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

Ada

City of

Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. of Hospital)

STATISTICS

File No.

36541

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Nathaniel J. Bendon

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

M.

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married (Write the word.)

6. DATE OF BIRTH

Aug 18

(Month)

(Day)

1841 (Year)

7. AGE

80 Yrs.

4 Mos.

28 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Retired Contractor

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

Bendon

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. B. Bendon

(Address)

Sidney street

15.

Filed

Jan 16 1922

Local Registrar

16. DATE OF DEATH

Jan 15

(Month)

(Day)

1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 9th 1922, to Jan 15th 1922that I last saw him alive on Jan 15th 1922and that death occurred on the date stated above, at 9:40^{PM}

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(Duration) Yrs. mos. ds.

Contributory (Secondary)

Similarity

(Duration) yrs. mos. ds.

(Signed)

C. M. Taylor

M. D.

1/16 1922

(Address)

Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Glendive Montana

DATE OF BURIAL

19

20. UNDERTAKER

Summers & Coe

ADDRESS

Boise Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No.

Primary Registration District No.

(No. 137 Warm Spring Ave. St.)

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

married

(Write the word.)

6. DATE OF BIRTH

March 24 1876
(Month) (Day) (Year)

7. AGE

45 Yrs. 10 Mos. 14 ds.

IF LESS than 1 day
how many Yrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

merchant

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

San Francisco
California

10. NAME OF FATHER

Joseph M Rothchild

11. BIRTHPLACE OF FATHER

(State or Country)

Kentucky U.S.A.

12. MAIDEN NAME OF MOTHER

Adelaide Marx

13. BIRTHPLACE OF MOTHER

(State or Country)

California

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Jef Falk
Boise Idaho

15.

Filed

19

Local Registrar

16. DATE OF DEATH

January 14 1922
(Month) (Day) (Year)7. I HEREBY CERTIFY, That I attended deceased from Jan 14th 1922, to Jan 14th 1922, that I last saw him alive on Jan 14th 1922, and that death occurred on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Aegina Pectoris

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed)

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Masonic Cemetery 11/18 1922

20. UNDERTAKER

ADDRESS

Schuyler Vidensfaden Boise

Dr Brock

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED

FEB 8 - 1922

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36543

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Ada BUREAU OF Registration District No. 1
City of Boise (No. 803 Franklin St.)
Primary Registration District No. 1188

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Louise Evelyn Allen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH Sept. 16, 1921
(Month) (Day) (Year)

7. AGE 4 Yrs. 4 Mos. 4 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Boise, Idaho.

10. NAME OF FATHER

Charlie Allen

11. BIRTHPLACE OF FATHER

(State or Country)

Don't know

12. MAIDEN NAME OF MOTHER

Pearl Lake

13. BIRTHPLACE OF MOTHER

(State or Country)

North Dakota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. McBratney

(Address)

Boise Idaho.

15.

Filed Jan 21, 1922 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan. 20, 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 21, 1921, to Jan 1922, that I last saw h. ex alive on Jan 20, 1922, and that death occurred on the date stated above, at M. The CAUSE OF DEATH* was as follows:

Inanition

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed)

1/21, 1922 (Address) Boise, Idaho, M. D.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Morris Hill Cemetery

DATE OF BURIAL

1/21, 1922

20. UNDERTAKER

W. McBratney Boise Idaho

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Adair

Registration District No.

City of Boise

Primary Registration District No.

(No. 301 Days St.)File No. 36544Registered No. 9

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Mary Elizabeth Larimer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

F WhiteWidow
(Write the word.)

6. DATE OF BIRTH

Mar 26 1898
(Month) (Day) (Year)

7. AGE

13 Yrs. 9 Mos. 24 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

at Home

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Illinois

10. NAME OF FATHER

Ernest Turkham

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Naomi Johnson

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. L. Larimer

(Address)

501 Days

15.

Filed

19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 20 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 20th 1922, to Jan 20 1922that I last saw her alive on Jan 20 1922and that death occurred on the date stated above, at P. M.

The CAUSE OF DEATH* was as follows:

Senility. (no special remarks)
Coma. (and death)

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) L. P. McCall M. D.1/21/1922 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Morris Hill Cemetery Jan 22, 1922

20. UNDERTAKER

ADDRESS

Summers & Krebs Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED CERTIFICATE OF DEATH

Ward.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada
City of Boise

Registration District No. _____

BUREAU OF VITAL STATISTICS
Primary Registration District No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

ST. No. 10 & Barnock St.File No. 36545Registered No. 19

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH

July 10 1904
(Month) (Day) (Year)

7. AGE

17 Yrs 6 Mos 10 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)At Home

9. BIRTHPLACE

(State or Country)

Boise Idaho

10. NAME OF FATHER

George Bay

11. BIRTHPLACE OF FATHER

(State or Country)

Iowa

12. MAIDEN NAME OF MOTHER

Anna Buffington

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Mary Willhite

(Address)

1492 Willow St, Boise, Id.

15.

Filed 3 1 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

January 20 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Dec 28 1921 to Jan 20 1922
that I last saw him alive on Jan 20 1922
and that death occurred on the date stated above, at 1:00 P.M.

The CAUSE OF DEATH was as follows:

Peripneumonia (type)
unde termined(Duration) 0 Yrs. 0 mos. 16 ds.Contributory
(Secondary)Perineal laceration(Duration) 0 yrs. 0 mos. 20 ds.

(Signed)

Roscoe B Ward M. D.1-21-22 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Morris Hill Country Jan 23 1922

20. UNDERTAKER

Summers & Kubs

ADDRESS

Boise Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada Registration District No. 132
City of Boise Primary Registration District No. St. Lukes Hospital St.)
BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ella S. HindmanFile No. 36546Registered No. 21

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

F.White.Widowed
(Write the word.)

6. DATE OF BIRTH

March 5 1854
(Month) (Day) (Year)

7. AGE

67 Yrs. 10 Mos. 6 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
-
- (b) General nature of industry, business or establishment in which employed (or employer)

At Home

9. BIRTHPLACE

(State or Country)

Pennsylvania

10. NAME OF FATHER

William Craig

11. BIRTHPLACE OF FATHER

(State or Country)

Pennsylvania

12. MAIDEN NAME OF MOTHER

Frances Myers

13. BIRTHPLACE OF MOTHER

(State or Country)

Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. H. Barton

(Address)

15.

Filed Jan 23 1927R. H. Smith
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 21 1927
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 17th 1927, to Jan 21st 1927
that I last saw him alive on Jan 21st 1927,
and that death occurred on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:

Operation to relieve ob-
struction of bowel due to
adhesions

(Duration) Yrs. mos. ds.

Contributory
(Secondary)Proctitis - appendicitis
abscess + perforation
adhesions (Duration) 2 yrs. mos. ds.

(Signed)

J. M. Taylor M. D.
Boise Idaho (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Celerion Penn.19

20. UNDERTAKER

ADDRESS

Summers & SchelsBoise Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36547

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of AdaCity of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. South 16 street St.)

2. FULL NAME

Thomas Williamson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word)

6. DATE OF BIRTH

April 27 1900
(Month) (Day) (Year)

7. AGE

2 Yrs. 8 Mos. 25 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

Automobile tire Salesman

9. BIRTHPLACE

(State or Country)

Canada

10. NAME OF FATHER

G. W. Williamson

11. BIRTHPLACE OF FATHER

(State or Country)

Scotland

12. MAIDEN NAME OF MOTHER

Maggie Williamson

13. BIRTHPLACE OF MOTHER

(State or Country)

Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

G. Williamson
5550 Harg St Portland

15.

Filed..... 19.....

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 22 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 22 1922 to Jan 22 1922that I last saw him on Jan 22 1922and that death occurred on the date stated above, at 20 M.

The CAUSE OF DEATH* was as follows:

Suicide (Gun shot wound with 38. Caliber)

(Duration)..... Yrs..... mos..... ds.

Contributory
(Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed)

Chas. E. Summers Coroner

(Address)

Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Portland Oregon Jan 26 1922

20. UNDERTAKER

ADDRESS

Summers & Sons

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36548

Registered No. 21

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Ada Registration District No. 1
City of Boise Primary Registration District No. 923 East Washington St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ellen Corrigan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED widow
(Write the word.)

6. DATE OF BIRTH

(Month) 1 (Day) 27 (Year) 1897

7. AGE

25 Yrs. 0 Mos. 0 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Retired

9. BIRTHPLACE

(State or Country)

Lisdownhall Ireland

10. NAME OF FATHER

Ahern

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Ellen Ahern

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mary E. Barry

(Address)

923 E. Wash St.

15.

Filed Jan 27 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 28 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

men 1921, to Jan 28 1922

that I last saw him alive on Jan 28 1922

and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Cerebral Hemorrhage

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) Dr. Cooney M. D.

19 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

St John's Cemetery

DATE OF BURIAL

1/25/1922

20. UNDERTAKER

Schreiber & Hidenfaden

ADDRESS

Boise

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of AdaCity of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. _____

Primary Registration District No. _____

(No. 103 West Idaho St.)State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 36549Registered No. 2

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Helga Anderson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

May 1 1997
(Month) (Day) (Year)

7. AGE

18 Yrs. 6 Mos. 23 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

At Home

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

U.S.A.

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

C. M. Sursee
Boise Idaho

15.

Filed Jan 27 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

January 24 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 24 1922 to Jan 24 1922that I last saw h. _____ alive on _____ 1922and that death occurred on the date stated above, at 230 P.M.

The CAUSE OF DEATH* was as follows:

Suicide. Self administering
Sulphate of Quinine

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Chas E Summers
Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mountain View Cemetery Jan 27 1922

20. UNDERTAKER

ADDRESS

Summers & Co. Boise Idaho

CERTIFICATE OF DEATH

36550

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Registration District No.

Registration District No.

File No.

Registered No.

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

(Year)

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF
FATHER11. BIRTHPLACE
OF FATHER

(State or Country)

12. MAIDEN NAME
OF MOTHER13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B. - Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH
in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

36551

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada
City of BoiseRegistration District No. 2Primary Registration District No. 127(No. 410 State Idaho St.)File No. 26Registered No. 1

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mrs. Sarah Jane Buffington

If death occurred in a hospital, institution or camp, its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widow
(Write the word.)6. DATE OF BIRTH August 24 1869
(Month) (Day) (Year)7. AGE 52 Yrs. Mos. ds. IF LESS than 1 day
how many hrs. or min.?8. OCCUPATION House Keeper
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)9. BIRTHPLACE Nebraska
(State or Country)10. NAME OF FATHER James Kelley11. BIRTHPLACE OF FATHER W. S. A.
(State or Country)12. MAIDEN NAME OF MOTHER Harriste Blanchard
not known13. BIRTHPLACE OF MOTHER W. S. A.
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Iona Cook
(Address) Wernon Hotel, Boise, Idaho15. Filed 1 1922 H. H. Pratt
Local Registrar

16. DATE OF DEATH

Jan. 28 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from 1/2 1922 to 1/28 1922
that I last saw her alive on 1/28 1922
and that death occurred on the date stated above, at 4 P. M.
The CAUSE OF DEATH* was as follows:Carcinoma uteri
(Duration) Yrs. mos. ds. 1 Yrs. 1 mos. 1 ds.
Contributory (Secondary) Hemorrhage
(Duration) Yrs. mos. ds. 1 Yrs. 1 mos. 1 ds.
(Signed) Ralph F. Bell M. D.
Boise 1/29 1922 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Meridian Idaho DATE OF BURIAL 1/30 192220. UNDERTAKER Schreiber & Vidensadex ADDRESS Boise

1. PLACE OF DEATH

County of *Ada*City of *Boise*

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
FEB 3 - 1922BUREAU OF VITAL
STATISTICS

CERTIFICATE OF DEATH

Registration District No. _____

Registration District No. _____

(No. *St Luke's Hospital*, St.)

2. FULL NAME

*Leona M. Perkins*State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

36552

Registered No.

26

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married

6. DATE OF BIRTH

Feb 4

(Month)

(Day)

1898

(Year)

7. AGE

22 Yrs. 11 Mos. 23 ds.

* IF LESS than 1 day

how many _____ hrs.

or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

at home

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

Harry C. Moore

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Elouise Nelson

13. BIRTHPLACE OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

O. L. Nelson

(Address)

15.

Filed

*1-28**1922**R. H. Pratt*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 27

(Month)

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 26 1922, to *Jan 27 1922*that I last saw her alive on *Jan 27 1922*and that death occurred on the date stated above, at *6 P. M.*

The CAUSE OF DEATH* was as follows:

Thrombotic emboli

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

P. P. French

M. D.

1-28 1922 (Address) *Boise Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Morris Hill Cemetery

DATE OF BURIAL

Jan 30 1922

20. UNDERTAKER

Summers & Co.

ADDRESS

Boise Ida.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Adams*
City of *Markese*

Registration District No.

Primary Registration District No.

(No. *Soldiers Home* St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Enos D. McCafferty

File No.

Registered No. *27*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED*M White* *Single*
(Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)
1839

7. AGE

83 Yrs. Mos. ds.
IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)*Veteran Civil War*

9. BIRTHPLACE

(State or Country)

Unknown

10. NAME OF FATHER

(State or Country)

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

(State or Country)

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Chas E Summers*(Address) *Boise Idaho*

15.

Filed *1-28* 19*22* Local Registrar *1 N. V. +*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

January 26 19*22*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 23 19*22* to *Jan 26* 19*22*
that I last saw him alive on *Jan 26* 19*22*

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Right Sided Hemiplegia

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *Chas E Summers* M. D.*1/28* 19*22* (Address) *Boise*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Morris Hill Cemetery *Jan 29* 19*22*

20. UNDERTAKER ADDRESS

Summers & Telford *Boise*

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Ada
City of Boise

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Harry S. Perkins

CERTIFICATE OF DEATH

Registration District No. _____
BUREAU OF Registration District No. _____
STATE Idaho Hospital _____
(No. _____) St. _____State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36554
Registered No. 28

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single

6. DATE OF BIRTH

Jan 27 1922
(Month) (Day) (Year)

7. AGE

Yrs. _____ Mos. 1 ds. _____IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)None

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Perry Perkins

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Glenn Moore

13. BIRTHPLACE OF MOTHER

(State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. Nelson

(Address) _____

15.

Filed

Jan 28 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 28 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 27 1922 to Jan 28 1922
that I last saw him alive on Jan 28 1922
and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Congestion of Lungs

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) P. P. French

M. D.

1-30 1922 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Moore's Hill Cemetery Jan 30 1922

20. UNDERTAKER

ADDRESS

Summers & Sons Boise Idaho

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada

Registration District No. _____

City of Boise

Primary Registration District No. _____

File No. 36555(No. 1618 St. 9th St.)Registered No. 29

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Hardy Harp.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

May 31
(Month)1852
(Day) (Year)

7. AGE

69 Yrs. 7 Mos. 28 ds.

IF LESS than 1 day

how many _____ hrs.

or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farming

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Mo

10. NAME OF FATHER

James Harp

11. BIRTHPLACE OF FATHER

(State or Country)

Iowa

12. MAIDEN NAME OF MOTHER

Sarah Clark

13. BIRTHPLACE OF MOTHER

(State or Country)

Va

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wagner Bratney

(Address)

Boise Idaho

15.

Filed

24 30 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 29 - 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 20 to Jan 29 1922
that I last saw him alive on Jan 28 1922and that death occurred on the date stated above, at 1 A.M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory (Secondary)

Bright disease(Duration) 3 yrs. _____ mos. _____ ds.

(Signed)

W. Bratney M. D.

Boise

(Address) Boise Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Boise Cemetery

DATE OF BURIAL

1/31/22 1922

20. UNDERTAKER

W. Bratney

ADDRESS

Boise Idaho

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH

FEB 3 - 1922

County of

Ada

BUREAU OF VITAL STATISTICS

City of

Boise

Registration District No. 8
Registration District No. 8
Boise County Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Clara M. Kellum

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36556
Registered No. 12

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

June, 15, - 1903
(Month) (Day) (Year)

7. AGE

18 Yrs. 6 Mos. 16 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Farmer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

J. O. Killum

11. BIRTHPLACE OF FATHER

(State or Country)

Iowa

12. MAIDEN NAME OF MOTHER

Clara M. Brown

13. BIRTHPLACE OF MOTHER

(State or Country)

Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wm. Bratney

(Address)

Boise Idaho

15.

Filed

Jan. 3, 1922

R. H. Bratney
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan - 1 - 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 31, 1921, to Jan 1, 1922

that I last saw ~~him~~ alive on Jan 1, 1922

and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Duration) 1 Yrs. mos. ds.

Contributory (Secondary) Diabetic Coma

(Duration) yrs. mos. 24 hrs. ds.

(Signed) T. N. Bratney M. D.

1/2/22 (Address) Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Morris Hill Cemetery

DATE OF BURIAL

1/3 - 1922

20. UNDERTAKER

Wm. Bratney

ADDRESS

Boise Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **36557**
Registered No. **7**

1. PLACE OF DEATH

County of Ada
City of _____

Registration District No. _____
Primary Registration District No. _____
(No. 1 Mile South of Boise St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Shannon Todd

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widower
(Write the word.)

6. DATE OF BIRTH

June 10 1882
(Month) (Day) (Year)

7. AGE

89 Yrs. 5 Mos. 2 ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

Elisha Todd

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Sarah Smith

13. BIRTHPLACE OF MOTHER

(State or Country)

Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John N. Todd

(Address)

Box 1002 Boise Ada

Filed

19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 12 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 12 1922 to Jan 12 1922
that I last saw him alive on Jan 12 1922
and that death occurred on the date stated above, at 3 A.M.

The CAUSE OF DEATH* was as follows:

Senility
No Physician in attendance

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Clayde E. Summers Coroner
442 1922 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Portland Oregon Jan 14 1922
20. UNDERTAKER Summers & Sons Boise Idaho ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **36558**
Registered No. **E 4**

1. PLACE OF DEATH

County of **Ada**City of **Boise**

Registration District No.

Primary Registration District No.

(No. **U.S.P.H.S. Hospital #52** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **James G.B. Ackaret**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED**Male****White****Single**
(Write the word.)

6. DATE OF BIRTH

June**14****1891**

(Month)

(Day)

(Year)

7. AGE

30Yrs. **X**Mos. **X**

ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. **Lumberman**

(b) General nature of industry, business or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country) **Colorado**

10. NAME OF FATHER

James R. Ackaret

11. BIRTHPLACE OF FATHER

(State or Country) **Don't know**

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country) **Unknown**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed **1-17****1922**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan.**16,****1922**

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from **Nov. 30, 1921,** to **Jan. 16, 1922**that I last saw him alive on **Jan. 16, 1922** and that death occurred on the date stated above, at **P. M.**The CAUSE OF DEATH* was as follows:
Nephritis, chronic parenchymatous**Unknown** (Duration)..... Yrs. mos. ds.Contributory.....
(Secondary) **Pyorrhea****Unknown** (Duration)..... Yrs. mos. ds.**RE, T J. G. Noble, P.A.S. (R.)**
Temporary in Charge.(Signed) **J. G. Noble**

M. D.

1-17-22 (Address) **Boise, Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death **X** yrs. **X** mos. **57** days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?.....

Unknown

Former or usual residence

Emmett, Idaho

19. PLACE OF BURIAL OR REMOVAL

Emmett, Idaho

DATE OF BURIAL

1-19 1922

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **36559**
Registered No. **1**

1. PLACE OF DEATH

County of **Idaho** Registration District No. **8**
Primary Registration District No. **2004**
City of **Boise** St. **Boise**
5 miles west of Boise

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Margaret J. Roberts

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

M **W** **Widow**
(Write the word.)

6. DATE OF BIRTH

Oct-17-1846
(Month) (Day) (Year)

7. AGE

75 Yrs. **3** Mos. **—** ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Ienn.

10. NAME OF FATHER

William Carro

11. BIRTHPLACE OF FATHER

(State or Country)

Ienn

12. MAIDEN NAME OF MOTHER

Jones

13. BIRTHPLACE OF MOTHER

(State or Country)

North Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. M. Britney

(Address)

Boise, Idaho

15.

Filed **19**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan. 17-1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 17 1922, to **Jan 12** 1922
that I last saw her alive on **Jan 17** 1922
and that death occurred on the date stated above, at **5 P. M.**

The CAUSE OF DEATH* was as follows:

Hemiplegia

(Duration) Yrs. mos. **4** ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) **H. M. Holmerson** M. D.

1/17/22 (Address) **Boise, Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Maxwell Cemetery

DATE OF BURIAL

1/20/22

20. UNDERTAKER

W. M. Britney

ADDRESS

Boise Idaho

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of AdaCity of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2

Primary Registration District No. 104
(No. U.S. Veterans' Hospital #52 St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36560Registered No. 10

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robert L. Pierce

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED
single
(Write the word.)

6. DATE OF BIRTH

XX XX 1891
(Month) (Day) (Year)

7. AGE

31 Yrs. XX Mos. XX ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Virginia

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country) Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan. 26 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
June 27 1921 to Jan. 26 1922

that I last saw him alive on Jan. 26 1:25 1922
and that death occurred on the date stated above, at P. M.

The CAUSE OF DEATH* was as follows:

Shock

XX (Duration) Yrs. mos. ds.

Contributory acidosis, post operative
(Secondary)

XX (Duration) yrs. mos. ds.

J.G. Noble, P.A.S. (R) Executive
(Signed) J.G. Noble Officer M. D.

Jan. 27 1922 (Address) Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. 213 days. In the Unknown State yrs. mos. days

Where was disease contracted if not at place of death? Unknown

Former or usual residence La Grande, Ore.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rural Retreat, Va19

20. UNDERTAKER

ADDRESS

J.G. NobleBoise Idaho

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Ada
 City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7
 Primary Registration District No. 7-2008
 (No. Ada County Hospital)

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 36561
 Registered No. 7

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Archibald Carmichael

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Don't know
 (Write the word.)

6. DATE OF BIRTH Jan. 22, 1830
 (Month) (Day) (Year)

7. AGE 92 Yrs. 9 Mos. 9 ds.
 If LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

Mining and Snapping

9. BIRTHPLACE

(State or Country)

New York

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

?

12. MAIDEN NAME OF MOTHER

?

13. BIRTHPLACE OF MOTHER

(State or Country)

?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. McBratney

(Address)

Boise, Ida.

15.

Filed Feb. 1, 1922

R. H. Pratt
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 31 - 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1919 to Jan 31 1922
 that I last saw him alive on Jan 30 1922
 and that death occurred on the date stated above, at 1 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration) 3 Yrs. 3 mos. 3 ds.

Contributory (Secondary)

Pulmonary Oedema

(Duration) 1 yrs. 1 mos. 1 ds.

(Signed)

T. N. Braxton M. D.

Feb. 1, 1922 (Address) Boise, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 3 yrs. 3 mos. 3 days In the State 3 yrs. 3 mos. 3 days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

County Cemetery

DATE OF BURIAL

Feb. 1, 1922

20. UNDERTAKER

W. McBratney

ADDRESS

Boise, Idaho.

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada Registration District No. 10-1922
 City of Meridian Primary Registration District No. 11
 State of Idaho

File No. 36562
 Registered No. 36562

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

John W. Keener

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Married

6. DATE OF BIRTH

July 31 1883
 (Month) (Day) (Year)

7. AGE

83 Yrs. 5 Mos. 14 ds.
 IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work Farmer
 (b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country) Tennessee

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country) Unknown

12. MAIDEN NAME OF MOTHER

" "

13. BIRTHPLACE OF MOTHER

(State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Gray Adams

(Address) Meridian

15.

Filed Jan 15 1922 H. F. Neal
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 14 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Dec. 28 1921 to Jan 5 1922
 that I last saw him alive on Jan 5 1922
 and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) H. F. Neal M. D.

Jan 19 22 (Address) Meridian Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state
 (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
 if not at place of death?

Former or
 usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Parson's Cemetery Jan 15 1922

20. UNDERTAKER

ADDRESS

W. B. Statton Meridian

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada Registration District No. 1002
City of Meridian Registration District No. 1002
St. IdahoFile No. 36563
Registered No. 3

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Sarah A. Topsy

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widow
(Write the word.)

6. DATE OF BIRTH

May 23 1868
(Month) (Day) (Year)

7. AGE

53 Yrs. Mos. ds. IF LESS than 1 day how many. hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work House Keeper
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Maine Co. Maine

10. NAME OF FATHER

John W. Kincaid

11. BIRTHPLACE OF FATHER

(State or Country) Maine Co. Maine

12. MAIDEN NAME OF MOTHER

Elybeth Brown

13. BIRTHPLACE OF MOTHER

(State or Country) Maine Co. Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Joe W. Fowler
(Address) Meridian, Idaho15. Jan. 10 19 22

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 9 19 22
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Jan 9 19 22 to Jan 9 19 22
that I last saw her alive on Jan 9 19 22
and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(Duration) Yrs. mos. ds.

Contributory (Secondary) dropsy

(Duration) yrs. mos. ds.

(Signed) J. F. Neal M. D.Jan. 10 19 22 (Address) Meridian

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Morris Hill

DATE OF BURIAL

Jan 11 19 22

20. UNDERTAKER

W. S. Matus Meridian

ADDRESS

FORM V. S. No. 5-25 M. 1-16-13

1. PLACE OF DEATH.

County of Bannock
City of Plummer

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Kate Lutesia Hess

RECEIVED

CERTIFICATE OF DEATH.

Registration District No. 46Bureau Registration District No. 2113

(STATISTICAL)

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 36566Registered No. 2

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widow

(Write the word.)

6. DATE OF BIRTH.

Aug 19

(Day)

1855

(Year)

7. AGE

67 Yrs.4 Mos.30 ds.IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....Domestic

9. BIRTHPLACE

(State or Country)

Dundee Ore

10. NAME OF FATHER

David Hess

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Catherine Lee

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

J. D. Hess

(Address)

Plummer, Ida

15.

Filed

Jan. 18 1922H. G. Gage

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan

(Month)

18

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 18 1922, to Jan 18 1922,that I last saw her alive on Jan 18 1922,and that death occurred on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:

Accidental Burn

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

D. C. Blalock

M. D.

19 (Address)

Plummer, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place
of death.....yrs.....mos.....days

In the

State.....yrs.....mos.....days

Where was disease contracted
if not at place of death?at homeFormer or
usual residencePlummer, Idaho

19. PLACE OF BURIAL OR REMOVAL

Plummer, Idaho

DATE OF BURIAL

Jan. 18 1922

20. UNDERTAKER

H. G. Gage

ADDRESS

Plummer
Idaho

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Purpuree
City of HomedaleRegistration District No. 3
Primary Registration District No. 2009
(No. St.)State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36586
Registered No. 3

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Fannie Lehner

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-OWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH

April 1st
(Month) (Day) (Year)

7. AGE

59 Yrs. 9 Mos. 4 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)House Wife

9. BIRTHPLACE

(State or Country)

Illinois

10. NAME OF FATHER

Samuel River

11. BIRTHPLACE OF FATHER

(State or Country)

Switzerland

12. MAIDEN NAME OF MOTHER

Maggie Bush

13. BIRTHPLACE OF MOTHER

(State or Country)

Don't know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

C. E. Lehner

(Address)

Homedale Ida

15.

Filed

Jan. 7- 1922 John V. Meyer

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 5 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from 1-5- 1922 to 1-5- 1922
that I last saw h..... alive on 1-5- 1922
and that death occurred on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach(Duration) Yrs. 2 mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) W. B. Beck M. D.19..... (Address) Wilder Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Fargo Minn. 1-7-1922

20. UNDERTAKER

ADDRESS

E. V. Beckham Caldwell

1. PLACE OF DEATH

County of CanyonCity of Baldwell

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED
JAN 19 1922
BUREAU OF
STATISTICS

CERTIFICATE OF DEATH

Registration District No. 3Registration District No. 1005

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 36587Registered No. 4

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

Mich 29 1852
(Month) (Day) (Year)

7. AGE

69 Yrs. 9 Mos. 14 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Turner

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Indiana

10. NAME OF FATHER

Ezra Lamkin

11. BIRTHPLACE OF FATHER

(State or Country)

Indiana

12. MAIDEN NAME OF MOTHER

Reed

13. BIRTHPLACE OF MOTHER

(State or Country)

Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Chas. Lamkin

(Address)

710 Belmont

15.

Filed

Jan 13 1922J. H. Meyer

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 13 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 6 1922, to Jan 12 1922
that I last saw him alive on Jan 12 1922
and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

Kavalis

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

G. F. Hunt H.B. M.D.

19

(Address)

Baldwell Id.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Canyon Hill

DATE OF BURIAL

1-14-1922

20. UNDERTAKER

CASE FURNITURE CO.

ADDRESS

Baldwell

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

Registration District No.

Primary Registration District No.

City of

(No.

St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from
Dec 28 1921 to June 4 1922
that I last saw him alive on June 4 1922
and that death occurred on the date stated above, at 11:30 A.M.
The CAUSE OF DEATH* was as follows:
General dyspnea with early
involvement of heart(Duration) Yrs. mos. ds.
Contributory (Secondary) Distant Biceps(Duration) 12 yrs. mos. ds.
(Signed) J. H. D. M. D.

19 (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B. - Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon Registration District No. 3
City of Baldwell Primary Registration District No. 2005
St. Idaho

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Martin John Derig

File No. 36589

Registered No. 1
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH

Dec 9 1885
(Month) (Day) (Year)

7. AGE

36 Yrs. 25 Mos. 5 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Rancher

9. BIRTHPLACE

(State or Country)

So. Dakota

10. NAME OF FATHER

John R. Derig

11. BIRTHPLACE OF FATHER

(State or Country)

Wis.

12. MAIDEN NAME OF MOTHER

Catherine Stanton

13. BIRTHPLACE OF MOTHER

(State or Country)

Wis.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William E. Derig
(Address) Baldwell R#2

15.

Filed Jan. 5 1922

John H. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 14 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from December 13, 1921 to January 4, 1922
that I last saw him alive on January 4, 1922
and that death occurred on the date stated above, at 9:30 P.M.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(Duration) Yrs. mos. One ds.
Contributory Chronic nephritis with hyper-
(Secondary) tension
(Duration) Five yrs. mos. ds.
(Signed) C. R. Whittenburger D.D.
Jan. 4, 1922 (Address) Baldwell, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence Baldwell R#2

19. PLACE OF BURIAL OR REMOVAL

Canyonville

DATE OF BURIAL

1-7 1922

20. UNDERTAKER

CASE FURNITURE CO.

ADDRESS

Baldwell

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

36591

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. **RECEIVED** Registration District No. 82
County of Caribou Primary Registration District No. 2159
City of Boise (No. 1 St.)
If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Edward Albertson

File No. 1

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH Not Known 1 (Month) (Day) (Year)

7. AGE About 58 IF LESS than 1 day how many hrs. or mins.?
..... yrs. mos. ds.

8. OCCUPATION (a) Trade, profession or particular kind of work Trapper (b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Norway

10. NAME OF FATHER Not Known

11. BIRTHPLACE OF FATHER (State or Country) Not Known

12. MAIDEN NAME OF MOTHER Not Known

13. BIRTHPLACE OF MOTHER (State or Country) Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edw. Kackley
(Address) Boise Springs, Idaho

15. Filed Jan 31, 1912 Edw. Kackley Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 23, 1912 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 15, 1911, to Jan 23, 1912, that I last saw him alive on Jan 23, 1912, and that death occurred on the date stated above, at 3 P. M. The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(Duration) 1 yrs. mos. ds.

Contributory None (Secondary)

(Duration) yrs. mos. ds.

(Signed) Edw. Kackley M. D.

Jan 31, 1912 (Address) Boise Springs, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Boise Springs, Idaho Jan 25, 1912

20. UNDERTAKER ADDRESS

Caribou Co.

CERTIFICATE OF DEATH **103.**State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **36598**

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of **Fremont.**
Ashton.

City of _____

Registration District No. _____

Primary Registration District No. **6**

St. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Frank Shelby Atchley.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single.

(Write the word.)

6. DATE OF BIRTH

January**5th****19 13**

(Month)

(Day)

(Year)

7. AGE

9 Yrs.**1** Mos.**8** ds.

IF LESS than 1 day

how many _____ hrs.

or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

At home on farm/

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

Marysville.

(State or Country)

10. NAME OF FATHER

John P. Atchley

11. BIRTHPLACE OF FATHER

Tennessee

(State or Country)

12. MAIDEN NAME OF MOTHER

Laura Johnston.

13. BIRTHPLACE OF MOTHER

Idaho.

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

John P. Atchley

(Informant)

(Address) **Ashton Idaho.**

15.

Filed **1-15-22** **Remickham**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

January**14th**

19

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Ashton 19____, to **Ashton** 19____that I last saw him alive on **Jan 14** 19____and that death occurred on the date stated above, at **9 P.** M.

The CAUSE OF DEATH* was as follows:

Burn shot in back

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed)

S. L. Haggis M. D.

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Schults Cemetery Idaho 1/16/1922

20. UNDERTAKER

Lewis Kiser / Ashton Idaho

ADDRESS

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No.

Primary Registration District No.

(No.)

(St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many..... hrs.

or.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw her alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

1/7 1922 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

1. PLACE OF DEATH.

County of Idaho
City of Strangerville

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Thomas L. Irwin

RECEIVED CERTIFICATE OF DEATH.

Registered District No. 103Primary Registration District No. 1001BUREAU OF
STATISTICS

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

36603Registered No. 1

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widower

(Write the word.)

6. DATE OF BIRTH.

Oct.1837

(Month)

(Day)

(Year)

7. AGE

843

Yrs.

Mos.

ds.

IF LESS than 1 day

how many.....hrs. or

min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work...

Farmer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country)

Bamberlain Ohio

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

P. J. Jesse

(Address)

Strangerville

15.

Filed

Feb 11922G. S. Stockton

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan

(Month)

24

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 1 1922 to Jan 24 1922that I last saw him alive on Jan 10 1922and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Senile decay

(Duration)Yrs.....mos.....ds.

Contributory (Secondary)

arterio sclerosis

(Duration)yrs.....mos.....ds.

(Signed)

G. S. Stockton

M. D.

1/30 1922 (Address) Strangerville Idaho

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death.....yrs.....mos.....days

In the

State.....yrs.....mos.....days

Where was disease contracted

if not at place of death?.....

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

Prarie View

DATE OF BURIAL

1-27 1922

20. UNDERTAKER

E. S. Hancock

ADDRESS

Strangerville

1. PLACE OF DEATH

County of **JEFFERSON**City of **MENAN**

If death occurs away from usual residence, give facts called for under special information.

FEDERAL BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATHRegistration District No. **98**Primary Registration District No. **2176**

BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **36604**

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME **MAUDE CHRISTOPHERSON OLAVERSON**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

FEMALE

4. COLOR OR RACE

WHITE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

MARRIED

(Write the word.)

6. DATE OF BIRTH

MARCH 25 1884

(Month)

(Day)

(Year)

7. AGE

37 Yrs. **10** Mos. **10** ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

HOUSE WIFE

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

MT. PLEASANT UTAH

10. NAME OF FATHER

WALTER CHRISTOPHERSON

11. BIRTHPLACE OF FATHER

(State or Country)

DENMARK

12. MAIDEN NAME OF MOTHER

ALICE DAY

13. BIRTHPLACE OF MOTHER

(State or Country)

IOWA

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

M. E. Olaverson
Manan, Ida.

15.

Filed **Feb 10** 19**22****Tray H. Fisher**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 16 1922
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from **July 16 1922** to **Jan 14 1922**that I last saw him alive on **Dec 16 1921** and that death occurred on the date stated above, at **29** M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) **Chas S Woody** M. D.19 (Address) **Menan,**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL
MENAN IDA. CEMETARYDATE OF BURIAL
1/17/22

20. UNDERTAKER

D. A. Harris

ADDRESS

Rigby Ida.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Jefferson Registration District No. 2176
 City of Lewistown Primary Registration District No. 2176
RECEIVED
FEB 7 - 1922 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

BUREAU OF VITAL STATISTICS
Virgil Tyler

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 36605
 Registered No. 13

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED single
 (Write the word.)

6. DATE OF BIRTH

1 - 22 - 922
 (Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
 how many 4 hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

John C. Tyler

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Lutie Riley

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John C. Tyler
Lewistown, Idaho

(Address)

15.

Filed

2 - 10 - 22

Ray Fisher
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

1 - 22 - 22
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1 - 22 - 22 to 1 - 22 - 22

that I last saw h. ex. alive on 1 - 22 - 22

and that death occurred on the date stated above, at 4 P.

The CAUSE OF DEATH* was as follows:

Premature

(Duration) Yrs. mos. ds.

Contributory.
 (Secondary)

(Duration) yrs. mos. ds.

(Signed) Ray Fisher M. D.

1-22-22 (Address) Rigby, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Lewistown

DATE OF BURIAL

1-24-22

20. UNDERTAKER

Friends

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of **JEFFERSON**City of **RIGBY**

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. **FEB 25 1922** St.)

File No.

Registered No. **12**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME **JOHN HERMAN ESCHLER**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

MALE

4. COLOR OR RACE

WHITE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

SINGLE

(Write the word.)

6. DATE OF BIRTH

APRIL 5th 1897
(Month) (Day) (Year)

7. AGE

24 Yrs. **9** Mos. **14** ds.IF LESS than 1 day
how many.....hrs.
or.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

FARMER

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) **Montpelier Ida.**

10. NAME OF FATHER

FRED ESCHLER

11. BIRTHPLACE OF FATHER

(State or Country) **SWITZERLAND**

12. MAIDEN NAME OF MOTHER

MINNIE SCHULTZ

13. BIRTHPLACE OF MOTHER

(State or Country) **GERMANY**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Minnie Brown**(Address) **Rigby Ida**

15.

Filed **Jan. 20** 19 **22** **Ray H. Fisher**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 19 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased ~~from~~On **Jan 10 1922** to **19**that I last saw him alive on **Jan 10 1922**and that death occurred on the date stated above, at **2 P.M.**

The CAUSE OF DEATH* was as follows:

**Cardiac Distention
and Insufficiency**(Duration) **one** Yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) **H. A. Anderson** M. D.19. (Address) **Rigby, Idaho.**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL
REXBURG IDA. CEMETARYDATE OF BURIAL
1/21/22

20. UNDERTAKER

Dr. Harris

ADDRESS

Rigby Ida

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Jefferson
City of RigbyRegistration District No. 98
Primary Registration District No. 2176
(No. Residence St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

James Earl BriggsFile No. 36608
Registered No. 11

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
(Write the word.)6. DATE OF BIRTH Sept 4 1853
(Month) (Day) (Year)7. AGE 68 Yrs. 4 Mos. 8 ds.
IF LESS than 1 day how many..... hrs. or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Employed by Sugar Co. as field man
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Wm Briggs

11. BIRTHPLACE OF FATHER

(State or Country) England

12. MAIDEN NAME OF MOTHER

Hanner Dean Briggs

13. BIRTHPLACE OF MOTHER

(State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) I to be James Earl Briggs
(Address) Idaho15. Feb 10 1922 Ray Fisher
Filed Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 12 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Jan 11 1922 to Jan 12 1922 that I last saw him alive on Jan 12 1922 and that death occurred on the date stated above, at 119 M.

The CAUSE OF DEATH* was as follows:

Fracture of ribs with perforation of the lungs

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. Call M. D.
1/14 1922 (Address) Rigby, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Lewisville Ida

DATE OF BURIAL

1-16 1922

20. UNDERTAKER

W. H. Woodley

ADDRESS

Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **36611**
Registered No. **8**

1. PLACE OF DEATH

County of **JEFFERSON**City of **RIGBY**Registration District No. **98**Primary Registration District No. **2176**

(No. _____)

(St. _____)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **JOHN KINGHORN**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

MALE

4. COLOR OR RACE

WHITE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

MARRIED

(Write the word.)

6. DATE OF BIRTH

JULY 30th. 1871

(Month)

(Day)

(Year)

7. AGE

50 Yrs. **5** Mos. **12** ds.

IF LESS than 1 day

how many _____ hrs.

or _____ min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

MANAGER OF THE

(b) General nature of industry, business or establishment in which employed (or employer).

RIGBY MILLING AND ELEVATOR CO.

9. BIRTHPLACE

(State or Country)

SALT LAKE CITY UTAH

10. NAME OF FATHER

ALEXANDER KINGHORN

11. BIRTHPLACE OF FATHER

(State or Country)

SCOTLAND

12. MAIDEN NAME OF MOTHER

JANE CAMBELL

13. BIRTHPLACE OF MOTHER

(State or Country)

SCOTLAND

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

19 **12**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 11 19 **22**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 1st 1922 to **Jan 11th 1922**

that I last saw him alive on **Dec 28 1922**

and that death occurred on the date stated above, at **7 P.M.**

The CAUSE OF DEATH* was as follows:

Sarcoma of bullock

(Duration) _____ Yrs. **4** mos. **7** ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) **H. G. Anderson** M. D.

19 _____ (Address) _____

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

BEWISVILLE IDA.

DATE OF BURIAL

1/15 22

20. UNDERTAKER

H. A. Harris

ADDRESS

Rigby, Ida

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **36612**
Registered No. **7**

1. PLACE OF DEATH

County of **Jefferson** Registration District No. **98**
City of **Rigby, 3rd** Primary Registration District No. **2176**
(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, ~~MARRIED~~, ~~WIDOWED~~ OR ~~DIVORCED~~ **Single**
(Write the word.)

6. DATE OF BIRTH

Jan 26 1922
(Month) (Day) (Year)

7. AGE

0 Yrs. **0** Mos. **0** ds. IF LESS than 1 day
how many **4** hrs.
or **?** min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. **None**
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) **Rigby, Idaho**

10. NAME OF FATHER

J. Morgan Lake

11. BIRTHPLACE OF FATHER

(State or Country) **Utah**

12. MAIDEN NAME OF MOTHER

Fern. Harris

13. BIRTHPLACE OF MOTHER

(State or Country) **Utah**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **J. Morgan Lake**

(Address) **Rigby, #2, Idaho**

15.

Filed **19**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 26 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 26 1922 to **Jan 26 1922**
that I last saw him alive on **Jan 26 1922**
and that death occurred on the date stated above, at **12 P. M.**

The CAUSE OF DEATH* was as follows:

Cerebral Rupture 7 1/2 mos
blood & brains

(Duration) _____ Yrs. _____ mos. **1 1/2** ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) **O. C. Ball** M. D.

19 (Address) **Rigby, Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Rigby, Idaho

DATE OF BURIAL

1-27 1922

20. UNDERTAKER

M. L. Fur. Co

ADDRESS

Rigby, Idaho

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of **JEFFERSON**

City of **RIGBY**

Registration District No. **98**

Primary Registration District No. **2176**

File No. **36613**

Registered No. **6**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **BESSIE ALTHARA CAMPBELL**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

FEMALE

4. COLOR OR RACE

WHITE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

SINGLE

(Write the word.)

6. DATE OF BIRTH

AUGUST

3rd.

1907

(Month)

(Day)

(Year)

7. AGE

14

Yrs.

5

Mos.

7

ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

SCHOOL GIRL

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

IDAHO.

10. NAME OF FATHER

MORRIS B. CAMPBELL

11. BIRTHPLACE OF FATHER

(State or Country)

IDAHO.

12. MAIDEN NAME OF MOTHER

AMY A. TURNER

13. BIRTHPLACE OF MOTHER

(State or Country)

IDAHO

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Morris B. Campbell

(Address)

RIGBY IDA.

15.

Filed

Feb 10 1922

Tracy H. Fisher

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

1 — 9

(Month)

(Day)

1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 8th 1922 to **Jan 9th 1922**

that I last saw him **3** alive on **Jan 9th 1922**

and that death occurred on the date stated above, at **7 P.M.**

The CAUSE OF DEATH* was as follows:

Diphtheria

(Duration) Yrs. mos. **3** ds.

Contributory (Secondary)

Nasal.

(Duration) yrs. mos. ds.

(Signed)

A. M. Palmer

M. D.

1/10 1922 (Address) **Rigby - Ida.**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

RIGBY CEMETARY

DATE OF BURIAL

1/10/22

20. UNDERTAKER

H. A. Harris

ADDRESS

Rigby Ida.

1. PLACE OF DEATH.

County of Lemhi Registration District No. 41
City of Salmon Primary Registration District No. 2116
(No. _____) (St.) _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Adelaide Elizabeth Kingbury

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widowed
(Write the word.)

6. DATE OF BIRTH.

March 17 1862
(Month) (Day) (Year)

7. AGE

59 Yrs. 9 Mos. 4 ds.IF LESS than 1 day
how many _____ hrs. or
_____ min. 2)

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).....Housewife

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

Wm Mitchel

11. BIRTHPLACE OF FATHER

(State or Country)

Iowa

12. MAIDEN NAME OF MOTHER

Mrs. Breckinridge

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Essa Terry

(Address)

Salmon, Ida.

15.

Filed

Jan 10 19221922Chas. C. Bellamy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 4 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 1919 to Jan 4 1922
that I last saw her alive on Jan 3 1922
and that death occurred on the date stated above, at 1 A M.

The CAUSE OF DEATH* was as follows:

shatter mottlesabout 3 years

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas. F. Hammer M. D.1922 (Address) Salmon

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Salmon Cemetery1-5 1922

20. UNDERTAKER

ADDRESS

Wm C. JacobySalmon

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED
JAN 19 1922
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of LewisCity of Nezperce(No. Route 8)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

* Richard C. StaplesRegistration District No. 47

Registration District No.

File No. 36619Registered No. 72

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Child
(write the word.)

6. DATE OF BIRTH.

* Feb
(Month)4
(Day)1919
(Year)

7. AGE

2 Yrs. 11 Mos. ds.IF LESS than 1 day
how many.....hrs. or
.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country)

Profino Idaho

10. NAME OF FATHER

Wm. Cullen Staples

11. BIRTHPLACE OF FATHER

(State or Country)

Missouri

12. MAIDEN NAME OF MOTHER

Leroy Bryant

13. BIRTHPLACE OF MOTHER

(State or Country)

Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) * Wm. Cullen Staples(Address) Nezperce Idaho

15.

Filed 1-15 19122Albert Hoff
Local Registrar

16. DATE OF DEATH

Jan 4
(Month) (Day)1922
(Year)17. I HEREBY CERTIFY, That I attended deceased from Dec 21, 1921 to Jan 4, 1922that I last saw him alive on Jan 4, 1922and that death occurred on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:

Scarlet Fever(Duration) Yrs. 1 mos. 1 ds.

Contributory (Secondary)

(Duration) Yrs. 1 mos. 1 ds.(Signed) Wm. Cullen Staples M. D.* 14 1922 (Address) Nezperce Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Nezperce Cemetery1-15 1922

20. UNDERTAKER

ADDRESS

Albert HoffNezperce Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36621
Registered No. 1

1. PLACE OF DEATH. Registration District No. 48-60
County of Lewis Primary Registration District No. 2127219
City of Winchester (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Albertine Nelson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married (Write the word.)

6. DATE OF BIRTH April 19 1857 (Month) (Day) (Year)

7. AGE 65 yrs. 2 mos. 28 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION (a) Trade, profession or particular kind of work Housewife (b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Sweden

10. NAME OF FATHER Johnson

11. BIRTHPLACE OF FATHER (State or Country) Sweden

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) S. P. Clauder (Address) Winchester Ida

15. Filed 1/24 1922 P. E. Duver Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. 22 1922 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 11th 1921, to Oct. 17th 1921, that I last saw her alive on Oct 17th 1921, and that death occurred on the date stated above, at 3:30 P. M.

The CAUSE OF DEATH* was as follows: Chronic Nephritis (Duration) 5 yrs. 3 mos. ds.

Contributory (Secondary) Liver congestion & Dropsy (Duration) 1 yrs. 2 mos. ds. (Signed) S. P. Clauder M. D. Jan 22 1922 (Address) Winchester Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state 1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. ds. In the State. yrs. mos. ds. Where was disease contracted. If not at place of death? Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL 1004 Cemetery DATE OF BURIAL 1/24 1922

20. UNDERTAKER S. P. Clauder ADDRESS Winchester Ida

S. P. Clauder.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Lewis*City of *Craigmont*RECEIVED
FEB 3 1922
BUREAU OF
STATISTICSRegistration District No. *30*Primary Registration District No. *2129*

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Eliza Ann Huff*State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. *36622*
Registered No. *2*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

*April**27**1847*

(Month)

(Day)

(Year)

7. AGE

74 Yrs. *9* Mos. *1* ds.IF LESS than 1 day
how many.....hrs.
or.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)*Housewife*

9. BIRTHPLACE

(State or Country)

Jackson Co. Mo.

10. NAME OF FATHER

Spottswood Thomas

11. BIRTHPLACE OF FATHER

(State or Country)

Virginia

12. MAIDEN NAME OF MOTHER

Elizabeth Conwell

13. BIRTHPLACE OF MOTHER

(State or Country)

Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. J. Thomas

(Address)

Clackston, Wash.

15.

Filed

*1/31**1922**RE Dumen*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

*January**28**1922*

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

*Jan 26 1922 to Jan 28 1922*that I last saw him alive on *Jan 28 1922*and that death occurred on the date stated above, at *4:45 P.M.*

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)*Branchioectasis*

(Duration)

Small

Yrs.

mos.

ds.

(Signed)

P. E. Dumen M. D.*1/31 1922* (Address) *Craigmont*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

Yrs.

mos.

days

In the

State

Yrs.

mos.

days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

FOOT cemetery

DATE OF BURIAL

1/31 1922

20. UNDERTAKER

Star Mortuary Co.

ADDRESS

Craigmont

CERTIFICATE OF DEATH

36630

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

RECEIVED

Registration District No. 92

County of

Primary Registration District No. 2170

City of

St.)

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

BUREAU OF VITAL STATISTICS

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

6. DATE OF BIRTH.

7. AGE

IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15.

Filed

1-30

1922

E.E. Watts

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to

191

that I last saw him alive on 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Gun shot wound
accidental

(Duration)

instant

mos. ds.

Contributory
(Secondary)

(Duration)

yrs. mos. ds.

(Signed)

E.E. Watts

M. D.

1-30-22 (Address)

Lifford Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lifford Idaho

2-2 1922

20. UNDERTAKER

ADDRESS

W.E. Stoddard

Lifford

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

36631

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 92

County of *Boise*

Primary Registration District No. 2170

City of *Boise*

FED. No. 192

St.)

File No. 3

Registered No. 39

If death occurs away from
usual residence, give facts
called for under special
information.

2. FULL NAME

*Mary A Newell*If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.*Female**White**Widow*
(Write the word.)

6. DATE OF BIRTH.

January 25 1840
(Month) (Day) (Year)

7. AGE

82 Yrs. *5* Mos. *5* ds.IF LESS than 1 day
how many.....hrs. or
.....min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work...
(b) General nature of in-
dustry, business, or estab-
lishment in which employ-
ed (or employer).....*house retired*

9. BIRTHPLACE

(State or Country)

*County Cork, Ireland*10. NAME OF
FATHER*Kelchler*11. BIRTHPLACE
OF FATHER

(State or Country)

*Ireland*12. MAIDEN NAME
OF MOTHER*-----*13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Howard E. Porter

(Address)

Summit Idaho

15.

Filed

*1-30**1922**E.E. Watts*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 30 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to *191*that I last saw h. *Er* alive on *191*and that death occurred on the date stated above, at *M.*

The CAUSE OF DEATH* was as follows:

*Carcinoma of
chest*

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

*E.E. Watts M.D.**1-30-1922* (Address)*Boise**State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted
if not at place of death?.....Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Boise Idaho**1-31 1922*

20. UNDERTAKER

ADDRESS

*W.C. Shadland**Boise*

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS
should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement
of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36632

Registered No. 2

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of PayetteCity of Payette

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED
JAN 28 1922

Registration District No. 4

Primary Registration District No. 1008

(No. 1205 - 7th Ave North St.)

S. AL

Jennie E. Crouch

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widow
(Write the word.)

6. DATE OF BIRTH

Mar - 5 - 1836
(Month) (Day) (Year)

7. AGE

85 Yrs. 10 Mos. 3 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

Luther Brown

11. BIRTHPLACE OF FATHER

(State or Country)

Mass.

12. MAIDEN NAME OF MOTHER

Margaret Raymond

13. BIRTHPLACE OF MOTHER

(State or Country)

New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. R. Whipple

(Address)

Payette, Idaho

15.

Filed

Jan 9 1922

1922

J. C. Woodward

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 8 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 19 1921, to Nov. 15 1921
that I last saw her alive on Nov. 15 1921
and that death occurred on the date stated above, at 1:00 P. M.

The CAUSE OF DEATH* was as follows:

Fracture of neck of right femur

(Duration) Since July 19, 1921, ds.
Contributory (Secondary) Paralysis of paralysis

(Duration) yrs. mos. ds.

(Signed) O. H. Aron M. D.

1/9/22 (Address) Payette, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery, Boise

1/11 1922

20. UNDERTAKER

ADDRESS

D. M. Bratney

Boise Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36633
Registered No. 3

1. PLACE OF DEATH

County of Payette Registration District No. 4
City or 2 miles from French Primary Registration District No. 1008
(No. 1008 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ira. A. Corbit

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH

July 12 1887
(Month) (Day) (Year)

7. AGE

54 Yrs. 5 Mos. 28 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Farmer & merchant

9. BIRTHPLACE

(State or Country) Iowa

10. NAME OF FATHER

Lester Corbit

11. BIRTHPLACE OF FATHER

(State or Country) Dont know

12. MAIDEN NAME OF MOTHER

Beaver

13. BIRTHPLACE OF MOTHER

(State or Country) Dont know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. M. Corbit
(Address) French Ida

15.

Filed Jan 14 19 20 J. Woodward
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

January 10 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from retrieved the remains of deceased
that I last saw him alive on Jan 12 - 1922
and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Gun shot wound self
inflicted. Suicidal
instantaneous
(Duration) Yrs mos ds

Contributory
(Secondary)

(Duration) Yrs mos ds

(Signed) H. F. Knight Doctor M.D.

(Address) New Plymouth, Ia.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs mos days In the State Yrs mos days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Payette Ida Jan 14 1922

20. UNDERTAKER

Glenn C. Landon Payette Ida

Registered No. ~~XXXXXXXXXX~~.....

STATISTICS

2. FULL NAME

2. FULL NAME..... Desrosiere Velma

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

..... January 14 1922
(Month) (Day) (Year)

IF LESS than 1 day
how many..... hrs.
or..... min.?

(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business or establishment in which employed (or employer).....

(State or Country) North Carolina

Mathew Love

(State or Country) North Carolina

L
L'ecceza Luvell

(State or Country) North Carolina

(Informant) James H. Hester

(Address) Mayella Delaney

15. *o. f. 2225*

Filed Jan 18 1922 EC Toddman

17. I HEREBY CERTIFY, That I attended deceased from October 1921, to Jan. 14 1922
that I last saw her alive on Jan. 14 1922
and that death occurred on the date stated above, at 12:42 AM

The CAUSE OF DEATH* was as follows:

Progressive spinal muscular atrophy. Aran-Duchenne type.

..... (Duration) 1 Yrs. 6 mos. ds.

Contributory.....
(Secondary)

.....(Duration)yrs.....mos.....ds.

(Signed) W. H. Hovey M. D.

1/4/ 1922 (Address) Payette, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted
if not at place of death

Former or usual residence *William Maule-Hackman*

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
<p>1. <u>St. John's Cemetery</u></p> <p>2. <u>St. John's Cemetery</u></p> <p>3. <u>St. John's Cemetery</u></p> <p>4. <u>St. John's Cemetery</u></p> <p>5. <u>St. John's Cemetery</u></p> <p>6. <u>St. John's Cemetery</u></p> <p>7. <u>St. John's Cemetery</u></p> <p>8. <u>St. John's Cemetery</u></p> <p>9. <u>St. John's Cemetery</u></p> <p>10. <u>St. John's Cemetery</u></p> <p>11. <u>St. John's Cemetery</u></p> <p>12. <u>St. John's Cemetery</u></p> <p>13. <u>St. John's Cemetery</u></p> <p>14. <u>St. John's Cemetery</u></p> <p>15. <u>St. John's Cemetery</u></p> <p>16. <u>St. John's Cemetery</u></p> <p>17. <u>St. John's Cemetery</u></p> <p>18. <u>St. John's Cemetery</u></p> <p>19. <u>St. John's Cemetery</u></p> <p>20. <u>St. John's Cemetery</u></p>	<p>1. <u>1900</u></p> <p>2. <u>1900</u></p> <p>3. <u>1900</u></p> <p>4. <u>1900</u></p> <p>5. <u>1900</u></p> <p>6. <u>1900</u></p> <p>7. <u>1900</u></p> <p>8. <u>1900</u></p> <p>9. <u>1900</u></p> <p>10. <u>1900</u></p> <p>11. <u>1900</u></p> <p>12. <u>1900</u></p> <p>13. <u>1900</u></p> <p>14. <u>1900</u></p> <p>15. <u>1900</u></p> <p>16. <u>1900</u></p> <p>17. <u>1900</u></p> <p>18. <u>1900</u></p> <p>19. <u>1900</u></p> <p>20. <u>1900</u></p>

Rosette Idaho Jan 16 1924

20. UNDERTAKER	ADDRESS.
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SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Payette Registration District No. 4
 City of Payette Primary Registration District No. 1008
 (No.) (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William H Cox

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 36635
 Registered No. 3

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID.
Widowed (Write the word.)

6. DATE OF BIRTH

Mar 26 1841
 (Month) (Day) (Year)

7. AGE

80 Yrs. 9 Mos. 13 ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

Farmer
Retired

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

Cox

11. BIRTHPLACE OF FATHER

(State or Country)

Missouri

12. MAIDEN NAME OF MOTHER

Not Known

13. BIRTHPLACE OF MOTHER

(State or Country)

Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. D. Thacker
Payette Ida

15.

Filed

Jan 20 1922
J. C. Woodward
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 14 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19, to 19,
 that I last saw him alive on 19,
 and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Hygienic found dead in bed

(Duration) Yrs. mos. ds.

Contributory
 (Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. C. Woodward M. D.
1922
 (Address) Payette Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Payette Ida Jan 17 1922

20. UNDERTAKER

ADDRESS

J. W. Adair Payette Ida

Registered No.....
If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

**5. SINGLE, MARRIED, WID-
OWED OR DIVORCED**

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work....

(b) General nature of industry, business or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME
OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on Jan 6 1927
and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

..(Duration)Yrs.....mos.....ds

**Contributory
(Secondary)**

..(Duration) 0 yrs. 12 mos. 12 ds

(Signed) William X. Neese M.D.

18 1927 (Address) Duland, Ore

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days.

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL / DATE OF BURIAL

ADDRESS

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36637
Registered No.

1. PLACE OF DEATH
County of Payette Registration District No.
City of Payette Primary Registration District No.
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME Henry Vecker

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH Nov 6 1860
(Month) (Day) (Year)

7. AGE 61 Yrs. 2 Mos. 1 ds.
IF LESS than 1 day how many hrs. or min. ?

8. OCCUPATION Retired Farmer
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE Germany
(State or Country)

10. NAME OF FATHER John Vecker

11. BIRTHPLACE OF FATHER Germany
(State or Country)

12. MAIDEN NAME OF MOTHER Not known

13. BIRTHPLACE OF MOTHER Not known
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. Vecker
(Address) Payette Idaho

15. Filed Jan 9 1922 66 Payton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 7 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1921, to Jan 7 1922
that I last saw him alive on Jan 6 1922
and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:
Cancer of Stomach

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) William J. Weese M. D.

1078 1922 (Address) Ontario Ore

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Under the Lida DATE OF BURIAL Jan 7 1922

20. UNDERTAKER W. Vecker ADDRESS Payette Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36638

Registered No.

1. PLACE OF DEATH

County of PayetteCity of Payette R 7th

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

St.)

2. FULL NAME

Luey Lenoir Marland

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Jan 24 1904
(Month) (Day) (Year)

7. AGE

18 Yrs. 11 Mos. 10 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Dayton Ohio

10. NAME OF FATHER

Jas Francis Marland

11. BIRTHPLACE OF FATHER

(State or Country)

Louis Tenn

12. MAIDEN NAME OF MOTHER

Nile Lewis

13. BIRTHPLACE OF MOTHER

(State or Country)

Knoxville Tenn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Jas Francis Marland
(Address) Payette Idaho R 7th

15.

Filed Jan 16 - 1922 66 Payton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

January 14 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Jan 13 1922 to Jan 14 1922
that I last saw her alive on Jan 14 1922
and that death occurred on the date stated above, at 12 M.
The CAUSE OF DEATH* was as follows:Lobar Pneumonia(Duration) ✓ Yrs. ✓ mos. 7 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J C Bartlett M. D.1/14 1922 (Address) Ontario Oregon

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Ontario Oregon Jan 16 1922

20. UNDERTAKER

ADDRESS

McDonald Co Inc Ontario Oregon
By J H Adams

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **36659**
Registered No.

1. PLACE OF DEATH

County of Twin Falls
City of Twin Falls

If death occurs away from
usual residence, give facts
called for under special in-
formation.

Registration District No. 37
Primary Registration District No. 1083
(No. County Hospital St.)

2. FULL NAME

Anna B Hunter

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Female white Married
(Write the word.)

6. DATE OF BIRTH

Oct 20 1
(Month) (Day) (Year)

7. AGE

47 Yrs. 2 Mos. 20 ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer).

House wife

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

W Patrick

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Moncey Brunson

13. BIRTHPLACE OF MOTHER

(State or Country)

Ind

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) D. W. Hunter

(Address) Twin Falls

15. Jan. 12 - 1922 John S. Laughlin
Filed Jan. 12 - 1922 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 10 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1/5 1922 to 1/10 1922
that I last saw him alive on 1/10 1922
and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Appendicitis

(Duration) 7 Yrs. mos. ds.

Contributory
(Secondary)

(Duration) mos. ds.

(Signed) E. D. Weaver M. D.

19..... (Address) Twin Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Twin Falls Ida 1-12-1922

20. UNDERTAKER

ADDRESS

E. D. Weaver Twin Falls

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **36661**
Registered No.

1. PLACE OF DEATH

County of *Idaho*
City of *Twin Falls*

Registration District No. *37*

Primary Registration District No. *2085*

(No. *OP* St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Joseph W. Winkington

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*

6. DATE OF BIRTH

Oct 21 1849
(Month) (Day) (Year)

7. AGE

72 Yrs. *2* Mos. *19* ds.
IF LESS than 1 day how many..... hrs. or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

Rancher

9. BIRTHPLACE

(State or Country)

Idaho of Wagon

10. NAME OF FATHER

Thomas Winkington

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Rachel Archibald

13. BIRTHPLACE OF MOTHER

(State or Country)

Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ada Winkington

(Address)

Twin Falls

15.

Filed *Jan. 3- 1922*

John T. Langley

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 3 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

February 1921 to *January 3 1922*
that I last saw him alive on *January 3 1922*
and that death occurred on the date stated above, at *5:45 P.M.*

The CAUSE OF DEATH* was as follows:

Haemorrhage

(Duration) *3* Yrs. mos. ds.
Contributory (Secondary) *Myocarditis, Stated Pneumonia*

(Duration) *10* mos. ds.
(Signed) *John T. Langley, D.*

(Address) *Twin Falls, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cambridge, Nebraska

19

20. UNDERTAKER

J. E. Davis

ADDRESS

Twin Falls

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Twin Falls* Registration District No. *38*
City of *Twin Falls* Primary Registration District No. *2086*
(No. *192* St.)File No. *36663*

Registered No. _____

If death occurred from
usual residence, facts
called for upon special in-
formation.BUREAU
STATIf death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.2. FULL NAME *Hazel Marie Reichert*

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED*Female* *White* *Single*
(Write the word.)

6. DATE OF BIRTH

Sept *29* *1922*
(Month) (Day) (Year)

7. AGE

0 Yrs. *3* Mos. *28* ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)*Infant*

9. BIRTHPLACE

(State or Country)

*Twin Falls County*10. NAME OF
FATHER*Charles Reichert*11. BIRTHPLACE
OF FATHER

(State or Country)

*Iowa*12. MAIDEN NAME
OF MOTHER*Rena Lancaster*13. BIRTHPLACE
OF MOTHER

(State or Country)

Colo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Chas. Reichert

(Address)

Filer T. F. D. #2

15.

Filed

Jan 27 *19**A. A. Newberry*

Local Registrar

16. DATE OF DEATH

Jan *27* *1922*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 24 *1922* to *Jan 27* *1922*
that I last saw *her* alive on *Jan 26* *1922*
and that death occurred on the date stated above, at *2:50 PM*.

The CAUSE OF DEATH* was as follows:

Hemorrhagic Purpura(Duration) *0* Yrs. *0* mos. *21* ds.Contributory *Malnutrition*
(Secondary)(Duration) *0* yrs. *2* mos. *0* ds.(Signed) *E. R. Van Cott* M. D.*1-27-22* (Address) *Twin Falls**State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)At place of death *0* yrs. *3* mos. *28* days. In the State *0* yrs. *3* mos. *28* daysWhere was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Filer**1-27-22*

20. UNDERTAKER

ADDRESS

J. E. Drake Silet

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH
in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH RECEIVED
County of Payson Registration District No. 38
City of Filer Primary Registration District No. 2086
(No. _____ St.)

File No. 36664
Registered No. _____

If death occurs away from
usual residence, give facts
called for under special in-
formation.

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH

Oct 14 1860
(Month) (Day) (Year)

7. AGE

62 Yrs. 3 Mos. 3 ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

farmer

9. BIRTHPLACE

(State or Country)

Belgium

10. NAME OF
FATHER

J. Ruzsone

11. BIRTHPLACE
OF FATHER

(State or Country)

Belgium

12. MAIDEN NAME
OF MOTHER

Adela Ruzil

13. BIRTHPLACE
OF MOTHER

(State or Country)

Belgium

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Mary J. Ruzsone
Filer

15. Jan 17 22 99 Newberry
Filed _____ 19 _____ Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

January 17 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan. 15 1922, to Jan. 17 1922
that I last saw h. live on Jan. 17, 1922.
and that death occurred on the date stated above, at 11:30 AM.
The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) 1 Yrs. 6 mos. _____ ds.

Contributory Toxin goitre
(Secondary)

unknown (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Hal Biele M. D.

Jan 18 1922 (Address) Twin Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place _____ In the
of death _____ yrs. _____ mos. _____ days. State _____ yrs. _____ mos. _____ days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Twin Falls Cemetery Jan 19 1922

20. UNDERTAKER ADDRESS

J. E. Ruzsone

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
MAXIMUM RESERVED FOR BINDING

B. - Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be fully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County

Registration District No.

Primary Registration District No.

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36665
Registered No.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH.

7. AGE

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) A. A. Newberry M. D.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the of death yrs. mos. days, State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. *8*
County of *Emmett* Primary Registration District No. *8*
City of *Emmett* (No. *10* St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Aroeta Hale Thompson*File No. *36670*

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *married*
(Write the word.)

6. DATE OF BIRTH

July 16 1903
(Month) (Day) (Year)

7. AGE

18 Yrs. *6* Mos. *17* ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).*Housewife*

9. BIRTHPLACE

(State or Country)

Wyoming

10. NAME OF FATHER

Fred A. Hale

11. BIRTHPLACE OF FATHER

(State or Country)

Nevada

12. MAIDEN NAME OF MOTHER

Eliza S. McComb

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Fred A. Hale

(Address)

New Plymouth, Ida.

15.

Filed *1/11* 19*22**C. H. Ryndale*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 3 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

29-Dec-1921, to *Jan 3 1922*that I last saw her alive on *Jan 3 1922*,
and that death occurred on the date stated above, at *11 P.M.*

The CAUSE OF DEATH* was as follows:

Scarlet Pneumonia

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. T. Ryndale M. D.*1-6-1922* (Address) *New Plymouth*

*State the Disease, Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Granville Idaho *1/6 1922*

20. UNDERTAKER

ADDRESS

C. H. Ryndale *Emmett Idaho*

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of AdaCity of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. 716 1/2 Main St.)

File No.

Registered No. 8

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles Bert. Dixon

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

Nov. 21, 1872
(Month) (Day) (Year)

7. AGE

49 Yrs. 2 Mos. 16 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

Carpenter

9. BIRTHPLACE

(State or Country)

Mo.

10. NAME OF FATHER

John Dixon

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Lucie Barth

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Dorothy B. Dixon

(Address)

Blackfoot, Idaho

15.

Filed

19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 7, 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 1, 1922 to Feb 7, 1922that I last saw him alive on Feb 6, 1922and that death occurred on the date stated above, at 9 M.

The CAUSE OF DEATH* was as follows:

Bright's Disease(Duration) 2 Yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

P. P. French M. D.24 19 22 (Address) 417 Overland Bldg Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Boise City, Montana Feb 12, 1922

20. UNDERTAKER

ADDRESS

Summers & Kubs Boise, Id

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

✓ CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 1410County of AdaPrimary Registration District No. 1City of Eagle

(No. _____ St.)

File No. 36672Registered No. 11

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Henry White

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

FemaleWhiteWidowed
(Write the word.)

6. DATE OF BIRTH.

June 25 1887
(Month) (Day) (Year)

7. AGE

84 Yrs. 6 Mos. 6 ds.

If LESS than 1 day
how many _____ hrs. or
_____ min.

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Tenn

10. NAME OF FATHER

John Broyles

11. BIRTHPLACE OF FATHER

(State or Country)

Tenn

12. MAIDEN NAME OF MOTHER

Mildred Howard

13. BIRTHPLACE OF MOTHER

(State or Country)

Tenn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Mrs Joseph Schuet
Eagle Ida

15.

Filed

Jan 31 1912

Drury John
Eagle Idaho

Local Registrar

16. DATE OF DEATH

January 30 1912
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 27 1912, to Jan 30 1912

that I last saw h&a alive on Jan 29 1912

and that death occurred on the date stated above, at 8:00 A.M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia(Duration) ✓ Yrs. ✓ mos. 4 ds.

Contributory (Secondary)

Smoking(Duration) ✓ yrs. ✓ mos. ✓ ds.(Signed) Geo. W. H. Hall M. D.

Jan 30 1912 (Address) Eagle Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Moss HillJan 31 1912

20. UNDERTAKER

ADDRESS

Sumner BethBarnes Idaho

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Ada.City of Boise.

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

No. 1619 No 26. St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36675Registered No. 36

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED
MAR 6 1928
BUREAU OF VITAL STATISTICS

2. MAR 6 1928

PERSONAL AND PARTICULARS

3. SEX F. 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married

6. DATE OF BIRTH Aug 28 1882

7. AGE 68 Yrs. 5 Mos. 27 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work at Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE

(State or Country) Ohio.

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country) Ohio.

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country) Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Bessie Downey Thomas

(Address)

15.

Filed 2-28 19 28

Local Registrar

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 27 19 28
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 27 1928 to Feb 27 1928
that I last saw him alive on Feb 27 1928

and that death occurred on the date stated above, at 7:30 M.

The CAUSE OF DEATH was as follows:

Dilatation of heart.

(Duration) Yrs. mos. ds.

Contributory (Secondary) Valvular lesions of aorta

Signatures (Duration) Yrs. mos. ds.

(Signed) John Back M. D.218 12 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Morris Hill Cemetery

DATE OF BURIAL

Mar 1 1928

20. UNDERTAKER

Summer & Schels

ADDRESS

Boise Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH **RECEIVED**
 County of Adams Registration District No. _____
 City of Boise Primary Registration District No. _____
 (No. 1515 North 14th St.)

File No. 36674
 Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary G. Haines

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widow
 (Write the word.)

6. DATE OF BIRTH

Aug 18 1850
 (Month) (Day) (Year)

7. AGE

71 Yrs. 7 Mos. 8 ds.

IF LESS than 1 day
 how many _____ hrs.
 or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

House wife

9. BIRTHPLACE

(State or Country)

Clermont Co. Ohio

10. NAME OF FATHER

Stephen Goble

11. BIRTHPLACE OF FATHER

(State or Country)

Am.

12. MAIDEN NAME OF MOTHER

Alice Brown

13. BIRTHPLACE OF MOTHER

(State or Country)

Am.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Margaret H. McVety

(Address)

Boise

15.

Filed

2-28

19

22R. H. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb. 25 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 22 1922 to Feb 25 1922
 that I last saw him alive on Feb 25 1922
 and that death occurred on the date stated above, at 4 P. M.
 The CAUSE OF DEATH* was as follows:

Central Hemorrhage

(Duration) _____ Yrs. _____ mos. 3 ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

C. H. Parker

M. D.

19

(Address) McKenty Bldg. Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

Portland Ore.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Portland OregonMarch 5 1922

20. UNDERTAKER

ADDRESS

Schubert Widengren Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Ada Registration District No. 1022
 City of Boise BUREAU OF VITAL STATISTICS
Boise St. 305 N. 14th St.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ida Cora Munson

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36675Registered No. 54

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
 (Write the word.)

6. DATE OF BIRTH

Feb 21, 1868
 (Month) (Day) (Year)

7. AGE

54 Yrs. X Mos. 4 ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Housewife

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

Levi A. Heemer

11. BIRTHPLACE OF FATHER

(State or Country)

Canada

12. MAIDEN NAME OF MOTHER

Mary C. Young

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

W. M. Ratney
Boise Idaho

15.

Filed 2-25 1922

R. H. Strath
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 25 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-6- 1921, to 2-25- 1922
 that I last saw her alive on 2-25- 1922
 and that death occurred on the date stated above, at 1:30 P.

The CAUSE OF DEATH* was as follows:

Gremia

(Duration) Yrs. 3 mos. ds.

Contributory (Secondary)

Chronic nephritis

(Duration) 3 yrs. mos. ds.

(Signed)

D. P. Hepp

M. D.

2-25-1922 (Address) 402, Idaho Bldg.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho Hill Cemetery

2/26/22

20. UNDERTAKER

ADDRESS

W. M. Ratney Boise Idaho

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Ada Registration District No. 1822
 City of Bonanza Primary Registration District No. 440 State Idaho St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mortimer Sullivan

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 36676Registered No. 53

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED Single (Write the word.)

6. DATE OF BIRTH

? ? 1846
 (Month) (Day) (Year)

7. AGE

78

Yrs. Mos. ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

Retired Rancher

9. BIRTHPLACE

(State or Country)

Ireland

10. NAME OF FATHER

not obtainable

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Not obtainable

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Sister Dr. Hinton

(Address)

St. Alphonsus Hospital

15.

Filed 2-25 19 22

R. J. Riatt
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

2 24 19 22
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

2-24-1922 to 2-24-1922

that I last saw him alive on 2-24-1922

and that death occurred on the date stated above, at 11:45 P.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) Yrs. mos. 40 W. ds.

Contributory Arterio Sclerosis
 (Secondary)

(Duration) 2 yrs. mos. ds.

(Signed) D. P. Haggis M. D.

2425 19 22 (Address) 402 Idaho Bldg.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Johns Cemetery 2/27/1922

20. UNDERTAKER

ADDRESS

Schreiber Undertaking Parlor

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada Registration District No. 1
City of Boise Primary Registration District No. 410 State Idaho St.)File No. 38677Registered No. 12

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mrs. Cora C. Titus

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female White married
(Write the word.)

6. DATE OF BIRTH

July 13 1874
(Month) (Day) (Year)

7. AGE

48 Yrs. 7 Mos. 17 ds.
IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).housewife

9. BIRTHPLACE

(State or Country)

St. James, Missouri

10. NAME OF FATHER

J. W. Skyles

11. BIRTHPLACE OF FATHER

(State or Country)

Tenn.

12. MAIDEN NAME OF MOTHER

Bessie Callier

13. BIRTHPLACE OF MOTHER

(State or Country)

Ky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Charles W. Titus

(Address)

Weiser, Idaho

15.

Filed

2-25 1922P. L. East
Local Registrar

16. DATE OF DEATH

2-24 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from 2-22 1922 to 2-24 1922that I last saw her alive on 2-24 1922and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

General Debris(Duration) Yrs. 1 1/2 mos. ds.
Contributory (Secondary) Pharyngitis(Duration) Yrs. several mos. ds.
(Signed) W. S. Titus M. D.2-25 1922 (Address) Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death... yrs... mos... days. In the State... yrs... mos... days

Where was disease contracted if not at place of death?

Former or usual residence

Fairfield Ida

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery2/27 1922

20. UNDERTAKER

ADDRESS

Schreiber & Hidenfaden Boise

Titus

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada Registration District No. _____
City of Near Boardman Soldiers Home St. _____
BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

David EarhartFile No. 36678

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

M White Widower
(Write the word.)

6. DATE OF BIRTH

1832
(Month) (Day) (Year)

7. AGE

90 Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

Veteran Civil War

9. BIRTHPLACE

(State or Country)

Tennessee

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Clyde E. Summers
Boise, Idaho

15.

Filed

19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 24 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 1919 1919 to Feb 24 1922
that I last saw him alive on Feb 22 1922and that death occurred on the date stated above, at 79 M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Frank A. Hume D.
Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Boise, Idaho Feb 26 1922

20. UNDERTAKER

ADDRESS

Summers & Krebs Boise, IdahoMARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

Boise Ld.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Idaho Registration District No. _____
 City of Boise Primary Registration District No. _____
 (No. 410 State _____ St.)

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

John Hunt

File No. 36680
 Registered No. _____

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED single

6. DATE OF BIRTH

1859 1 (Month) (Day) (Year)

7. AGE

63 yrs. Mos. ____ ds. IF LESS than 1 day
how many ____ hrs.
or ____ min. ?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Unknown

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Clyde E. Summers

(Address)

Boise, Idaho

15.

Filed

2-1-221922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

February 22 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Dec 2nd 1921, to Feb - 22 1922,
that I last saw him alive on Feb 21 1922,
and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Emaciated Abscess at foot, like
liver, causing general peritonitis
Emaciated Abscess in colon,

(Duration) Yrs. 2 mos. 18 ds.Contributory
(Secondary)Emaciated Abscess(Duration) 23 yrs. ____ m. ____ ds.

(Signed)

L. P. McCulloch M. D.2-7-1922 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days. In the ____ State ____ yrs. ____ mos. ____ days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery Feb 23 1922

20. UNDERTAKER

ADDRESS

Summers & Weber Boise Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Adair* Registration District No. _____
City of *Bainbridge* Primary Registration District No. *410 State* St. _____

If death occurs away from usual residence, give facts called for under special information.

File No. *36689*
Registered No. *25*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Sarah Olive King

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *F.* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*
(Write the word.)6. DATE OF BIRTH *Dec 28th 1860*
(Month) (Day) (Year)7. AGE *61* Yrs. *1* Mos. *23* ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)*Housekeeper*

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

Daniel Fisher

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Mary Ann Danner

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mrs Geo F. Nelson*
(Address) *Kuma, Ida.*15. Filed *19* Local Registrar *H. Pratt*
Dr. Pittenger

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51088

16. DATE OF DEATH

Feb 21st 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

2/20 1922 to 2/21 1922
that I last saw her alive on *2/21 1922*
and that death occurred on the date stated above, at *11 A.M.*
The CAUSE OF DEATH* was as follows:*Shock*

(Duration) Yrs. mos. ds.

Contributory (Secondary) *operation for Gall**stones* (Duration) yrs. mos. ds.(Signed) *Al Pittenger* M. D.*7/21 1922* (Address) *Bainbridge*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence *Kuma, Idaho.*

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Morris Hill Cemetery 2/25/22

20. UNDERTAKER ADDRESS

Schreiber & Widemeyer (Boir)

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Ada
City of Boise

If death occurs away from usual residence, give facts called for under special information.

RECEIVED

MAR 6 1922

BUREAU OF VITAL STATISTICS

Registration District No.

Primary Registration District No.

(No. 332)

St.)

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36682Registered No. 47

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Whalen, Buck, Spencer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

(Write the word.)

6. DATE OF BIRTH

Feb 20 1922
(Month) (Day) (Year)

7. AGE

Yrs. 2 Mos. 2 ds.

If LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

None

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Boise Idaho

10. NAME OF FATHER

M. N. Spencer

11. BIRTHPLACE OF FATHER

(State or Country)

Colorado

12. MAIDEN NAME OF MOTHER

Amanda Thompson

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. H. Spencer

(Address)

552 15th

15.

Filed 2-23 1922

R. H. Pratt
Local Registrar

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 21 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 20 1922, to Feb 21 1922
that I last saw him alive on Feb 21 1922
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Diabetes due to
Premature birth

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

John Back M. D.Feb 21 1922 (Address) Boise Id

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery Feb 23 22

20. UNDERTAKER

ADDRESS

Summers & Krebs Boise Id

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada Registration District No. _____
City of Boise Primary Registration District No. _____
(No. Quedens Home St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Edwin SmithFile No. 36683
Registered No. 12

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M White

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widower

6. DATE OF BIRTH

1845 1 (Month) (Day) (Year)

7. AGE

77 Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

Veteran Civil War

9. BIRTHPLACE

(State or Country)

Unknown

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Chas E Summers

(Address)

Boise Idaho

15.

Filed

2-23-22 P. H. Rao

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 21 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
Jan 2 1922 to Feb 21 1922that I last saw him alive on Feb 20 1922and that death occurred on the date stated above, at 1 A M.

The CAUSE OF DEATH* was as follows:

Splenic Leukemia

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

Fred A. Pungler M. D.2/22 1922 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery Feb 22 1922

20. UNDERTAKER

ADDRESS

Summers & Krebs Boise Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No.

Secondary Registration District No.

(No. St. Luke's Hospital St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

2-18

1922

P. H. R. R.
Local Registrar

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

Coronary Atherosclerosis
Following Operation for
Chronic Pancreatitis

(Duration) Yrs. mos. ds.

Contributory (Secondary) Chronic Pancreatitis

(Duration) Yrs. mos. ds.

(Signed) J. M. D.

2/17/22 (Address) Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cem

Feb 17, 1922

20. UNDERTAKER

ADDRESS

Summers & Co

Boise, Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **36685**
Registered No. **4**

1. PLACE OF DEATH

County of

Ada

City of

Boise

Registration District No.

Primary Registration District No.

(No. *907*)*Ada*

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Thomas Myers

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Sept
(Month)

(Day)

1872
(Year)

7. AGE

49 Yrs.*5* Mos.

ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Virginia

10. NAME OF FATHER

Mr Myers

11. BIRTHPLACE OF FATHER

(State or Country)

Am.

12. MAIDEN NAME OF MOTHER

Not obtainable

13. BIRTHPLACE OF MOTHER

(State or Country)

Am.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Virgil F. Ghormley

(Address)

907 Ada

15.

Filed

19

Local Registrar

16. DATE OF DEATH

Feb
(Month)*13*
(Day)*1922*
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

*2-13**1922*

to

*2-13**1922*that I last saw him alive on *2-13* *1922*and that death occurred on the date stated above, at *8 P.M.*

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration)

Yrs.

mos.

1 ds.Contributory
(Secondary)*Arterio Sclerosis*

(Duration)

5 yrs.

mos.

ds.

(Signed)

D. P. Hagg

M. D.

2-13-1922

(Address)

Boise, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

yrs.

mos.

days.

In the

State

yrs.

mos.

days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Morris Hill Cemetery**2/19/1922*

20. UNDERTAKER

ADDRESS

*Hagg**Boise*

FORM V. S. No. 1-28 M. 1-19

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH

Boise

Boise

City of

Boise

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

George W. Eagle

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widower

6. DATE OF BIRTH

Feb 22

1835

7. AGE

86 Yrs 11 Mos 23 ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Tennessee

10. NAME OF FATHER

Charles Eagle

11. BIRTHPLACE OF FATHER

(State or Country) Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address) Rhoda G. Coberly

15. Filed

2-18 1922

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

State of Idaho

BOARD OF HEALTH

Bureau of Vital Statistics

File No. 366

Registered No. 73

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 16 1922

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 4 1922 to Feb 16 1922

that I last saw him alive on Feb 16 1922

and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

fractured rib

(Duration) Yrs. mos. ds.

Contributory Pneumonia

(Secondary)

(Duration) yrs. mos. 7 ds.

(Signed) H. M. Hobson M. D.

4/17 1922, (Address) 517 Empire B Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Buried in Hill View

DATE OF BURIAL

Feb 18 1922

20. UNDERTAKER

Summers & Co. Boise Ida

ADDRESS

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **36687**Registered No. **42**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH **Idaho**
County of **Boise**
City of **Boise**
Registration District No. _____
Primary Registration District No. _____
(No. **2418 Pleasanton** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Alice E. Pfister**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **F.** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Single**
(Write the word.)6. DATE OF BIRTH **June 22** 19**18**
(Month) (Day) (Year)7. AGE **3** Yrs. **7** Mos. **15** ds.
IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work **None**
(b) General nature of industry, business or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country) **Washington**

10. NAME OF FATHER

Ralph Pfister

11. BIRTHPLACE OF FATHER

(State or Country) **Switzerland**

12. MAIDEN NAME OF MOTHER

Mina R. Wood

13. BIRTHPLACE OF MOTHER

(State or Country) **Minnesota**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Alice Pfister**
(Address) **Boise Id.**

15.

Filed **2-18** 19**22** **G. H. Pratt**
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 16 19**22**
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I **saw** deceased **from** **Feb 16, 1922** to **19**that I last saw her alive on **dead Feb 16, 1922**and that death occurred on the date stated above, at **11 A.M.**

The CAUSE OF DEATH* was as follows:

Pneumonia(Duration) _____ Yrs. _____ mos. _____ ds.
Contributory **Sick only few hours**
(Secondary)(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) **Clayde E. Summers** Coroner**7/16** 19**22** (Address) **Boise Idaho** **Idaho** County

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL **Morris Dies Cemetery** DATE OF BURIAL **Feb 18, 1922**20. UNDERTAKER **Summers & Kraf** ADDRESS **Boise Id.**

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada Registration District No. _____
City of Boise Primary Registration District No. _____
(No. 410 State _____ St.)

File No. 36688Registered No. 11

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Anna Harla

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F.

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

July 24th 1891
(Month) (Day) (Year)

7. AGE

30 Yrs. 6 Mos. 21 ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

housekeeper
and Geo. Treasurer
of Valley Co. Ida.

9. BIRTHPLACE

(State or Country)

Oregon

10. NAME OF FATHER

John Harla

11. BIRTHPLACE OF FATHER

(State or Country)

Finland

12. MAIDEN NAME OF MOTHER

Anna Johnson

13. BIRTHPLACE OF MOTHER

(State or Country)

Finland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs Helen Pitts,

(Address)

Butte, Mont.

15.

Filed

2 18 1922

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Dr. Stewart

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 15th 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 8 1922 to Feb 15 1922
that I last saw him alive on Feb 15 1922
and that death occurred on the date stated above, at 3:30 P.M.

The CAUSE OF DEATH* was as follows:

Post-operative tuberculin
fever.
Removal of ovary and
ovarian cyst.
(Duration) 7 yrs. 3 mos. 3 ds.
Contributory (Secondary) James H. Stewart
(Duration) 7 yrs. 3 mos. 3 ds.
(Signed) James H. Stewart M. D.
(Address) 132 N. 1st St.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

Rosebury, Idaho.

19. PLACE OF BURIAL OR REMOVAL

Rosebury, Idaho

DATE OF BURIAL

2/17/1922

20. UNDERTAKER

Schreiber & Shidenfader (Boise)

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Ada*City of *Boise*

If death occurs away from usual residence, give facts called for under special information.

RECEIVED

Registration District No. _____

Primary Registration District No. _____

State of *Idaho*

File No. _____

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Anna Skvor

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female White

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

April 20 1881
(Month) (Day) (Year)

7. AGE

40 Yrs. *9* Mos. *26* ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Town

10. NAME OF FATHER

Not obtainable

11. BIRTHPLACE OF FATHER

(State or Country)

Prag Bohemia

12. MAIDEN NAME OF MOTHER

Not obtainable

13. BIRTHPLACE OF MOTHER

(State or Country)

Bohemia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Geo J Skvor

(Address)

1817 Mannock

15.

Filed

*2 18**1922**P. H. Hall*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 16 19 *22*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1 - 1 19 *22*, to *2 - 16* 19 *22*,that I last saw her alive on *2 16* 19 *22*,and that death occurred on the date stated above, at *11 AM*.

The CAUSE OF DEATH* was as follows:

Cancer of intestine(Duration) _____ Yrs. *6* mos. _____ ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) *S. P. Higgs* M. D.*2-16 1922* (Address) *407 Idaho Bldg.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

Boise, Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*St. Johns Cemetery**2/19 1922*

20. UNDERTAKER

ADDRESS

*Schreibers Undertakers**Boise Idaho*

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36690
Registered No. 1

1. PLACE OF DEATH
County of Ada Registration District No. WAI
City of Boise Primary Registration District No. St
City No. 1106 Vermont St (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary J. Pearce

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH Dec, 30 1844
(Month) (Day) (Year)

7. AGE 77 Yrs. 1 Mos. 10 ds.
IF LESS than 1 day how many... hrs. or... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE St Louis, Mo.
(State or Country)

10. NAME OF FATHER John J. Johns.

11. BIRTHPLACE OF FATHER Virginia
(State or Country)

12. MAIDEN NAME OF MOTHER Don't know

13. BIRTHPLACE OF MOTHER VA
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm Bratney
(Address) Boise Idaho

15. Filed Jan 3 1922
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 10 - 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 16 1921, to Feb. 10, 1922
that I last saw her alive on Feb. 10, 1922
and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:
Angina Pectoris

(Duration) 7 yrs. — mos. — ds.
Contributory (Secondary) Half doses
(Duration) 7 yrs. — mos. — ds.
(Signed) Joseph M. Davis M. D.
713 1922 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death... yrs... mos... days. In the State... yrs... mos... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Morris Hill Cemetery DATE OF BURIAL 7/12 1922
20. UNDERTAKER Wm Bratney ADDRESS Boise Idaho

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada
City of BoiseRegistration District No. _____
Primary Registration District No. _____
St. Luke's Hospital (St.)File No. 36691
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

A. H. Hand.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH

Nov 17 - 1854
(Month) (Day) (Year)

7. AGE

67 Yrs. 2 Mos. 20 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Farmer

9. BIRTHPLACE

(State or Country)

Georgia

10. NAME OF FATHER

Don't know

11. BIRTHPLACE OF FATHER

(State or Country)

?

12. MAIDEN NAME OF MOTHER

?

13. BIRTHPLACE OF MOTHER

(State or Country)

?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. McBratney

(Address)

Boise, Idaho

15.

Filed 1 1922

Local Registrar

16. DATE OF DEATH

Feb - 7 - 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1-27 1922 to 2-7 1922
that I last saw him alive on 2-7 1922
and that death occurred on the date stated above, at P. M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

2/8/22

(Address)

R. H. Green, M. D.
Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Morm Hill Cemetery

DATE OF BURIAL

2/9/22

20. UNDERTAKER

W. McBratney

ADDRESS

Boise Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada
City of Boise

Registration District No.

Primary Registration District No.

(No. 13th & River Sts St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Wayne H. Smit

File No.

Registered No. 36

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-OWED OR DIVORCED

M. W. Single
(Write the word.)

6. DATE OF BIRTH

June 20-1907
(Month) (Day) (Year)

7. AGE

14 Yrs. 7 Mos. 15 ds.If LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)In school

9. BIRTHPLACE

(State or Country)

Georgetown Idaho

10. NAME OF FATHER

Wm J. Smit

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Alice M. Sorenson

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wm J. Smit

(Address)

Boise, Idaho

15.

Filed 2-6 19 22W. H. Smit
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 5-1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 19²¹ to Feb 5-1922
that I last saw h. in alive on Feb 5-1922
and that death occurred on the date stated above, at 5³¹ PM

The CAUSE OF DEATH* was as follows:

Acute Embolus corditis(Duration) 6 Yrs. mos. ds.Contributory
(Secondary)Genese aneurysm(Duration) — yrs. mos. ds.

(Signed)

J. Sorenson M. D.7/6 1922 (Address) Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Morris Hill Cemetery

DATE OF BURIAL

7/7/22 19

20. UNDERTAKER

Wm J. Smit

ADDRESS

Boise Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH
in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH MAR 6 1922

Registration District No.

County of Ada

BUREAU OF VITAL

Primary Registration District No.

City of Boise(No. St. Alphonsus Hosp. St.)

File No.

Registered No. 33

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME Stephen C. Calkins

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX M4. COLOR OR RACE White5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDWidower
(Write the word.)

6. DATE OF BIRTH

Mar17

(Month)

(Day)

1892

(Year)

7. AGE

29 Yrs.8 Mos.22 ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of workMiner.(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country)

Illinois10. NAME OF
FATHERHugh Calkins.11. BIRTHPLACE
OF FATHER

(State or Country)

Unknown.12. MAIDEN NAME
OF MOTHERRuth Crawford.13. BIRTHPLACE
OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles H. Calkins(Address) Miner Idaho

15.

Filed 41922Local Registrar J. H. Hunt

16. DATE OF DEATH

Feb 4

(Month)

(Day)

1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 21 1922, to Feb 24 1922,that I last saw him alive on Feb 24 1922,and that death occurred on the date stated above, at 2:45 P.M.

The CAUSE OF DEATH* was as follows:

Uremia(Duration) Yrs. mos. 3 ds.Contributory
(Secondary)Arterio Sclerosis
and Paralysis(Duration) 5 yrs. mos. ds.

(Signed)

J. R. Summers M. D.44 1922 (Address) Boise Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death..... yrs. mos. In the..... days. State..... yrs. mos. days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Caldwell Idaho Feb 6 1922

20. UNDERTAKER

ADDRESS

Summers & Krebs Boise, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back

City of Boise (No. 100 So 25 St.) Registered No. 2
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME Dorothy S. Shelley.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX F. 4. COLOR OR RACE White. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single (ord.)
6. DATE OF BIRTH Jan 8 1920
(Month) (Day) (Year)
7. AGE 2 Yrs. 25 Mos. 25 ds.
IF LESS than 1 day how many 1 hrs. or 1 min.?
8. OCCUPATION None.
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).
9. BIRTHPLACE Idaho.
(State or Country)
10. NAME OF FATHER George Shelley.
11. BIRTHPLACE OF FATHER Idaho.
(State or Country)
12. MAIDEN NAME OF MOTHER Minnie Reddington
13. BIRTHPLACE OF MOTHER Idaho.
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) George Shelley
(Address) Boise Idaho.

15. Filed 19 X

16. DATE OF DEATH Feb 2 1922
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Jan 21 1922 to Feb 2 1922, that I last saw her alive on Feb 2 1922, and that death occurred on the date stated above, at 3 P. M.
The CAUSE OF DEATH was as follows:

Influenza
(Duration) 1 Yrs. 4 mos. 4 ds.
Contributory (Secondary) Pneumonia
(Duration) 3 yrs. 3 mos. 3 ds.
(Signed) W. H. H. H. H. M. D.
1/4 1922 (Address) Boise Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 1 yrs. 4 mos. 4 days. In the State 1 yrs. 4 mos. 4 days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Morris Hill Cem DATE OF BURIAL Feb 4 1922

20. UNDERTAKER Sumner Stib ADDRESS Boise Ida.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada Registration District No. _____
City of Boise Primary Registration District No. _____
(No. 1611 n. 7) (St.) _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William E Hanna

File No. 36697
Registered No. 51

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH June 11 1855
(Month) (Day) (Year)

7. AGE 66.7 Yrs. 21 Mos. 21 ds.
IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Blacksmith

9. BIRTHPLACE

(State or Country)

Oregon

10. NAME OF FATHER

James Hanna

11. BIRTHPLACE OF FATHER

(State or Country)

Mo

12. MAIDEN NAME OF MOTHER

May Fleming

13. BIRTHPLACE OF MOTHER

(State or Country)

Wis

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

James E Hanna
Boise Idaho

15.

Filed

3

19.2

W. N. P. Smith
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

February 2nd 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 26 1922 to February 2 1922, that I last saw him alive on Feb 2 1922, and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

myocarditis Die in an
attack of Angina pectoris

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

L. P. McCall M. D.

4/3 1922 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Morris Hill Cemetery

DATE OF BURIAL

Feb. 5 1922

20. UNDERTAKER

Summers & Tuck

ADDRESS

Boise Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada Registration District No. 1
City of Boise Primary Registration District No. 1
City of Boise Idaho County Hospital St. (No.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Sampson NollFile No. 36699
Registered No. 16

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widower
(Write the word.)6. DATE OF BIRTH — — 1830
(Month) (Day) (Year)7. AGE 91 Yrs. # Mos. # ds. IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)None

9. BIRTHPLACE

(State or Country)

Unknown

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

W. McBratney
Boise, Idaho

15.

Filed 2-7 1922 R. H. Rath
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb - 5 - 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Jan 15 1919, to Feb 5 1922
that I last saw him alive on Feb 4 1922
and that death occurred on the date stated above, at 5:15 PM.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis & Chronic
nephritis(Duration) 3 Yrs. — mos. — ds.Contributory Uræmia
(Secondary)(Duration) — yrs. 3 mos. — ds.

(Signed)

J. H. Brantley

M. D.

7/6/22 (Address) Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death — yrs. — mos. — days In the State — yrs. — mos. — days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

County Cemetery

DATE OF BURIAL

7/8/22 1922

20. UNDERTAKER

W. McBratney

ADDRESS

Boise
Idaho

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH
in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
36700

1. PLACE OF DEATH Idaho Registration District No. _____
County of _____ Primary Registration District No. _____
City of _____ (No. 7 miles west of Boise St.)

File No. _____
Registered No. 22

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ether B Eyerly

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX F. 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Married

6. DATE OF BIRTH Oct 8
(Month) (Day) (Year)

7. AGE 29 Yrs. 4 Mos. 19 ds. IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work At Home
(b) General nature of industry, business or establishment in which employed (or employer) _____

9. BIRTHPLACE Iowa
(State or Country)

10. NAME OF FATHER Frank B Brock

11. BIRTHPLACE OF FATHER Iowa
(State or Country)

12. MAIDEN NAME OF MOTHER Ladie Ragon

13. BIRTHPLACE OF MOTHER Iowa
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fred Eyerly
(Address) _____

15. Filed 2-28 1922 R. H. Pratt
Local Registrar

16. DATE OF DEATH Feb 27 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 21 1922 to Feb 27 1922
that I last saw h. u alive on Feb 27 1922
and that death occurred on the date stated above, at 10:45 A.M.

The CAUSE OF DEATH* was as follows:
Flu

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory (Secondary) _____

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) John Bouck M. D.

Feb 28 1922 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Moore Hill Cem. DATE OF BURIAL Mar. 1 1922

20. UNDERTAKER Summers & Sons ADDRESS Boise Idaho

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAR 6 1922
PLACE OF DEATH
County of Ada BUREAU OF VITAL STATISTICS
City of No. 3 mi south of Boise St.)
Registration District No. _____
Primary Registration District No. _____
If death occurs away from usual residence, give facts called for under special information.

BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36701
Registered No. _____
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Carl O. Nelson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE White. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single (the word.)
6. DATE OF BIRTH Oct 3 (Month) (Day) (Year)
7. AGE 13 Yrs. 4 Mos. 9 ds. IF LESS than 1 day how many hrs. or min.?
8. OCCUPATION (a) Trade, profession or particular kind of work Student (b) General nature of industry, business or establishment in which employed (or employer) _____
9. BIRTHPLACE (State or Country) Idaho
10. NAME OF FATHER Charles A. Nelson
11. BIRTHPLACE OF FATHER (State or Country) Sweden
12. MAIDEN NAME OF MOTHER Anna Olsen
13. BIRTHPLACE OF MOTHER (State or Country) Sweden
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Charles A. Nelson (Address) _____

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 12 1922 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Jan 18 1922 to Feb 11 1922 that I last saw him alive on Feb 11 1922 and that death occurred on the date stated above, at 12:30 A. M.
The CAUSE OF DEATH* was as follows:
Splenic Leukemia
(Duration) _____ Yrs. _____ mos. _____ ds.
Contributory (Secondary) _____ (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) Fred T. Tuttle M. D. 2/14 1922 (Address) Boise
*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.
18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days
Where was disease contracted if not at place of death? _____
Former or usual residence _____
19. PLACE OF BURIAL OR REMOVAL Morris Ailes Cemetery DATE OF BURIAL Feb 15 1922
20. UNDERTAKER Summers & Co. ADDRESS Boise Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Bannock*Registration District No. *28*City of *Pocatello*Primary Registration District No. *2161*File No. *36780*Registered No. *3732*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Judge Felix Van Rente
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male *White* *Married*
(Write the word.)

6. DATE OF BIRTH

Jan 9th 1844
(Month) (Day) (Year)

7. AGE

*76 yrs. 11 Mos. 22 ds.*IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).*Retired Justice of the Peace*

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Felix Van Rente

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Catherine G. Vanderhaar

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Felix Van Rente
(Address) *136 S. 3rd St.*

15. Filed

1/3 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 1st 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 11 1921 to Jan 1 1922
that I last saw him alive on *Jan 1 1922*
and that death occurred on the date stated above, at *12:00 P.M.*

The CAUSE OF DEATH* was as follows:

Carcinoma of Sigmoid flexure of colon (rectum)(Duration) *1 Yrs. 2 mos. ds.*

Contributory (Secondary)

None(Duration) *1 Yrs. 2 mos. ds.*

(Signed)

H. D. Castle M. D.
1/2/22 (Address) *Longmont, Colo.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Poplar Hill Burial *Jan 3 1922*

20. UNDERTAKER

ADDRESS

Chumack Hall Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH **RECEIVED** ✓ CERTIFICATE OF DEATH
 County of **Bannock** Registration District No. **28**
 City of **POCATELLO, IDAHO** Primary Registration District No. **2161**
 (No. **300 So Hayes** St.)

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. **486709**
 Registered No. **3738**

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Flourance Rosabell Downey

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Married**

6. DATE OF BIRTH

November 9, 1861
 (Month) (Day) (Year)

7. AGE

60 Yrs. **1** Mos. **25** ds.

IF LESS than 1 day
 how many..... hrs.
 or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

house wife

9. BIRTHPLACE

(State or Country) **Utah**

10. NAME OF FATHER

James W. Brown

11. BIRTHPLACE OF FATHER

(State or Country) **Tennessee**

12. MAIDEN NAME OF MOTHER

Anna Raper

13. BIRTHPLACE OF MOTHER

(State or Country) **Kentucky**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. James S. Orr

(Address) **POCATELLO, IDAHO**

15.

Filed **Jan 4 1921**

J. Young
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 4 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 3 1922, to **Jan 3 1922**

that I last saw him alive on **Jan 3 1922**

and that death occurred on the date stated above, at **3:30 A.M.**

The CAUSE OF DEATH* was as follows:

Carcinoma of breast

(Duration) **2** Yrs. mos. ds.

Contributory
 (Secondary)

(Duration) yrs. mos. ds.

(Signed)

Ann. Newton

Jan 4 1922 (Address) **Pocatello Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

Salt Lake City, Utah

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Ogden, Utah

Jan 5 1922

20. UNDERTAKER

ADDRESS

H. L. McHAN

POCATELLO, IDAHO

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County *Blaine*
City *Basement*

Registration District No. _____

Primary Registration District No. _____

If death occurs away from usual residence, give facts called for under special information.

BUREAU

2. FULL NAME

William H. Smith

File No. _____

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male *White* *Widowed*
(Write the word.)

6. DATE OF BIRTH

Jan 23rd 1882
(Month) (Day) (Year)

7. AGE

39 Yrs. *11* Mos. *11* ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)*Load water maker*

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Henry Smith

11. BIRTHPLACE OF FATHER

(State or Country)

unknown

12. MAIDEN NAME OF MOTHER

Mary A. Goddard

13. BIRTHPLACE OF MOTHER

(State or Country)

Mass-

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wm. H. Smith

(Address)

Open street

15.

Filed

15 *1922*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 4th 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 27 *1922* to *Jan 4th 1922*
that I last saw him alive on *Jan 3rd 1922*
and that death occurred on the date stated above, at *5¹⁵ a.m.*

The CAUSE OF DEATH* was as follows:

Mesenteric Obstruction(Duration) Yrs. *1* Mos. *12* ds.Contributory
(Secondary)*Ch. Interstinal Reptn.*(Duration) Yrs. *4* Mos. *4* ds.

(Signed)

Wm. F. Mullen M. D.*15* *1922* (Address) *Row Bldg.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mountain View *Jan 6 1922*

20. UNDERTAKER

ADDRESS

Chumacher & Sons *Basement*

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

K CERTIFICATE OF DEATH

1. PLACE OF DEATH POCATELLO, IDAHO Registration District No. 28
County of Bannock Primary Registration District No. 2161
City of POCATELLO, IDAHO STATISTICAL No. 639 West Lewis St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hong Kee

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 436711
Registered No. 3737

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE Chinese 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Married

6. DATE OF BIRTH

August 7 1869
(Month) (Da.) (Year)

7. AGE

52 Yrs. 4 Mos. 29 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Proprietor of U.S. Cafe

9. BIRTHPLACE

(State or Country)

China

10. NAME OF FATHER

Yee Tiway

11. BIRTHPLACE OF FATHER

(State or Country)

China

12. MAIDEN NAME OF MOTHER

Chen Shee

13. BIRTHPLACE OF MOTHER

(State or Country)

China

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

George Kee (son)(Address) POCATELLO, IDAHO

15.

Filed Jan 6 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan. 5 1922
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from Jan 5 1922 to Jan 5 1922
that I last saw him alive on Jan 5 1922
and that death occurred on the date stated above, at 3:30 P.
The CAUSE OF DEATH* was as follows:

Brain aneurysm and Myocarditis.
(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signature) W. B. Kearney M. D.19. ADDRESS) POCATELLO, IDAHO

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 40 yrs. mos. days. In the State 40 yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence China

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hong Kong China Jan 8 1922

20. UNDERTAKER

ADDRESS

H. L. McHANPOCATELLO, IDAHO

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No.

Registration District No.

28

2161

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED, OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from
Dec 20 1921, to Jan 7 1922
that I last saw him alive on Jan 7 1922
and that death occurred on the date stated above, 2 P. M.

The CAUSE OF DEATH* was as follows:

Cystitis

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

M. D.

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 28
County of Bannock Primary Registration District No. 2161
City of Pocatello (No. 221, N. Harrison St.)File No. 36713
Registered No. 8739

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

BUREAU OF VITAL STATISTICS

John E. Henshaw

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male white married

6. DATE OF BIRTH

Jan 27 1867
(Month) (Day) (Year)

7. AGE

54 Yrs. 11 Mos. 18 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

Master mechanic
R.R. Shops

9. BIRTHPLACE

(State or Country)

Michigan

10. NAME OF FATHER

John Henshaw

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Anne Hilton

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs John E. Henshaw
(Address) Pocatello, Idaho

15.

Filed Jan 9 1922 J. Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 9 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 1921 to Jan 9th 1922
that I last saw him alive on Jan 8th 1922
and that death occurred on the date stated above, at 3:50 AM

The CAUSE OF DEATH* was as follows:

Pulmonary edema(Duration) _____ Yrs. _____ mos. _____ ds.
Contributory (Secondary) Chronic interstitial nephritis
About(Duration) 5 yrs. _____ mos. _____ ds.
(Signed) W. A. Drury M. D.
1/9 1922 (Address) Pocatello, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 1 yrs. 6 mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence Missouri

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mt View Pocatello 1/9 1922

20. UNDERTAKER

ADDRESS

H. L. McHan Pocatello
Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Blaine*
City of *Gacater*

Registration District No. _____

Primary Registration District No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Evangelina White*File No. *88714*Registered No. *3740*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female *White* *Married*
(Write the words)

6. DATE OF BIRTH

June 15th 1902
(Month) (Day) (Year)

7. AGE

19 Yrs. 6 Mos. 36 ds.
IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)*Housewife*

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

David Rice

11. BIRTHPLACE OF FATHER

(State or Country)

unknown

12. MAIDEN NAME OF MOTHER

Smith

13. BIRTHPLACE OF MOTHER

(State or Country)

unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Virgil White

(Address)

616 N. Garfield

15.

Filed

1/11 1922

Local Registrar

16. DATE OF DEATH

Jan 11 1922
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from

*Jan 5 1922 to Jan 11 1922*that I last saw her alive on *Jan 11 1922*and that death occurred on the date stated above, at *12:15 M.*

The CAUSE OF DEATH* was as follows:

Lobar pneumonia(Duration) _____ Yrs. _____ mos. *5* ds.Contributory *Acute nephritis*

(Secondary)

(Duration) _____ yrs. *1* mos. _____ ds.(Signed) *Ass. Newton* M. D.*Jan 11 1922* (Address) *Boastella, Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho Falls Jan 13 1922

20. UNDERTAKER

ADDRESS

Chuncheon Hay City

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4736715
Registered No. 3741

1. PLACE OF DEATH

Registration District No. 28
County of Bannock
Primary Registration District No. 2161
City of Pocatello (No. Office Valentine Building St.)

If death occurs away from usual residence, give facts called for under special information.

BUREAU OF
STATISTICS

2. FULL NAME

H. Smith Woolley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH

Aug 6th 1874
(Month) (Day) (Year)

7. AGE

47 Yrs. 5 Mos. 2 ds. IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Physician & Surgeon
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Hawaiian Islands

10. NAME OF FATHER

Hyrum S. Woolley

11. BIRTHPLACE OF FATHER

(State or Country) Utah

12. MAIDEN NAME OF MOTHER

Minerva Marian Rich

13. BIRTHPLACE OF MOTHER

(State or Country) California

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jesse R. D. Budge
(Address) Pocatello, Idaho

15.

Filed 1/12 1922 Young
Local Registrar

16. DATE OF DEATH

Jan 8th 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

.....19....., to19.....
that I last saw h..... alive on19.....
and that death occurred on the date stated above, at.....M.

The CAUSE OF DEATH* was as follows:

Gun shot wounds in heart
(Duration)Yrs.mos.ds.

Contributory
(Secondary)

(Duration)yrs.mos.ds.

(Signed) J. S. Ferguson Coroner
Pocatello

1-12-1922 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.mos.days. In the State.....yrs.mos.days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Mountain View Cem Jan 12 1922

20. UNDERTAKER

Schumacher & Hall Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH

County of BannockCity of Pocatello

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED
FEB 8 - 1922
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 28Primary Registration District No. 2141(No. 1)(St. Idaho)State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 86716Registered No. 3742

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDChild
(Write the word.)

6. DATE OF BIRTH

October 12 1916
(Month) (Day) (Year)

7. AGE

5 Yrs. 3 Mos. - ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)At Home

9. BIRTHPLACE

(State or Country)

Salt Lake City Ut.

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

A. J. Peterson
Pleasant Grove, Ut.

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Lena Nelson
Spanish Fork, Ut.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. J. Peterson(Address) Pocatello, Ida.

15.

Filed 1/3 1922Local Registrar J. Young

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

January 12 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 3 1922 to Jan 12 1922
that I last saw him alive on Jan 12 1922
and that death occurred on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:

Acute Nephritis - with
albuminuria -(Duration) 0 Yrs. 0 mos. 9 ds.
Contributory (Secondary) Diphtheria(Duration) 0 yrs. 0 mos. 9 ds.
(Signed) J. F. Miller M. D.1/13/1922 (Address) Box 124 Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs mos days In the State yrs mos days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Spanish Fork, Ut. Jan 15 1922

20. UNDERTAKER

Schumacher & Ball Pocatello

ADDRESS

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

RECEIVED
FEB 8 - CERTIFICATE OF DEATH
BUREAU OF VITAL STATISTICS
Registration District No. 28
City of Pocatello
State of Idaho

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from
January 13, 1922, to January 13, 1922
that I last saw him alive on January 13, 1922
and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Premature birth

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Amy Newton M. D.

Jan 14 1922 (Address) Pocatello, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Registration District No.

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

19

22

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from
that I last saw h. alive on
and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

Jan. 14, 1922 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

36719

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of *Bannock* Registration District No.
City of *Pocatello* Primary Registration District No.
St. Anthony Hospital (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary Ellen Keating

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Infant
(Write the word.)

6. DATE OF BIRTH

January 7, 1922
(Month) (Day) (Year)

7. AGE

8 yrs. *8* mos. *8* ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).*Infant*

9. BIRTHPLACE

(State or Country) *Pocatello Ida.*

10. NAME OF FATHER

J. E. Keating

11. BIRTHPLACE OF FATHER

(State or Country) *So Dakota*

12. MAIDEN NAME OF MOTHER

Sarah Knable

13. BIRTHPLACE OF MOTHER

(State or Country) *Iowa*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. E. Keating

(Address)

Pocatello Ida.

15.

Filed

*1/14**1922**J. Young*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

January 14, 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 8, 1922 to *Jan 14, 1922*
that I last saw him alive on *Jan 14, 1922*
and that death occurred on the date stated above, at *2:15 P. M.*

The CAUSE OF DEATH* was as follows:

Premature birth(Duration) *4* yrs. *mos.* *ds.*Contributory
(Secondary)(Duration) *0* yrs. *mos.* *ds.*(Signed) *Asm Newton* M. D.*Jan 14, 1922* (Address) *Pocatello Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death *0* yrs. *mos.* *days.* In the State *0* yrs. *mos.* *days.*

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Mountain View Cem.

DATE OF BURIAL

1/14, 1922

20. UNDERTAKER

Schumacher & Hall

ADDRESS

Pocatello

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Bannock*City of *Pocatello*Registration District No. *28*Primary Registration District No. *2161*File No. *436720*Registered No. *3746*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Archie Obrien

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female white

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single (widowed ward.)

6. DATE OF BIRTH

Nov 14 1916
(Month) (Day) (Year)

7. AGE

*5 Yrs. 2 Mos. — ds.*IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

none

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Pocatello, Idaho

10. NAME OF FATHER

Wm Obrien

11. BIRTHPLACE OF FATHER

(State or Country)

May Hansen

12. MAIDEN NAME OF MOTHER

May Hansen

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Win. Obrien(Address) *1351 N. 3. Pocatello, Ida*

15.

Filed *Jan 16 1922**J. Young*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 14 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

*1/14 1922 to 1/14 1922*that I last saw *her* alive on *1/14 1922*and that death occurred on the date stated above, at *1:15 P.M.*

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction(Duration) Yrs. mos. *3* ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. P. Young M. D.*1/16 1922* (Address) *Pocatello, Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Mt View Cem

DATE OF BURIAL

Jan 16 1922

20. UNDERTAKER

H. L. McHan

ADDRESS

Pocatello, Ida.

FORM V. S. No. 5-A—25 M. 1-19

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Bannock*City of *Pocatello*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No. *28*Primary Registration District No. *316*File No. *436722*Registered No. *3748*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female White married

(Write the word.)

6. DATE OF BIRTH

May 1st 1857
(Month) (Day) (Year)

7. AGE

64 Yrs. *8* Mos. *3* ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)*Retired*

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

Missouri

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

*C. D. Smith
Pocatello Idaho*

15.

Filed

121 1922

Local Registrar

16. DATE OF DEATH

Jan 21st 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *June 1902* to *Jan 21st 1922* that I last saw her alive on *Jan 20th 1922* and that death occurred on the date stated above, at *6:00pm*.

The CAUSE OF DEATH* was as follows:

Coronary (acute)(Duration) Yrs. mos. ds. *14*
Contributory (Secondary) *Arterio Sclerosis*(Duration) Yrs. mos. ds. *35*
(Signed) *W. A. Wright* M. D.
(Address) *Pocatello, Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Mountain View Jan 23 1922

20. UNDERTAKER

ADDRESS

Chuncker Hoop City

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **86723**

1. PLACE OF DEATH
County of *Bannock* Registration District No. *28*
City of *Pocatello* Primary Registration District No. *2161*
(No. *home* St.)

If death occurs away from usual residence, give facts called for under special information.

Registered No. *3749*
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME *Infant Jeffery*

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *single*
(Write the word.)

6. DATE OF BIRTH *Jan 20 1922*
(Month) (Day) (Year)

7. AGE *0* Yrs. *0* Mos. *0* ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. *none*
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) *Bannock, Idaho*

10. NAME OF FATHER *H. L. Jeffery*

11. BIRTHPLACE OF FATHER
(State or Country) *Laurens, Iowa*

12. MAIDEN NAME OF MOTHER *Louise Meyer*

13. BIRTHPLACE OF MOTHER
(State or Country) *Wisconsin*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *H. L. Jeffery*
(Address) *621 West Clark*

15. Filed *1/23 1922*
Local Registrar *J. Young*

16. DATE OF DEATH *January 20 1922*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *1-20 1922* to *Jan 20 1922*
that I last saw him *live* on *1-26 1922*
and that death occurred on the date stated above, at *6 P. M.*

The CAUSE OF DEATH* was as follows:
Premature birth due to injury of mother by fall.
(Duration) Yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) *S. C. Ray* M. D.
1922 (Address) *Pocatello, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Mt. View Cem* DATE OF BURIAL *Jan 22 1922*

20. UNDERTAKER *A. L. McHaw* ADDRESS *Pocatello Idaho*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 438724
Registered No. 37501

1. PLACE OF DEATH

County of SanwockCity of PocatelloRegistration District No. 28Primary Registration District No. 2161

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant daughter of Mrs. Mirnadi

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female ItalianSingle
(Write the word.)

6. DATE OF BIRTH

January 2119221922
(Month) (Day) (Year)

7. AGE

Yrs. 3

Mos.

ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Pocatello

10. NAME OF FATHER

John Mirnadi

11. BIRTHPLACE OF FATHER

(State or Country)

Italy

12. MAIDEN NAME OF MOTHER

Sergia Bichtra

13. BIRTHPLACE OF MOTHER

(State or Country)

Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John Mirnadi

(Address)

Pocatello

15.

Filed 1/251922

Local Registrar

16. DATE OF DEATH

(Month)

(Day)

January 22
(Year)

17. I HEREBY CERTIFY That I attended deceased from

January 21, 1922, to January 24, 1922that I last saw her alive on January 21, 1922and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) — Yrs. — mos. — ds.

Contributory

(Secondary)

None

(Duration) — yrs. — mos. — ds.

(Signed)

J. W. Brown, M. D.Jan 24, 1922 (Address) 440 W. Hayden St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Lawrence 1/25 1922

20. UNDERTAKER

ADDRESS

M. W. Walker Pocatello

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

36726

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36726

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 53
County of Bear Lake
City of Bloomington
St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Tom Taylor

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single

(Write the word.)

6. DATE OF BIRTH.

Spt

15

1850

(Month)

(Day)

(Year)

7. AGE

71

Yrs.

4

Mos.

13

ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

Rancher

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Charles Taylor

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Mary Edwards

13. BIRTHPLACE OF MOTHER

(State or Country)

Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Geo. C. Piggott

(Address)

Bloomington

15.

Filed Jan 30 1922

Mrs. J. S. Skinner
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan

28

1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 15 1922 to Jan 27 1922

that I last saw him alive on Jan 20 1922

and that death occurred on the date stated above, at 5:00 A.M.

The CAUSE OF DEATH* was as follows:

Chr. Parenchymatous
Nephritis

(Duration) Yrs. 3 mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) C. Piggott M. D.

128 1922 (Address) Paris, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs mos days In the State yrs mos days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bloomington

Jan 31 1922

20. UNDERTAKER

ADDRESS

Bishop A. A. Hart Bloomington

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bear Lake
City of St Charles

Registration District No.

Primary Registration District No. 55

(No., St.)

File No. 36727

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ola Mattson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male white married
(Write the word.)

6. DATE OF BIRTH

October 19 1838
(Month) (Day) (Year)

7. AGE

84 Yrs. 2 Mos. 25 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Sweden

10. NAME OF FATHER

Sven Mattson

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME OF MOTHER

Hannah Oleson

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs Laurence Stewart

(Address)

St Charles Ida.

15.

Filed Feb 11 1922John Mattson
Local Registrar

16. DATE OF DEATH

Jan 25 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 19 21 to Jan 25 19 22
that I last saw him alive on Jan 1 1922
and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

uraemia. + Old Age(Duration) 2 Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

R. D. Smith

M. D.

(Address)

Paris

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

St Charles Ida Jan 30 1922

20. UNDERTAKER

ADDRESS

K
CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bear Lake, Registration District No. 5
 City of Montpelier, Primary Registration District No. 2136
 If death occurs away from usual residence, give facts called for under special information.
 2. FULL NAME Sarah F. Pope.

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 36728
 Registered No.
 If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-OWED OR DIVORCED.
Infant.
 (Write the word.)

6. DATE OF BIRTH. Feb. 27 1922
 (Month) (Day) (Year)

7. AGE IF LESS than 1 day
how many 5 hrs. or
Yrs. Mos. ds. min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Infant
 (b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho.

10. NAME OF FATHER Wm. B. Pope.

11. BIRTHPLACE OF FATHER Utah.
 (State or Country)

12. MAIDEN NAME OF MOTHER Gertrude Farner.

13. BIRTHPLACE OF MOTHER Utah.
 (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm B Pope
 (Address) Montpelier, Idaho.

15. 2-27-22
 Filed 191

Local Registrar. N.H. King

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 27. 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 27 1922 to Feb 27 1922
 that I last saw him alive on Feb 27 1922
 and that death occurred on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:

premature birth

(Duration) Yrs. mos. ds.

Contributory
 (Secondary)

(Duration) Yrs. mos. ds.

(Signed) A. S. Muelles M. D.

Feb 28 1922 (Address) Montpelier, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Garden City, Utah

DATE OF BURIAL Feb. 28 1922

20. UNDERTAKER

ADDRESS Montpelier, Idaho

should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36729
Registered No.
If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

1. PLACE OF DEATH

County of Bear Lake...
City of Montpelier...
If death occurs away from
usual residence, give facts
called for under special
information.
2. FULL NAME ... Unknown Greek.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE Greek 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.
Not Known
(Write the word.)

6. DATE OF BIRTH.
Not Known
(Month) (Day) (Year)

7. AGE Not Known IF LESS than 1 day
how many ... hrs. or
... Yrs. ... Mos. ... ds. ... min.?

8. OCCUPATION
(a) Trade, profession or
particular kind of work Not Known
(b) General nature of in-
dustry, business, or estab-
lishment in which em-
ployed (or employer)

9. BIRTHPLACE Greece.
(State or Country)

10. NAME OF FATHER Not Known

11. BIRTHPLACE OF FATHER Greece
(State or Country)

12. MAIDEN NAME OF MOTHER Not Known

13. BIRTHPLACE OF MOTHER Greece.
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) ...
(Address) Montpelier, Idaho

15. Filed 2-4-22 1922
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Feb. 3. 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
191... to 191...
that I last saw h... alive on 191...
and that death occurred on the date stated above, at ... M.

The CAUSE OF DEATH* was as follows:
Shot by officers while resisting
Arrest, as murder suspects.
Officers killed him in self defence.
(Duration) ... Yrs. ... mos. ... ds.

Contributory
(Secondary)
(Duration) ... Yrs. ... mos. ... ds.
(Signed) J. M. Williams XXXX
County Coroner.
v. 3. 19. 22 (Address)

*State the Disease Causing Death; or in deaths from Violent
Causes, state (1) Means of Injury; and (2) whether Accidental,
Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place In the
of death ... yrs. ... mos. ... days, State ... yrs. ... mos. ... days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Kemmerer Wyoming. Feb. 7. 1922

20. UNDERTAKER ADDRESS
J. M. Williams Montpelier, Id.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS
should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement
of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH **RECEIVED** **CERTIFICATE OF DEATH**
 County of **Bear Lake.** **MAR 6 1922** District No. **52**
 City of **Montpelier,** **BUREAU OF VITAL STATISTICS** District No. **2136**
 If death occurs away from usual residence, give facts called for under special information. St.)
 2. FULL NAME **Gus Thamos.**

State of Idaho
BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. **36730**
 Registered No.
 If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **Greek** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
not known
 (Write the word.)

6. DATE OF BIRTH. **Not Known.**
 (Month) (Day) (Year)

7. AGE **not known** IF LESS than 1 day how many hrs. or min.?
 Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work **miner (Coal)**
 (b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) **Probably Greece**

10. NAME OF FATHER

Not Known

11. BIRTHPLACE OF FATHER

(State or Country) **Greece**

12. MAIDEN NAME OF MOTHER

Not Known

13. BIRTHPLACE OF MOTHER

(State or Country) **Greece**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **J. M. Williams**
 (Address) **Montpelier, Idaho**

15. **2-4-22**
 Filed **191.** **Local Registrar.**

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb. 3 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191. to 191.

that I last saw h. alive on 191.

and that death occurred on the date stated above, at **1:30 P.M.**

The CAUSE OF DEATH* was as follows:

Shot by officers, while resisting arrest as murder suspects. Officers killed him in self defence.

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) **J. M. Williams** **XXX**

2-3-22 County Coroner, **Montpelier, Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **Kemmerer Wyoming.**

DATE OF BURIAL **Feb. 7. 1922**

20. UNDERTAKER **J. M. Williams** ADDRESS **Montpelier, Idaho**

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics1. PLACE OF DEATH
County of *Blaine* Registration District No. *52*
City of *Montpelier* Primary Registration District No. *2136*
(No. *52*) St.)File No. *36731*
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME *Baby Parks.*

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED *Infant*
(Write the word.)

16. DATE OF DEATH

6. DATE OF BIRTH *Jan 22 1922*
(Month) (Day) (Year)7. AGE *12* Yrs. Mos. ds.
IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).9. BIRTHPLACE *Montpelier Idaho*
(State or Country)10. NAME OF FATHER *Ray A. Parks*11. BIRTHPLACE OF FATHER *Oklahoma*
(State or Country)12. MAIDEN NAME OF MOTHER *Jennie McDonald*13. BIRTHPLACE OF MOTHER *Utah*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Ray A. Parks*
(Address) *Montpelier Idaho*15. *2-4-22* Filed *11/11/22* 19 *22*

Local Registrar

I HEREBY CERTIFY, That I attended deceased from *Jan 22* 19 *22*, to *2-3* 19 *22*
that I last saw him alive on *2-1* 19 *22*
and that death occurred on the date stated above, at *6 P.* M.

The CAUSE OF DEATH* was as follows:

This was about a 7 1/2 month child

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) *W. F. Kelley* M. D.*4* 19 *22* (Address) *Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Montpelier Idaho* DATE OF BURIAL *2-4-1922*20. UNDERTAKER *W. Williams* ADDRESS *Montpelier*

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. **36732**
 Registered No.
 If death occurred in a hos-
 pital, institution or camp,
 give its NAME instead of
 street and number.

1. PLACE OF DEATH

County of **Bear Lake**
 City of **Montpelier**
 If death occurs away from
 usual residence, give facts
 called for under special
 information.

Registration District No. **52**
 Primary Registration District No. **2136**
 (No. St.)

2. FULL NAME

Gen Baby Felgeangan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

Caucasian

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

Infant
 (Write the word.)

6. DATE OF BIRTH.

Jan 29 1922
 (Month) (Day) (Year)

7. AGE

3
 Yrs. Mos. ds.

IF LESS than 1 day
 how many hrs. or
 min.?

8. OCCUPATION

(a) Trade, profession or
 particular kind of work
 (b) General nature of in-
 dustry, business, or estab-
 lishment in which em-
 ployed (or employer)

Infant

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF
FATHER

Jack Felgeangan

11. BIRTHPLACE
OF FATHER

(State or Country)

Minnesota

12. MAIDEN NAME
OF MOTHER

Louise Doyen

13. BIRTHPLACE
OF MOTHER

(State or Country)

Minnesota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Jack Felgeangan
 (Address) **Montpelier, Idaho**

2-2-1922
 Filed **1922**

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 1 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 29 1922 to **Feb 7 1922**
 that I last saw him alive on **Feb 1 1922**
 and that death occurred on the date stated above, at **11:00** M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) Yrs. mos. ds.

Contributory
 (Secondary)

(Duration) Yrs. mos. ds.

(Signed) **Dr. F. C. ...** M. D.

(Address) **Montpelier**

*State the Disease Causing Death; or in deaths from Violent
 Causes, state (1) Means of Injury; and (2) whether Accidental,
 Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted
 if not at place of death?

Former or
 usual residence

19. PLACE OF BURIAL OR REMOVAL

Montpelier, Idaho

DATE OF BURIAL

Feb 2 1922

20. UNDERTAKER

F. M. Williams

ADDRESS

Montpelier, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No.

Primary Registration District No.

St.)

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

male

white

widower

(Write the word.)

6. DATE OF BIRTH

Oct 2 1859

(Month)

(Day)

(Year)

7. AGE

62

Yrs.

Mos.

27

ds.

IF LESS than 1 day

how many hrs

or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

Rancher

9. BIRTHPLACE

(State or Country)

Indiana

10. NAME OF FATHER

Jacob H. Young

11. BIRTHPLACE OF FATHER

(State or Country)

Pennsylvania

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

January 31 1922

N. A. King
Local Registrar

16. DATE OF DEATH

I HEREBY CERTIFY, That I attended deceased from

Jan 27 1922 to Jan 27 1922

that I last saw him alive on Jan 27 1922

and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Signed)

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Murfreesboro, Idaho

Jan 31 1922

20. UNDERTAKER

ADDRESS

F. M. Williams

Murfreesboro, Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 8-2County of Blair LakePrimary Registration District No. 2136File No. 36734City of Montpelier

(No. St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Virginia Allen Sturman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

girl

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

single
(Write the word.)

6. DATE OF BIRTH

Jan 25 1922
(Month) (Day) (Year)

7. AGE

0 0 2 1/2
Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Montpelier Ida

10. NAME OF FATHER

Earl William Sturman

11. BIRTHPLACE OF FATHER

(State or Country)

Berlingame Kas

12. MAIDEN NAME OF MOTHER

Ada E Conway

13. BIRTHPLACE OF MOTHER

(State or Country)

Lawrence Kas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Earl William Sturman

(Address)

Montpelier

15.

Filed

2-1-1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 27 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 25 1922 to Jan 27 1922
that I last saw him alive on Jan 27 1922and that death occurred on the date stated above, at 11:30 P.

The CAUSE OF DEATH* was as follows:

Premature birth

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

A. S. Needles, M. D.2-1-1922(Address) Montpelier

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Montpelier

DATE OF BURIAL

Jan 27 1922

20. UNDERTAKER

A. M. Williams

ADDRESS

Montpelier, Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 38735

1. PLACE OF DEATH

County of Bevy LakeCity of Montpelier

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Vergil Cook

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH.

Mar 14 1909
(Month) (Day) (Year)

7. AGE

12 Yrs. 9 Mos. 26 ds.IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)at School

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Clifford Cook

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Arminia Wilcox

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Clifford Cook
Montpelier, Idaho

15. FILED

1-10-22
191

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 9 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Jan 5 1922 to Jan 9 1922that I last saw him alive on Jan 9 1922
and that death occurred on the date stated above, at 1:30 P. M.

The CAUSE OF DEATH* was as follows:

Cyphoid fever

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

1922 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the ... State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Montpelier Idaho

DATE OF BURIAL

20. UNDERTAKER

F M Wilbur

ADDRESS

Montpelier Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bear Lake
City of St. Charles

Registration District No.

Primary Registration District No. 53

(No. St.)

File No.

Registered No. 36736

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary Staniforth Pugnaire

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

widowed
(Write the word.)

6. DATE OF BIRTH

October 8th 1841
(Month) (Day) (Year)

7. AGE

80 Yrs. 3 Mos. 11 ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

General Housekeeping

9. BIRTHPLACE

(State or Country) Loughbrough, Leistershire, England

10. NAME OF FATHER

William Staniforth

11. BIRTHPLACE OF FATHER

(State or Country) England

12. MAIDEN NAME OF MOTHER

Ann Henshaw

13. BIRTHPLACE OF MOTHER

(State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Annie S. Keetch

(Address) St Charles, Idaho

15.

Filed Feb. 13 1923

John Matton
Local Registrar

16. DATE OF DEATH

January 19 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan. 15 1922 to Jan. 19 1922
that I last saw her alive on Jan. 19 1922,
and that death occurred on the date stated above, at 5:15 AM.

The CAUSE OF DEATH* was as follows:

Bronchitis & Heart Failure

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Dr. J. S. ... M. D.

19..... (Address) Paris, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St Charles Id. Jan 23 1922

20. UNDERTAKER

ADDRESS

FORM V. S. No. 5-A—25 M. 1-19.

1. PLACE OF DEATH

County of BenjaminCity of Benjamin

If death occurs away from usual residence, give place called for under special information.

2. FULL NAME

RECEIVED CERTIFICATE OF DEATH

Registration District No. 52Primary Registration District No. 2136City of Benjamin

St.)

Registered No. _____

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 36731

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Jan 13 1922

(Month)

(Day)

(Year)

7. AGE

Yrs.

Mos.

ds.

IF LESS than 1 day
how many 12 hrs.
or 12 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1-14-22

19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 13 1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 13 1922 to Jan 13 1922that I last saw him alive on Jan 13 1922and that death occurred on the date stated above, at 3 p.m.

The CAUSE OF DEATH* was as follows:

Myocardial Infarction(Heart Disease)

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) W. H. King M. D.14 1922 (Address) Benjamin

*State the Disease Causing Death; or in death from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Benjamin

DATE OF BURIAL

14 1922

20. UNDERTAKER

Bishop Hulme

ADDRESS

Benjamin

✓ CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Benevolence
City of St. MariesRegistration District No. 32Primary Registration District No. 2049

(No. _____) (St. _____)

File No. 36740
Registered No. 6

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Charlotte Davis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Jan 24 1922
(Month) (Day) (Year)

7. AGE

____ Yrs. ____ Mos. ____ ds.

IF LESS than 1 day
how many 4 hrs.
or ____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. X

(b) General nature of industry, business or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country) St. Maries

10. NAME OF FATHER

Harry W Davis

11. BIRTHPLACE OF FATHER

(State or Country) Oregon

12. MAIDEN NAME OF MOTHER

Lola Maude Brown

13. BIRTHPLACE OF MOTHER

(State or Country) Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harry W Davis(Address) St. Maries

15.

Filed Jan 25 1922H E Hunt

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 24 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 24 1922 to Jan 24 1922
that I last saw h. er alive on Jan 24 1922
and that death occurred on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Remature Birth

(Duration) ____ Yrs. ____ mos. ____ ds.

Contributory
(Secondary) _____

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) C B Smith M. D.1/24/22 (Address) St. Maries, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Woodlawn

DATE OF BURIAL

1-26-1922

20. UNDERTAKER

H E Hunt Co

ADDRESS

St. Maries

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Benevol
City of St. MariesRegistration District No. 32Primary Registration District No. 2049

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Henry WolfState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 36741Registered No. 3

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Unmarried
(Write the word.)

6. DATE OF BIRTH

March
(Month)15
(Day)1846
(Year)

7. AGE

75

Yrs.

Mos.

ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Mercantile man

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Indiana

10. NAME OF FATHER

Not known

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Not known

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

H. D. Wolf

(Address)

St. Maries

15.

Filed Jan 21 1922St. Maries
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan
(Month)19
(Day)1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 19 1922, to Jan 19 1922that I last saw him alive on Jan 19 1922and that death occurred on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration)

20 minutes

Yrs.

mos.

ds.

Contributory
(Secondary)High blood pressure

(Duration)

One hour

Yrs.

mos.

ds.

(Signed)

D. P. Hall

M. D.

121 1922 (Address) St. Maries

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death: yrs. mos. days. In the State: yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Woodlawn

DATE OF BURIAL

1-22 1922

20. UNDERTAKER

A. E. Hunt Co.

ADDRESS

St. Maries

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Benedict
City of Big LostRegistration District No. 3Primary Registration District No. 2049

(No. St.)

File No. 36742

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Horatio B. Combs

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH

July 11 1881
(Month) (Day) (Year)

7. AGE

70 Yrs. 6 Mos. 6 ds.IF LESS than 1 day
how many 10 hrs.
or 15 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

carpenter

(b) General nature of industry, business or establishment in which employed (or employer)

Lumber Mill Winton River
Idaho

9. BIRTHPLACE

(State or Country)

Penn

10. NAME OF FATHER

Rodney Combs

11. BIRTHPLACE OF FATHER

(State or Country)

Penn

12. MAIDEN NAME OF MOTHER

Mary Shaft

13. BIRTHPLACE OF MOTHER

(State or Country)

Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

R. F. Combs

(Address)

24 Joe St. Ida.

15.

Filed

Jan 19 1922H. E. Stump
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

January 17 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

January 12, 1922, to January 17, 1922,
that I last saw him alive on January 17, 1922,
and that death occurred on the date stated above, at 1:45 PM.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage(Duration) Yrs. 5 ds.Contributory Arterio-sclerosis
(Secondary)(Duration) unknown ds.(Signed) C. A. Robins M. D.1/19/1922 (Address) St. Maries, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death? Unknown

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Woodlawn

DATE OF BURIAL

1/19 1922

20. UNDERTAKER

H. E. Stump & Co

ADDRESS

St. Maries

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Benevolah*
City of *St. Maries*Registration District No. *32*Primary Registration District No. *2049*

(No. _____) (St.)

File No. *36743*Registered No. *3*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Albert Porter

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

single

(Write the word.)

6. DATE OF BIRTH

Oct
(Month)*23*
(Day)*1890*
(Year)

7. AGE

31 Yrs.*2* Mos.*19* ds.

IF LESS than 1 day

how many _____ hrs.

or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Bookkeeper

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

North Dakota

10. NAME OF FATHER

Sam Porter

11. BIRTHPLACE OF FATHER

(State or Country)

Illinois

12. MAIDEN NAME OF MOTHER

Julia Davis

13. BIRTHPLACE OF MOTHER

(State or Country)

Texas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. J. Knows

(Address)

Spokane Wash

15.

Filed

*Jan 11 1922**H. E. Smith*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan
(Month)*11*
(Day)*1922*
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 7 1922 to *Jan 11 1922*that I last saw him alive on *Jan 11 1922*and that death occurred on the date stated above, at *6 A.M.*

The CAUSE OF DEATH* was as follows:

*Traumatic rupture of bladder,
Traumatic ileus, fracture of
pelvis, peritonitis, general contusions*(Duration) _____ Yrs. _____ mos. *4* ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

H. E. Smith

M. D.

11 1922 (Address) *St Maries Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Loon Lake Wash

DATE OF BURIAL

19

20. UNDERTAKER

H. E. Smith

ADDRESS

St Maries Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of BennettRegistration District No. 32City of St. MariesPrimary Registration District No. 2049

(No. _____) (St. _____)

File No. 36744Registered No. 2

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mellie B. Miles

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female white

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

May 17 1873
(Month) (Day) (Year)

7. AGE

48 Yrs. 7 Mos. 23 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Nebraska

10. NAME OF FATHER

Parsons

11. BIRTHPLACE OF FATHER

(State or Country)

N. Y. State

12. MAIDEN NAME OF MOTHER

Cynthia S. Bagley

13. BIRTHPLACE OF MOTHER

(State or Country)

N. Y. State

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henry H. Miles(Address) Warwick

15.

Filed Jan 9 1922H. E. Hunt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 9 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 11 1921, to Jan 9 1922that I last saw her alive on Jan 9 1922and that death occurred on the date stated above, at 1:30 a.m.

The CAUSE OF DEATH* was as follows:

Myocarditis(Duration) unknown mos. _____ ds.Contributory —
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) C. A. Robins M. D.1/9 1922 (Address) St. Maries, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. 30 days. In the _____ State _____ yrs. _____ mos. _____ daysWhere was disease contracted if not at place of death? UnknownFormer or usual residence Warley, Ida

19. PLACE OF BURIAL OR REMOVAL

Warley, Idaho

DATE OF BURIAL

19

20. UNDERTAKER

H. E. Hunt Co.

ADDRESS

St. Maries, Ida

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state C. OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Benewah
City of St. Maries

Registration District No. 32
Primary Registration District No. 207
(No. _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36745
Registered No. 1

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dorothy Marie Dillon

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH

Dec. 26 1921
(Month) (Day) (Year)

7. AGE

Yrs. 12 Mos. 12 ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. X
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) St. Maries

10. NAME OF FATHER

Roy Dillon

11. BIRTHPLACE OF FATHER

(State or Country) Nebraska

12. MAIDEN NAME OF MOTHER

Ethel Hemphill

13. BIRTHPLACE OF MOTHER

(State or Country) Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Roy Dillon
(Address) St. Maries

15. Filed Jan 7 1922 H. E. Hunt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 7 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 26 1921 to Jan 7 1922
that I last saw her alive on Jan 7 1922
and that death occurred on the date stated above, at 11 A.M.
The CAUSE OF DEATH* was as follows:

Brain Tumor

(Duration) _____ Yrs. _____ mos. 7 ds.

Contributory (Secondary)

(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed)

E. D. Platt M. D.
Jan 7 1922 (Address) St. Maries

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Woodlawn

DATE OF BURIAL

1 7 1922

20. UNDERTAKER

H. E. Hunt Co

ADDRESS

St. Maries

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of *Bingham*
City of *De Smet*Registration District No. *31*
Primary Registration District No. _____
(No. _____ St.)File No. *136746*
Registered No. *48*If death occurs away from
usual residence, give facts
called for under special
information.2. FULL NAME *Louis Victor*If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

*Indian*5. SINGLE, MARRIED, WID-
OWED OR, DIVORCED.*married*
(Write the word.)

6. DATE OF BIRTH.

December 20 *1844*
(Month) (Day) (Year)

7. AGE

77 Yrs. *1* Mos. *3* ds.IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work...
(b) General nature of in-
dustry, business, or estab-
lishment in which employ-
ed (or employer).....*Farmer*

9. BIRTHPLACE

(State or Country)

*Wash.*10. NAME OF
FATHER*Not known*11. BIRTHPLACE
OF FATHER

(State or Country)

12. MAIDEN NAME
OF MOTHER13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

J. B. Valler
Desmet *Idaho*

15.

Filed *Jan 24* *1922**J. E. Bihan*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

January 23 *1922*
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
Jan. 22 *1922*, to *Jan. 23* *1922*,
that I last saw him alive on *Jan. 22* *1922*,
and that death occurred on the date stated above, at *12* M.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia(Duration) — Yrs. — mos. *6* ds.Contributory
(Secondary)

(Duration) — yrs. — mos. — ds.

(Signed) *Fred Barteau* M. D.*Jan 23 1922* (Address) *De Smet, Ida.**State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted
if not at place of death?.....Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Desmet *Idaho**Jan 25 1922*

20. UNDERTAKER

ADDRESS

*J. Falcon**Desmet*

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 36747
Registered No. 36747

1. PLACE OF DEATH

County of BenewahCity of St. Maries, Ida.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Phil J. Miller

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCED
Single

(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

(Year)

7. AGE

55

Yrs.

Mos.

ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Blacksmith Helper(b) General nature of industry, business or establishment in which employed (or employer) Railroad

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed Feb 27 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

February

(Month)

27

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from January 24 1922, to February 27 1922.that I last saw him alive on February 27 1922, and that death occurred on the date stated above, at 9:45 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage(Duration) Yrs. 1 mos. 1 ds.Contributory Diffuse Nephritis, Arterio-sclerosis, MyocarditisUnknown (Duration) Yrs. 1 mos. 1 ds.(Signed) C. Robinson M. D.2/27/22 (Address) St. Maries, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. 1 mos. 3 days. In the State Yrs. 1 mos. 3 daysWhere was disease contracted if not at place of death? UnknownFormer or usual residence Malden, Washington.

19. PLACE OF BURIAL OR REMOVAL

Woodlawn

DATE OF BURIAL

3/2 1922

20. UNDERTAKER

Heathmont Co

ADDRESS

St Maries

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bennett
City of St. MariesRegistration District No. 32
Primary Registration District No. 2049
(No. 1 St.)File No. 36748
Registered No. 16

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Harold Conkey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male white Single
(Write the word.)

6. DATE OF BIRTH

Feb. 22 1909
(Month) (Day) (Year)

7. AGE

12 Yrs. 11 Mos. 26 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

School Boy

9. BIRTHPLACE

(State or Country)

Calif.

10. NAME OF FATHER

J N Conkey

11. BIRTHPLACE OF FATHER

(State or Country)

Canada

12. MAIDEN NAME OF MOTHER

Brecker Bowman

13. BIRTHPLACE OF MOTHER

(State or Country)

Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J N Conkey
St. Maries

15.

Filed Feb. 20 1922H E Hunt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb. 20 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb. 15 1922 to Feb. 19 1922that I last saw him alive on Feb. 19 1922and that death occurred on the date stated above, at 440 A.M.

The CAUSE OF DEATH* was as follows:

Typhoid Fever(Duration) Yrs. mos. 25 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Dr. J. E. Masters D.C.2219.22 (Address) St. Maries

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Woodlawn

DATE OF BURIAL

2-21-1922

20. UNDERTAKER

H E Hunt & Co.

ADDRESS

St. Maries

1. PLACE OF DEATH

County of Bernewah
City of St. Maries

If death occurs away from usual residence, give facts called for under special information.

RECEIVED

MAR 6 1922

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 32
Primary Registration District No. 2049
() St.)State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 36749
Registered No. 7

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Elmer Benton Woodworth

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

April 27 1921
(Month) (Day) (Year)

7. AGE

9 Yrs. 15 Mos. 5 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) St. Maries

10. NAME OF FATHER

Roy Woodworth

11. BIRTHPLACE OF FATHER

(State or Country) Calif.

12. MAIDEN NAME OF MOTHER

Jessie M. Easton

13. BIRTHPLACE OF MOTHER

(State or Country) Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Jessie Woodworth(Address) St. Maries

15.

Filed Feb. 11 1922 H. E. Hunt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb. 11 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 9 1922 to Feb 11 1922that I last saw h. in alive on Feb 10 1922and that death occurred on the date stated above, at 3 A M.

The CAUSE OF DEATH* was as follows:

Diphtheria

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) C. B. Smith M. D.2/11/1922 (Address) St. Maries

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Woodlawn

DATE OF BURIAL

2/12/1922

20. UNDERTAKER

H. E. Hunt Co.

ADDRESS

St. Maries

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of LatahCity of Bozwell

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 32Primary Registration District No. 2049

(No. _____ St.)

File No. 36750Registered No. 8

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Gilbert A. Douglas

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

married

(Write the word.)

6. DATE OF BIRTH

Jan281865

(Month)

(Day)

(Year)

7. AGE

57

Yrs.

Mos.

10

ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Lumberman

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Canada

10. NAME OF FATHER

John Douglas

11. BIRTHPLACE OF FATHER

(State or Country)

Scotland

12. MAIDEN NAME OF MOTHER

Anna Pringle

13. BIRTHPLACE OF MOTHER

(State or Country)

Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs G. A. Douglas

(Address)

Cour d'Alene Ida

15.

Filed

Feb. 71922H. E. Hunt

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb.61922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 3rd 1922, to Feb 6 1922that I last saw him alive on Feb 6 1922and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Paralytic Stroke

(Duration)

Yrs.

mos.

2 ds.Contributory
(Secondary)Operative Hernia

(Duration)

Yrs.

mos.

ds.

(Signed)

J. C. Gibson

M. D.

2/6 1922 (Address) Bozwell Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

Yrs.

mos.

3 days.

In the

State

Yrs.

mos.

8 days

Where was disease contracted if not at place of death?

Former or usual residence

Bozwell Idaho

19. PLACE OF BURIAL OR REMOVAL

Cour d'Alene Ida

DATE OF BURIAL

Mar 2nd 1922

20. UNDERTAKER

H. E. Hunt Co.

ADDRESS

St Marie L

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bingham Registration District No. 121
City of Blackfoot Primary Registration District No. 2194
(No. 08 St.)File No. 36754
Registered No. 56

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Else Christensen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single (Word.)6. DATE OF BIRTH February 2 1921
(Month) (Day) (Year)7. AGE 10 Yrs. 29 Mos. 29 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)None

9. BIRTHPLACE

(State or Country)

Blackfoot Ida

10. NAME OF FATHER

Simon Christensen

11. BIRTHPLACE OF FATHER

(State or Country)

Norway

12. MAIDEN NAME OF MOTHER

Ingrid Paulson

13. BIRTHPLACE OF MOTHER

(State or Country)

Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Simon Christensen

(Address)

Blackfoot R.O. 1

15.

Filed

Jan - 2 1922 Mr. Halse E. Pattee
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

January 1 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 30 1921, to Dec 31 1921that I last saw her alive on Dec 31 1921and that death occurred on the date stated above, at 4:50 A.M.

The CAUSE OF DEATH* was as follows:

Edema of Glottis(Duration) Yrs. 1 mos. 1 ds.Contributory
(Secondary)Tonsillitis and
Bronchitis(Duration) Yrs. 5 mos. 5 ds.

(Signed)

W. W. Beck M. D.1/2 1922 (Address) Blackfoot, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Grove City Cemetery Jan 3 1922

20. UNDERTAKER

ADDRESS

E. A. Ogli Blackfoot

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Bingham
City of Blackfoot

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Manda Coffin Kent

CERTIFICATE OF DEATH

Registration District No. 121Primary Registration District No. 1007

(No. _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 36755Registered No. 1755

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single Married
(Write the word.)

6. DATE OF BIRTH

Sept 26 1869
(Month) (Day) (Year)

7. AGE

55 Yrs. 3 Mos. 5 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Housewife

9. BIRTHPLACE

(State or Country)

Hunterville, etc.

10. NAME OF FATHER

Nathan Coffin

11. BIRTHPLACE OF FATHER

(State or Country)

Indiana

12. MAIDEN NAME OF MOTHER

Chestina M. Murtagh

13. BIRTHPLACE OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

John H. Kent
Blackfoot

15.

Filed Jan. 2 1922 Mr. Hales E. Pater
Local Registrar

6. DATE OF DEATH

January 1 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1921, to Jan 1 1921
that I last saw h. er alive on Jan 1 1921
and that death occurred on the date stated above, at 7 P.M.
The CAUSE OF DEATH* was (as follows):
Heart Disease(Duration) _____ Yrs. _____ mos. 1 ds.Contributory
(Secondary)

(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed)

Patric M. D.
1-2 1922 (Address) Blackfoot Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Grove City Cemetery 1-3 1922

20. UNDERTAKER

ADDRESS

E. L. Egli Blackfoot, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 121

County of Bligham

Primary Registration District No. 1007

City of Blackfoot

(No. Central Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Minnie Ann Nelson Child

File No. 36756

Registered No. 18

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F.

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Dec 11-1887

Jan 3
(Month)

1922
(Day)

(Year)

7. AGE

34 yrs.

0 mos.

23 ds.

IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work

Housewife

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Joseph S. Nelson

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Sarah Ann Broadbent

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Leo Nelson

(Address)

Blackfoot

15.

Filed

Jan 4 1922

Mrs. Helen E. Palmer

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan

3

1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 6.

1921,

to Jan 3

1922

that I last saw her alive on Jan 3 1922,

and that death occurred on the date stated above, at 4. a. M.

The CAUSE OF DEATH* was as follows:

Apoplexy - Cerebral Hemorrhage

(Duration)

a few minutes

yrs.

mos.

ds.

Contributory (Secondary)

Dementia Praecox

(Duration)

yrs.

mos.

ds.

(Signed)

W. Jackson

M. D.

Jan 3

1922

(Address)

Blackfoot

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL,

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

yrs.

2

mos.

28

ds.

In the

yrs.

2

mos.

28

ds.

Where was Disease contracted,

If not at place of death?

Thayne - Wyoming

Former or

usual residence.

Thayne - Wyoming

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

From Carl Cemetery Jan 5 1922

20. UNDERTAKER

ADDRESS

G. J. Park Blackfoot

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

Dec 17 1921, to Jan 3 1922

that I last saw him alive on Jan 3 1922

and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Typhoid fever

(Duration) Yrs. 1 mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) F. W. Mitchell M. D.

1/3 1922 (Address) Blackfoot, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Thomas Howard Cem. 1-4 1922

20. UNDERTAKER

ADDRESS

C. L. Ogli Blackfoot

1. PLACE OF DEATH

County of Bingham
City of Groveland

If death occurs away from usual residence, give facts called for under special information.

CERTIFICATE OF DEATH

Registration District No. 121
Primary Registration District No. 2194
No. 35 St.)State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 36758
Registered No. 358

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Vera Eliza Hammond

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDFemale White Married
(Write the word.)

6. DATE OF BIRTH

April 9 1886
(Month) (Day) (Year)

7. AGE

35 Yrs. 8 Mos. 26 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Housewife

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Thos. H. Wilde

11. BIRTHPLACE OF FATHER

(State or Country) England

12. MAIDEN NAME OF MOTHER

Louisa J. Carter

13. BIRTHPLACE OF MOTHER

(State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

S. S. Hammond
(Address) Route 1 Blackfoot

15. Filed

Jan - 6 1922 Mrs. Katherine Patrice

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

January 5 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 19 1921, to Jan 4 1922
that I last saw her alive on Jan 4 1922
and that death occurred on the date stated above, at 11:30 PM.

The CAUSE OF DEATH* was as follows:

Hemorrhage from premature detachment of placenta
(Duration) Yrs. mos. 16 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. A. Beck M. D.
1/5 1922 (Address) Blackfoot, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Groveland Cemetery Jan 8 1922

20. UNDERTAKER

ADDRESS

E. L. Egli

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD.
N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11-1922

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 121
County of Blaine Primary Registration District No. 1007
City of Blackfoot (No. Central Hospital St.)

File No. 36759
Registered No. 36759

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ruth M. (Priddy) Wright

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widow (Write the word.)

6. DATE OF BIRTH July 11 1859 (Month) (Day) (Year)

7. AGE 62 yrs. 5 mos. 26 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Tennessee

10. NAME OF FATHER

William Priddy

11. BIRTHPLACE OF FATHER

(State or Country)

N. Carolina

12. MAIDEN NAME OF MOTHER

Ruth Tillery

13. BIRTHPLACE OF MOTHER

(State or Country)

N. C.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Blackfoot

15.

Filed Jan 9 1922

Wm. H. E. Value
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 6 1922 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 5 1922, to Jan 6 1922 that I last saw her alive on Jan 6 1922, and that death occurred on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

Influenza (Sudden, severe head neuralgia, unconscious, and cyanotic from inception)
(Duration) yrs. mos. 17 hours

Contributory (Secondary)

(Duration) yrs. mos. ds. (Signed) R. Jackson M. D. 1922 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the of death yrs. mos. ds. State yrs. mos. ds. Where was Disease contracted, If not at place of death? Home, Blackfoot Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Summit Cemetery Jan 10 1922

20. UNDERTAKER

ADDRESS

E. J. Park Blackfoot

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

Registration District No.

Primary Registration District No.

(No.)

St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

The CAUSE OF DEATH* was as follows:

Contributory (Secondary)

(Signed)

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs mos days In the State yrs mos days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED
CERTIFICATE OF DEATHState of Idaho
BOARD OF HEALTH

Bureau of Vital Statistics

File No. 36761

Registered No. 23

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of BinghamCity of Blackfoot

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No. 121

Primary Registration District No. 358

St. Idaho

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

6. DATE OF BIRTH

March 8 1907
(Month) (Day) (Year)

7. AGE

14 Yrs. 10 Mos. 2 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)At school

9. BIRTHPLACE

(State or Country)

Eugene Oregon

10. NAME OF FATHER

Chas. C. Hurst

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Laura Mace

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

C. C. Hurst

(Address)

Blackfoot

15.

Filed June 11 1922 Wm. H. E. Pater

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

January 10 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 21 1922 to Jan 10 1922that I last saw him alive on Jan 10 1922and that death occurred on the date stated above, at 11 P M.

The CAUSE OF DEATH* was as follows:

Diphtheria

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) W. E. Pater M. D.19 (Address) Blackfoot

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Grove City Cemetery 1/11 1922

20. UNDERTAKER

C. E. Egli Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH.

Registration District No.

Registration District No.

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

6. DATE OF BIRTH.

7. AGE

IF LESS than 1 day
how many . hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15.

Filed

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw her alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

(Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

Registration District No.

Primary Registration District No.

St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Signed) M. D.

1919 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Bingham Registration District No. 121
 City of Blackfoot Primary Registration District No. 1067
342 West Jackson St.

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Sarah Ann Welch

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36764Registered No. 586

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Widowed

(Write the word.)

6. DATE OF BIRTH

Jan 28 1899
(Month) (Day) (Year)

7. AGE

72 Yrs. 11 Mos. 17 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer).

Retail

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

Endrick Shumaker

11. BIRTHPLACE OF FATHER

(State or Country)

W. S.

12. MAIDEN NAME OF MOTHER

Went Know

13. BIRTHPLACE OF MOTHER

(State or Country)

Went Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. W. Welch
Blackfoot Idaho

15.

Filed

Jan-16 1922 Mr. Walter E. Pater
Local Registrar

CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

January 15 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 10 1922 to Jan 14 1922
that I last saw him alive on Jan 14 1922
and that death occurred on the date stated above, at 10:20 PM.

The CAUSE OF DEATH* was as follows:

paralysis of bowels

(Duration) Yrs. 2 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. W. Welch M. D.1/16 1922 (Address) Blackfoot Idaho

*State the Disease Causing Death; or in deaths from violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Sanctuary 17 1922

20. UNDERTAKER

ADDRESS

Ed. R. R. Blackfoot

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 121
County of Bingham Primary Registration District No. 2/94
City of Blackfoot (No. R H 2 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John M. McCarthyFile No. 36765
Registered No. 1

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH

April 10 1880
(Month) (Day) (Year)

7. AGE

41 Yrs. 9 Mos. 6 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Farmer

9. BIRTHPLACE

(State or Country)

Ireland

10. NAME OF FATHER

Not Known

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Not Known

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

R. B. Sogel

15. Filed

June 17 1922 Mr. Walter E. Pater
Local Registrar

16. DATE OF DEATH

June 16 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from June 6 1922 to June 16 1922
that I last saw him alive on June 16 1922
and that death occurred on the date stated above, at 11:30 P. M.

The CAUSE OF DEATH* was as follows:

Pulver Pneumonia(Duration) _____ Yrs. _____ mos. 10 ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

F. W. Mutchler M. D.
4/16 1922 (Address) Blackfoot, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Marionland Idaho June 18 1922

20. UNDERTAKER

ADDRESS

E. J. Rich Blackfoot

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Bingham*
City of *Blackfoot*Registration District No. *121*
Primary Registration District No. *2194*
(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Sarah Ann Peterson*State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. *36766*
Registered No. *28*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*

6. DATE OF BIRTH

October 22 1865
(Month) (Day) (Year)

7. AGE

*56 Yrs. 2 Mos. 26 ds.*IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).*At home*

9. BIRTHPLACE

(State or Country)

Ogden Utah

10. NAME OF FATHER

Joseph Wheeler

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Sarah Woods

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Harry W. Peters

(Address)

Blackfoot Id.

15. Filled

Jan 21 1922 Mrs. Helen E. Peters
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

January 18 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 1 1921, to Jan 18 1922
that I last saw her alive on *Jan 7 1922*
and that death occurred on the date stated above, at *9 P.M.*

The CAUSE OF DEATH* was as follows:

concur breast

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) *H. J. Simmon* M. D.*1/20 1922* (Address) *Blackfoot Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Thomas Diverside *Jan 21 1922*

20. UNDERTAKER

ADDRESS

E. L. Boyle *Blackfoot*

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bingham
City of BlackfootRegistration District No. 121Primary Registration District No. 1007238 North Stout C. Hospital St.

If death occurs away from usual residence, give facts called for under special information.

File No. 36767
Registered No. 257

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Thomas Nathan Rupert.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Male White Single (Write the word.)

6. DATE OF BIRTH

May 5 1867
Not Known (Month) (Day) (Year)

7. AGE

54 Yrs. 8 Mos. 16 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Barber
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Pa.

10. NAME OF FATHER

Chas Albert Rupert

11. BIRTHPLACE OF FATHER

(State or Country) Pa

12. MAIDEN NAME OF MOTHER

Ellen Schelitto

13. BIRTHPLACE OF MOTHER

(State or Country) Pa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. L. Egle, Coroner(Address) Blackfoot

15.

Filed Jan 21 1922Local Registrar E. L. Egle

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

January 21 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Jan 18 1922 to Jan 21 1922 that I last saw him alive on Jan 20 1922 and that death occurred on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia
& Diabetic Coma

(Duration) Yrs. mos. ds.

Contributory (Secondary)

Diabetic Mellitus

(Duration) Yrs. mos. ds.

(Signed)

W. E. Patie M. D.Jan 21 1922 (Address) Blackfoot

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. 3 days. In the State yrs. mos. daysWhere was disease contracted if not at place of death? at Co HospitalFormer or usual residence Aberdeen, Idaho19. PLACE OF BURIAL OR REMOVAL
Grove City CemeteryDATE OF BURIAL
1/28 1922

20. UNDERTAKER

ADDRESS
Blackfoot.

1. PLACE OF DEATH

County of Bingham
City of Blackfoot

If death occurs away from usual residence, give facts called for under special information.

CERTIFICATE OF DEATH

Registration District No. 121Primary Registration District No. 2194

(No. of VITAL STATISTICS)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 36768Registered No. 30

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Velma Marie Smith

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female White

4. COLOR OR RACE

5. SINGLE-MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Dec 27 1921
(Month) (Day) (Year)

7. AGE

24 yrs. Mos. ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

None

9. BIRTHPLACE

(State or Country)

Riverside Ida

10. NAME OF FATHER

Don C. Smith

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Alice V. Ogden

13. BIRTHPLACE OF MOTHER

(State or Country)

Michigan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Don C. Smith

(Address)

Riverside

15. Filled

Jan. 21 1922Mr. Walter E. Latta

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 21 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 21 1922 to Jan 21 1922
that I last saw her alive on Jan 21 1922
and that death occurred on the date stated above, at 1:30 M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia
(Duration) yrs. mos. 3 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. W. Beck M. D.Jan 21 1922 (Address) Blackfoot, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Thomas + Riverside Jan 23 1922

20. UNDERTAKER

ADDRESS

E. L. Ogden Blackfoot

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of *Brighton*City of *Bluffton*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No. *121*Registration District No. *2194*(No. *Miller*St.) *Martin*State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *36769*Registered No. *37*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female*4. COLOR OR RACE *white*5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*

(Write the word.)

6. DATE OF BIRTH

Jan. (Month)*9* (Day)*1922* (Year)

7. AGE

Yrs. *15* Mos. *12* ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. *none*

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) *Idaho*10. NAME OF FATHER *Martin E. Miller*

11. BIRTHPLACE OF FATHER

(State or Country) *MO*12. MAIDEN NAME OF MOTHER *Held. Russ*

13. BIRTHPLACE OF MOTHER

(State or Country) *Cuba*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Martin E. Miller*(Address) *Bluffton, Idaho*15. Filed *Jan 20 1922**Mrs. H. E. Miller*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 24 (Month) *24* (Day) *1922* (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 24 1922 to *Jan 24 1922*that I last saw *her* alive on *Jan 24 1922*and that death occurred on the date stated above, at *1 P.M.*

The CAUSE OF DEATH* was as follows:

Order and destruction(Duration) *3* Yrs. *3* mos. *3* ds.

Contributory (Secondary)

(Duration) *3* yrs. *3* mos. *3* ds.(Signed) *F. W. Miller*

M. D.

1/24 1922 (Address) *Bluffton, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Grove City, Can *Jan 25 1922*

20. UNDERTAKER

ADDRESS

E. J. R. K. *Bluffton*

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Benewah
City of BlackfootRegistration District No. 121Primary Registration District No. 219K(No. R H V St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Emma BrackState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 36720Registered No. 35

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widow
(Write the word.)

6. DATE OF BIRTH

Jan 27 1838
(Month) (Day) (Year)

7. AGE

83 Yrs. 11 Mos. 30 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

none

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

Schwantrusch

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Shut Kline

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

First Minister
Blackfoot Idaho

15.

Filed

Jan. 26 1922 Wm. H. E. Pater
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 26 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I Investigated deceased fromdeath 19..... to 19.....that I last saw him alive on 19.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Heart failure
Valvular disease heart & old age
(Duration) Yrs. mos. ds.Contributory Senile Debility
(Secondary)

(Duration) yrs. mos. ds.

(Signed) W. E. Pater M. D.19..... (Address) Co Health Officer

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Fun. Co. Cemetery 28 1922

20. UNDERTAKER

ADDRESS

G. J. Burk

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH
in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of BinghamCity of Blackfoot

If death occurs away from
usual residence, give facts
called for under special in-
formation.

CERTIFICATE OF DEATH

Registration District No. 121Primary Registration District No. 1087(No. North University St.)

2. FULL NAME

Amy Ellen Ellis

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36771Registered No. 38

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDSingle
(Write the word.)

6. DATE OF BIRTH

September 22 1853

(Month) (Day) (Year)

7. AGE

88 Yrs. 4 Mos. 5 ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.None(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

Maine

(State or Country)

10. NAME OF
FATHERUnknown11. BIRTHPLACE
OF FATHERMaine

(State or Country)

12. MAIDEN NAME
OF MOTHERNot Known13. BIRTHPLACE
OF MOTHER

(State or Country)

Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) M E Ellis(Address) Blackfoot

15.

Filed Jan 28 1922Mrs Kate E. Pattee

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

January 27th 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 10 1922 to Jan 27 1922
that I last saw her alive on Jan 27 1922
and that death occurred on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:

mytrial Insufficiency

(Duration) Yrs. mos. ds.

Contributory
(Secondary)Senile Debility

(Duration) yrs. mos. ds.

(Signed) Effimovs M. D.

1/28 1922 (Address) Blackfoot Ida
*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted
if not at place of death?

Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Augusta Montana
20. E. D. Ogli
ADDRESS Blackfoot

2. FULL NAME..... Lewis Dunbar Wilson

MEDICAL CERTIFICATE OF DEATH

[illegible]

✓ CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

Registration District No. 116
County of Bingham Primary Registration District No. 2155
City of Shoshone (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Odette Mc Gahay

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female White Single
(Write the word.)

6. DATE OF BIRTH

Jan 24 1922
(Month) (Day) (Year)

7. AGE

Yrs. — Mos. — ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Jackson Bruner Mc Gahay

11. BIRTHPLACE OF FATHER

(State or Country)

Oklahoma

12. MAIDEN NAME OF MOTHER

Mary Neville

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. B. Mc Gahay
Shoshone, Ida

15.

Filed

Jan 24 1922 McGinnis

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 24 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 24 1922, to Jan 24 1922
that I last saw her alive on Jan 24 1922
and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Hydrocephalus (marked)
Premature Birth 28 weeks

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) M. C. McKinnon M. D.(Address) Shoshone, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

P.O. 87 Cemetery, Shoshone, Ida Jan 26 1922

20. UNDERTAKER

ADDRESS

McGinnis

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 116

County of

Primary Registration District No. 2195-

City of

(No.

St.)

File No. 36725

Registered No. 64

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jacob Taroos

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male white

married
(Write the word.)

6. DATE OF BIRTH.

June 26 1838
(Month) (Day) (Year)

7. AGE

83 Yrs. 6 Mos. 7 ds.

IF LESS than 1 day
how many hrs. or
min. 2

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Clergyman

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

Jacob Taroos

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Marie Evans

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

J. E. Taroos
Abbecon St. St.

15.

Filed

Jan 5 - 22 1912 Mcmenamin

Local Registrar

16. DATE OF DEATH

Jan 2 22 1912
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11:00 AM to 1:00 PM

that I last saw him alive on Dec 29 1912 and that death occurred on the date stated above, at 4:20 A.M.

The CAUSE OF DEATH* was as follows:

myocarditis

(Duration) Yrs. 2 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Mcmenamin M.D.

(Address) Abbecon St.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death...yrs...mos...days In the State...yrs...mos...days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mcmenamin

Jan 5 1912

20. UNDERTAKER

ADDRESS

Freid

FORM V. S. No. 5-25 M. 1-19.

✓
CERTIFICATE OF DEATHState of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Blaine*City of *Hailey*

If death occurs away from usual residence, give facts called for under special information.

Registration District No. *57*Primary Registration District No. *2022*

(No. _____ St.)

File No. *36776*Registered No. *2*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME *Albert Jennings Larko*

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

Jan.

(Month)

19.

(Day)

1906

(Year)

7. AGE

*15*Yrs. *11*Mos. *13*

ds.

IF LESS than 1 day

how many _____ hrs.

or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) *Idaho.*

10. NAME OF FATHER

C. D. Larko

11. BIRTHPLACE OF FATHER

(State or Country) *Idaho.*

12. MAIDEN NAME OF MOTHER

Sarah Lewis.

13. BIRTHPLACE OF MOTHER

(State or Country) *Idaho.*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Harry J Bates*(Address) *Hailey, Idaho.*

15.

Filed *1-15*19 *22**R. H. Wright*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

*1922**Jan.*

(Month)

11

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan. 5 19 *22* to *Jan. 11* 19 *22*that I last saw him alive on *Jan. 10* 19 *22*and that death occurred on the date stated above, at *4 P. M.*

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) *Robert H. Wright*

M. D.

1/11 19 *22* (Address) *Hailey, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Hailey, Ida

DATE OF BURIAL

1-13 19 *22*

20. UNDERTAKER

R. D. Harris

ADDRESS

Hailey

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

✓
CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Blaine
City of Gannett

Registration District No. 57
Primary Registration District No. 2022
(No. _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36377
Registered No. 36377

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Alice Jane Southern

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH Jan. 6 1881
(Month) (Day) (Year)

7. AGE 40 Yrs. 25 Mos. 25 ds. IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Housewife

9. BIRTHPLACE
(State or Country)

Idah.

10. NAME OF FATHER

Mr. Rogers

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

✓

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John Southern
Gannett, Ida

(Address)

15.

Filed 2-5 19 22 R. H. Wright

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 31 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 29 1922 to Jan 31 1922 that I last saw her alive on Jan 31 1922 and that death occurred on the date stated above, at 4 M.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(Duration) Yrs. mos. ds.

Contributory (Secondary)

Septicemia

(Duration) yrs. mos. ds.

(Signed)

R. H. Wright M. D.

1/31 1922 (Address) Harley, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Gannett, Ida

7 19 22

20. UNDERTAKER

ADDRESS

Booth Harris

Harley, Ida

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Blaine*
City of *Hailey*Registration District No. *57*Primary Registration District No. *2022*

(No. _____ St.)

File No. *36778*Registered No. *4*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Bell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*

(Write the word.)

6. DATE OF BIRTH

Jan. 1st 1922
(Month) (Day) (Year)

7. AGE

8 Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Hailey Idaho

10. NAME OF FATHER

James Bell

11. BIRTHPLACE OF FATHER

(State or Country)

Scotland

12. MAIDEN NAME OF MOTHER

Mary Potter

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *X*

(Address)

James Bell
Muldon, Idaho

15.

Filed *1-15* 19 *22**Robt H. Wright*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan. 9 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1/1 1922 to 1/9 1922
that I last saw him alive on *1/9 1922*
and that death occurred on the date stated above, at *—* M.

The CAUSE OF DEATH* was as follows:

Pneumonia -
In amission

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *E. S. Fox* M. D.*19 1922* (Address) *Hailey, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hailey, Idaho *1-10 1922*

20. UNDERTAKER

ADDRESS

Ralph Harris *Hailey, Idaho*

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Singola RE
City of District FEBRegistration District No. 57Primary Registration District No. 2022

(No. _____ St.)

File No. 36779

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Johnny Matson Tender

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married

(Write the word.)

6. DATE OF BIRTH

Feb. 9 1851
(Month) (Day) (Year)

7. AGE

46 72 Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Farmer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Illinois

10. NAME OF FATHER

Andrew Tender.

11. BIRTHPLACE OF FATHER

(State or Country)

South Carolina

12. MAIDEN NAME OF MOTHER

✓

13. BIRTHPLACE OF MOTHER

(State or Country)

✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs L P Mustard(Address) District Ida

15.

Filed 1-10 1922 R. H. Wright

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 5 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec. 15 1921, to Jan 3. 1922
that I last saw him alive on Dec 24 1921,
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver(Duration) 3 Yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas F Tiller M. D.1/5 1922 (Address) Jerome, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Hailey, Idaho.

DATE OF BURIAL

1-7 1922

20. UNDERTAKER

G. J. Harris

ADDRESS

Hailey

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36780

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

Registration District No. 78
County of Bonanza
City of Sandpoint
Registration District No. 2155
Barnard Hotel St.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Harry Ellis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

M. white Single
(Write the word.)

6. DATE OF BIRTH

Sept. 18 1877
(Month) (Day) (Year)

7. AGE

45 Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Miner

9. BIRTHPLACE

(State or Country)

Canada

10. NAME OF FATHER

Jno Ellis

11. BIRTHPLACE OF FATHER

(State or Country)

Canada

12. MAIDEN NAME OF MOTHER

Margaret Nick

13. BIRTHPLACE OF MOTHER

(State or Country)

Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

H. S. Ellis

(Address)

Regina Sask.

15.

Filed Feb 6 1922

Hoyd Wendt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan. 2 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 30 1921, to Jan 2 1922
that I last saw him alive on Jan 1 1922

and that death occurred on the date stated above, at A.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) Yrs. mos. ds. Several

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) E. P. Staecher M. D.

1-14-1922 (Address) Sandpoint, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sandpoint Ida 1/6 1922

20. UNDERTAKER

ADDRESS

B. H. Pugh, Sandpoint, Ida

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1922

Local Registrar

Registration District No.

Primary Registration District No.

Village & Ontario St.)

BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Signed)

1922

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

1. PLACE OF DEATH

County *Bonner* Registration District No. *78*
 City of *Sandpoint* Registration District No. *2155* City *Hospital* St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

H. F. Moore

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. *36782*

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M.* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *married*
 (Write the word.)

6. DATE OF BIRTH

Sept. 29 1875
 (Month) (Day) (Year)

7. AGE

47 Yrs. Mos. ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

Timberman

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

H. M. Moore

11. BIRTHPLACE OF FATHER

(State or Country)

New Brunswick

12. MAIDEN NAME OF MOTHER

Marie Moore

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. H. F. Moore

(Address)

Sandpoint, Idaho.

15.

Filed

Feb 6 1922

Local Registrar

Hogdson

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan. 14 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan. 1 1922 to *Jan. 14 1922*
 that I last saw him alive on *Jan. 14 1922*
 and that death occurred on the date stated above, at *3 P. M.*

The CAUSE OF DEATH* was as follows:

ursemia & chronic renal disease. Suprapubic cystostomy for bladder calculus.

(Duration) *4* Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

*J. P. Wallentine M. D.**1-25-1922* (Address) *Sandpoint, Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Westmond Ida. 1/17 1922

20. UNDERTAKER

ADDRESS

B. H. Pugh, Sandpoint, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

RECEIVED

CERTIFICATE OF DEATH

FEB 21 1922

1. PLACE OF DEATH.

County of Bonner

City of Laclede

Registration District No. 81

Previous Registration District No. 3155

(No. Laclede, Ida. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. Harriet P. Baxter

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 136783

Registered No. 316

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widow
(Write the word.)

6. DATE OF BIRTH

August 29 1847
(Month) (Day) (Year)

7. AGE

74 yrs. 4 mos. 5 ds.

IF LESS than 1 day
how many..... hrs. or
..... min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Housewife

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Illinois

10. NAME OF FATHER

Elijah Phillips

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Roana Rice

13. BIRTHPLACE OF MOTHER

(State or Country)

Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Flora Foster

(Address)

Laclede, Ida.

15.

Filed Jan 6 1922

F. W. Didier
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

January 2 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 1 1921, to Jan 3 1922

that I last saw her alive on Jan 2 1922

and that death occurred on the date stated above, at 12:30 A.M.

The CAUSE OF DEATH* was as follows:

Sabaz Pneumonia

(Duration) 20 yrs. mos. ds.

Contributory (Secondary)

Bronchitis

(Duration) 10 yrs. mos. ds.

(Signed)

F. W. Didier M. D.

Jan 3 1922 (Address) Laclede, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death..... yrs. mos. ds. State..... yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sandpoint, Ida.

Jan 4 1922

20. UNDERTAKER

ADDRESS

B. H. Pugh, Sandpoint, Ida.

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH

FEB 21 1922

County of

Bonneville

Registration District No.

City of

Lacide

Registration District No.

(No. On Ranch, near Morton St. Ida)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Nels Osterberg

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

436784

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WID-
OWED, OR DIVORCEDDivorced
(Write the word.)

6. DATE OF BIRTH

May

31

1856

(Month)

(Day)

(Year)

7. AGE

65

Yrs.

Mos.

ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Miner

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Sweden

10. NAME OF FATHER

Osterberg

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Sebert Osterberg

(Address)

Morton, Idaho.

15.

Filed

Jan 21 22 Fredrick

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan.

4

1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 3 1922 to Jan 3 1922

that I last saw him alive on Jan 3 1922

and that death occurred on the date stated above, at 9:00 A.M.

The CAUSE OF DEATH* was as follows:

Self Shot wound - self inflicted -

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

S. M. Moore

(Address)

Sandpoint, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sandpoint, Idaho.

1/6. 1922

20. UNDERTAKER

ADDRESS

B. H. Pugh, Sandpoint, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH

County of *Bonner*City of *Laclede, Idaho*

If death occurs away from usual residence, give facts called for under special information.

RECEIVED CERTIFICATE OF DEATH

Registration District No. *81*Primary Registration District No. *2155*City of *Laclede, Idaho* St. *White Camp No. 4*2. FULL NAME *Vittorio Negro*State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *336785*Registered No. *96*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

(Year)

7. AGE

18

Yrs.

Mos.

ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Laborer

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Italy

10. NAME OF FATHER

Peter Antonio Negro

11. BIRTHPLACE OF FATHER

(State or Country)

Italy

12. MAIDEN NAME OF MOTHER

Filomena Silvagni

13. BIRTHPLACE OF MOTHER

(State or Country)

Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Frank Pagnotti*(Address) *Crest River, Idaho*

15.

Filed *Jan 21, 1922**F. W. Dodier*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

January

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

*Jan 20, 1922, to Jan 20, 1922*that I last saw him alive on *Jan 20, 1922*and that death occurred on the date stated above, at *4:50 P.M.*

The CAUSE OF DEATH* was as follows:

Injury, accidental, Crushed by log in chute.

(Duration) Yrs. mos. ds.

Contributory (Secondary) *Shock and exposure*

(Duration) Yrs. mos. ds.

(Signed) *F. W. Dodier* M. D.*Jan 21, 1922* (Address) *Laclede, Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Crest River, Ida Jan 22, 1922

20. UNDERTAKER ADDRESS

B. H. Lusk, Sand Point, Ida

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 236786Registered No. 35

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of BonnerCity of Laclede

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. Old Ranch, near Sawyer, Ida.)

2. FULL NAME

Ora Bushe

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F.

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

Nov.191922

(Month)

(Day)

(Year)

7. AGE

21 Yrs.Mos. 2

ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Housewife

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Wis

10. NAME OF FATHER

Heliah Semers

11. BIRTHPLACE OF FATHER

(State or Country)

Canada

12. MAIDEN NAME OF MOTHER

Salina Semers

13. BIRTHPLACE OF MOTHER

(State or Country)

Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. E. Semers

(Address)

Sandpoint, Idaho.

15.

Filed

Jan 21 1923W. D. Didier

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan.191922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 19 1922 to Jan 19 1922that I last saw him alive on Jan 19 1922and that death occurred on the date stated above, at 7:00 AM.

The CAUSE OF DEATH* was as follows:

Uterine Hemorrhage(Duration) 2 Yrs. 2 mos. 2 ds.

Contributory (Secondary)

Childbirth(Duration) 2 yrs. 2 mos. 2 ds.

(Signed)

W. D. Didier

M. D.

19.1922 (Address) Laclede, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sandpoint Idaho.1/23 1922

20. UNDERTAKER

ADDRESS

B. H. Pugh, Sandpoint, Ida.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.

85

County of BonnerPrimary Registration District No. 2185

File No.

City of Priest River

(No. _____ St.)

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Josie Bossio

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

FemaleWhiteSingle

(Write the word.)

6. DATE OF BIRTH

Dec 31 1921
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day

Yrs. Mos. 2 ds.how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

None

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

IDAHO

10. NAME OF FATHER

Joe Bossio

11. BIRTHPLACE OF FATHER

(State or Country)

Italy

12. MAIDEN NAME OF MOTHER

Mary Altimora

13. BIRTHPLACE OF MOTHER

(State or Country)

Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank Naccarato

(Address)

Priest River

15.

Filed Feb 1 - 1922

Local Registrar

16. DATE OF DEATH

Jan 2 1922 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 31 1921 to Jan 2 1922 19that I last saw her alive on Jan 1 1922 19and that death occurred on the date stated above, at A M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia(Duration) Yrs. mos. 2 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Jan 2 1922 (Address) Priest River, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Priest RiverJan 3 1922

20. UNDERTAKER Neighbor

ADDRESS

Gus NaccaratoPriest River

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully applied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36788
Registered No. _____

1. PLACE OF DEATH
County of Bonner
City of Priest River
Registration District No. _____
Primary Registration District No. _____
(No. Dakota Camp #3 St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurs in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sam Olson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH Unknown 18 70
(Month) (Day) (Year)

7. AGE 52 Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Teamster
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE Sweden
(State or Country)

10. NAME OF FATHER Olson

11. BIRTHPLACE OF FATHER Sweden
(State or Country)

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER Sweden
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. E. Craney
(Address) Nordman, Ida.

15. Filed Feb 1 1922 C. F. Giff
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. 7 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 19____, to _____ 19____, that I last saw him alive on _____ 19____, and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:
Natural Causes - Possibly
Thrombosis - and Aneurism -

(Duration) _____ Yrs. mos. ds.

Contributory (Secondary) _____
(Duration) _____ yrs. mos. ds.

(Signed) E. M. Ingou
19____ (Address) Sandpoint, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. mos. days. In the State _____ yrs. mos. days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Spokane, Wash. DATE OF BURIAL _____ 19____

20. UNDERTAKER B. H. Pugh, Sandpoint, Ida. ADDRESS _____

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of BannockCity of Idaho Falls

Registration District No.

Primary Registration District No.

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Geo. Wm JonesState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 36789Registered No. 13

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED

Single

(Write the word.)

6. DATE OF BIRTH

Nov181908

(Month)

(Day)

(Year)

7. AGE

13 Yrs.2 Mos.12 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

at Home

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

McCon, Ida

10. NAME OF FATHER

John W Jones

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Marion E. Glissold

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John William Jones

(Address)

Idaho Falls

15.

Filed

1/27

19

22

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 24 1922

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from Jan - 11 22 to Jan. 24 22that I last saw him alive on Dec 19 22and that death occurred on the date stated above, at 14

The CAUSE OF DEATH* was as follows:

Thrombosis Latent
Senile

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)Acute myocardial

(Duration)

Yrs.

mos.

ds.

(Signed)

H. D. Mumford M. D.

JAN 27 1922

(Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

McCon, Ida

DATE OF BURIAL

1-26 1922

20. UNDERTAKER

E. D. Mumford

ADDRESS

Idaho Falls

FORM V. S. No. 5-25 M. 1-19.

V CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bannock
City of Idaho FallsRegistration District No. 73
Primary Registration District No. 2150
(No. _____ St.)State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. _____
Registered No. 12

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

George O. Scott

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widowed
(Write the word.)

6. DATE OF BIRTH

May 11 1839
(Month) (Day) (Year)

7. AGE

82 Yrs. 7 Mos. 25 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Retired Merchant

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

New Hampshire

10. NAME OF FATHER

Geo. E. Scott

11. BIRTHPLACE OF FATHER

(State or Country)

New Hampshire

12. MAIDEN NAME OF MOTHER

Fanny Dabittle

13. BIRTHPLACE OF MOTHER

(State or Country)

Mass.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Geo M Scott

(Address)

City

15.

Filed

1/27

19

22 W. M. Munn
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 5 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from December 29 1921 to Jan 5 1922that I last saw him alive on Jan 5 1922and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Heart Disease(Duration) Yrs. mos. 7 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. M. Munn M. D.1-6 1922 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Idaho Falls

DATE OF BURIAL

1-7 1922

20. UNDERTAKER

E. E. Munn

ADDRESS

Idaho Falls

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Bozeman*
City of *Idaho Falls*Registration District No. *73*Primary Registration District No. *2140*
(No. *4 miles east Idaho Falls* St.)File No. *36791*

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mrs. Angeline Hughes

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

Oct 28 1847
(Month) (Day) (Year)

7. AGE

74 Yrs. *2* Mos. *25* ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

House wife

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idy.

10. NAME OF FATHER

Eliza Howard

11. BIRTHPLACE OF FATHER

(State or Country)

Idy.

12. MAIDEN NAME OF MOTHER

Don't know.

13. BIRTHPLACE OF MOTHER

(State or Country)

Idy.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. W. Hughes(Address) *Idaho Falls Ida.*

15.

Filed *1/21* 19 *22* *W. M. Mendenhall*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan. 17 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 16 1922 to *Jan 17 1922*
that I last saw her alive on *Jan 17 1922*and that death occurred on the date stated above, at *4:15 P.M.*

The CAUSE OF DEATH* was as follows:

Acute Myocarditis(Duration) Yrs. *3* mos. ds.

Contributory (Secondary)

Chronic nephritis(Duration) Yrs. *2* mos. ds.

(Signed)

J. W. Hughes M. D.*Jan 19 1922* (Address) *Idaho Falls*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Bozeman Mont

DATE OF BURIAL

Jan 19 1922

20. UNDERTAKER

Chaffey

ADDRESS

Idaho Falls Ida.

✓ CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of BannockCity of Idaho Falls

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 73Primary Registration District No. 2150

(No., St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 36792Registered No. 10

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Annie Larsen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female White

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDMarried
(Write the word.)

6. DATE OF BIRTH

Sep 29 1872
(Month) (Day) (Year)

7. AGE

49 Yrs. 3 Mos. 21 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

at Home

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Denmark

10. NAME OF FATHER

Petersen

11. BIRTHPLACE OF FATHER

(State or Country)

Denmark

12. MAIDEN NAME OF MOTHER

Petersen

13. BIRTHPLACE OF MOTHER

(State or Country)

Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles A. Larsen(Address) Briggs Idaho

15.

Filed 1/21 19 22 W. E. Woodward
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 20 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19..... to 19.....

that I last saw him alive on 19.....

and that death occurred on the date stated above, at 99 M.

The CAUSE OF DEATH* was as follows:

Acute Cholecystitis(Duration) Yrs. mos. 6 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) W. E. Woodward M. D.1/21 1922 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Briggs Ida

DATE OF BURIAL

1-22 1922

20. UNDERTAKER

W. E. Woodward

ADDRESS

Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2
(No. People St. St.)

File No. 36793
Registered No. 7

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Alpha E Locke

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH ? ? 1894
(Month) (Day) (Year)

7. AGE 28 Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION House wife
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE ?
(State or Country)

10. NAME OF FATHER Earl Shaw

11. BIRTHPLACE OF FATHER ?
(State or Country)

12. MAIDEN NAME OF MOTHER ?

13. BIRTHPLACE OF MOTHER ?
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Earl Locke
(Address) Warlington Ida.

15. Filled 1/16 19 22 W. J. J. J.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 8 19 22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 14 19 21 to Jan 8 19 22
that I last saw her alive on Jan 8 19 22
and that death occurred on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:

Pyloic obstruction
Perforating ulcer stomach
(Duration) Yrs. 1 mos. ds.
Contributory Pregnancy
(Secondary) (Duration) yrs. 3 mos. ds.
(Signed) W. J. J. J. M. D.
19 22 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Idaho Falls DATE OF BURIAL Jan 19 22

20. UNDERTAKER W. J. J. J. ADDRESS Idaho Falls

V
CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bonanza
City of Idaho Falls

Registration District No.

Primary Registration District No.
(No. Eastern Ave. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Elberta McAlisterState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 36794Registered No. 7

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH

Nov. 9 1921
(Month) (Day) (Year)

7. AGE

7 yrs. 7 mos. 7 wks.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho Falls

10. NAME OF FATHER

Chas. McAlister

11. BIRTHPLACE OF FATHER

(State or Country)

Michigan

12. MAIDEN NAME OF MOTHER

Stella Young

13. BIRTHPLACE OF MOTHER

(State or Country)

California

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Chas. McAlister

(Address)

Idaho Falls

15.

Filed

1/16 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 3 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 23 1921 to Jan 3 1922
that I last saw her alive on 31 Dec 1921
and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Flu Colitis(Duration) Yrs. mos. 10 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

A. J. [Signature] M. D.

19

(Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho Falls Jan 6 1922

20. UNDERTAKER

ADDRESS

Idaho Falls

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bonneville
City of Idaho FallsRegistration District No. 73
Primary Registration District No. 214-0
(No. Spencer St. St.)File No. 36795
Registered No. 7

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ervin Candland

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)6. DATE OF BIRTH Feb 26 1920
(Month) (Day) (Year)7. AGE 1 Yrs. 8 wks. Mos. ds.
IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)9. BIRTHPLACE Id South Dakota
(State or Country)10. NAME OF FATHER Ervin Candland11. BIRTHPLACE OF FATHER Utah
(State or Country)12. MAIDEN NAME OF MOTHER Theresa Bowring13. BIRTHPLACE OF MOTHER Utah
(State or Country)14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ervin Candland
(Address) Idaho Falls Ida15. Filed 1/16 1922
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 31 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from 12-31 1921, to 1-3- 1922
that I last saw him alive on 1-3- 1922
and that death occurred on the date stated above, at 9 P. M.
The CAUSE OF DEATH* was as follows:Acute Intestinal Intoxication

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) J. A. Hall M. D.

19. (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Sage Lake Id. DATE OF BURIAL Feb 22 192220. UNDERTAKER Jeffrey ADDRESS Idaho Falls

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Bonneville*
City of *Idaho Falls*Registration District No. *13*
Primary Registration District No. *211-0*
(No. *County* St.)File No. *36786*
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

James J. Wagaman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*
(Write the word.)

6. DATE OF BIRTH

Sept 3, 1839
(Month) (Day) (Year)

7. AGE

87 Yrs. Mos. ds. IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)*Retired*

9. BIRTHPLACE

(State or Country)

Idy

10. NAME OF FATHER

Wagaman

11. BIRTHPLACE OF FATHER

(State or Country)

Don't know

12. MAIDEN NAME OF MOTHER

" "

13. BIRTHPLACE OF MOTHER

(State or Country)

" "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. J. Wagaman
Idaho Falls R.F.D. #1

15.

Filed

1/16 19 *22* *Wagaman*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 4, 1921
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *May 5* 19 *21*, to *Oct 29* 19 *21*

that I last saw him alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Caner

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

El Rogers

19

(Address)

Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Rose Hill**Jan 6, 1921*

20. UNDERTAKER

ADDRESS

*El Rogers**Idaho Falls*

FORM V. S. No. 5-25 M. 1-19.

V
CERTIFICATE OF DEATHState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 36797
Registered No. 329

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of *Bonner*
City of *Idaho Falls*
*Ida*Registration District No. *73*
Primary Registration District No. *21, V-0*
(No. *Proph. Hosp.* St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Wm James V. Chapin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

married

(Write the word.)

6. DATE OF BIRTH

Nov 12 1875
(Month) (Day) (Year)

7. AGE

49 Yrs. Mos. ds.

IF LESS than 1 day

how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

House wife

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Tennessee

10. NAME OF FATHER

Hughes

11. BIRTHPLACE OF FATHER

(State or Country)

Tennessee

12. MAIDEN NAME OF MOTHER

Mariah

13. BIRTHPLACE OF MOTHER

(State or Country)

Tennessee

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Clarence Chapin
Idaho Falls Ida

15.

Filed *1/16* 19*22* *W. J. Chapman*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 7 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 5 1921 to *Jan 7 1922*that I last saw him alive on *19*and that death occurred on the date stated above, at *M.*

The CAUSE OF DEATH* was as follows:

Cancer

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

D. E. Rogers M. D.19 (Address) *Idaho Falls Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Ross St. Church *Jan 10 1922*

20. UNDERTAKER

ADDRESS

Jeffrey Hayes *Idaho Falls Ida*

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Bonnieville*
City of *Idaho Falls*Registration District No. *73*
Primary Registration District No. *215-0*
(No. *General Hosp.* St.)File No. *36798*
Registered No. *4*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Winifred C. Cramer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*
(Write the word.)

6. DATE OF BIRTH

July 13 1918
(Month) (Day) (Year)

7. AGE

3 Yrs. *5* Mos. *27* ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Maac Idaho

10. NAME OF FATHER

Herley Cramer

11. BIRTHPLACE OF FATHER

(State or Country)

Iowa

12. MAIDEN NAME OF MOTHER

Gretchen Froelich

13. BIRTHPLACE OF MOTHER

(State or Country)

Wash

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Herley Cramer

(Address)

Idaho Falls

15.

Filed

*1/14*19 *22**Wm. C. Cramer*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 10 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *Dec 26 1921* to *Jan 10 1922*
that I last saw him alive on *Jan 10 1922*
and that death occurred on the date stated above, at *7 A.M.*

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) *A. R. Soderquist* M. D.*1/14 1922* (Address) *Idaho Falls Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Waconia Wash.

DATE OF BURIAL

Jan 15 1922

20. UNDERTAKER

Jeffrey

ADDRESS

Idaho Falls

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **36802**
Registered No. _____

1. PLACE OF DEATH

County of Boundary
City of Bonners FerryRegistration District No. 79
Primary Registration District No. 2156
(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Daniel Warren Chisholm

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male | White | (Write the word.)

6. DATE OF BIRTH

Dec. 19 1921
(Month) (Day) (Year)

7. AGE

19 Yrs. Mos. ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Infant

9. BIRTHPLACE

(State or Country)

Bonners Ferry Idaho

10. NAME OF FATHER

Donald Hugh Chisholm

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Sibyl Josephine Poston

13. BIRTHPLACE OF MOTHER

(State or Country)

Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Donald Chisholm

(Address)

Bonners Ferry Idaho

15. Filed

Jan 3rd 1922E. E. Fry
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

January 7 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec. 19 1921, to Dec. 22 1921,
that I last saw him alive on Dec. 22 1921,
and that death occurred on the date stated above, at 10³⁰ A.M.

The CAUSE OF DEATH* was as follows:

Premature
7 months -

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

R. B. Bowler M. D.1/7 1922 (Address) Bonners Ferry Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Bonners Ferry, Ida

DATE OF BURIAL

1/7/1922

20. UNDERTAKER

D. W. Chisholm

ADDRESS

Bonners Ferry, Ida

FORM V. S. No. 5-25 M. 1-19.

V
CERTIFICATE OF DEATHState of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **36803**
Registered No. _____

1. PLACE OF DEATH

County of Bannock
City of Bonners FerryRegistration District No. 73156
Primary Registration District No. _____
(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Hiram Wesley Covell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH

April 22 1902
(Month) (Day) (Year)

7. AGE

69 Yrs. 8 Mos. 18 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Laborer
Wood Turner

9. BIRTHPLACE

(State or Country)

Canada

10. NAME OF FATHER

A. Covell

11. BIRTHPLACE OF FATHER

(State or Country)

Canada

12. MAIDEN NAME OF MOTHER

Mary Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas. B. Covell
(Address) Sand Point IdaFiled Jan. 11th 1922E. E. Fry
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 10 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Dec. 1920 to Jan. 10th 1922
that I last saw him alive on Jan. 10th 1922
and that death occurred on the date stated above, at 6:30 P.M.
The CAUSE OF DEATH* was as follows:Chronic Myocarditis(Duration) 1 Yrs. 2 mos. _____ ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

E. E. Fry M. D.
1/11/1922 (Address) Bonners Ferry, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. 5 days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence Bonners Ferry, Ida

19. PLACE OF BURIAL OR REMOVAL

Bonners Ferry, Ida

DATE OF BURIAL

1/12 1922

20. UNDERTAKER

E. E. Fry

ADDRESS

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36804

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH. Registration District No. 29.
County of Boundary Primary Registration District No. 1st.
City of Caddie (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs L. M. Harris

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female white (Write the word.)

6. DATE OF BIRTH

July 28 1846
(Month) (Day) (Year)

7. AGE

75 yrs. 5 mos. 16 ds.

IF LESS than 1 day
how many hrs. or
. mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Saxington N. York

10. NAME OF FATHER

unknown

11. BIRTHPLACE OF FATHER

(State or Country)

unknown

12. MAIDEN NAME OF MOTHER

unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. N. Ward

(Address) Caddie Ida.

15.

Filed Jan 16th 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

January 14 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191. to 191.

that I last saw h. alive on 191.

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage.

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

1/16/22 (Address) Bonner Ferry, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bonner Ferry Ida

1/16 1922

20. UNDERTAKER

ADDRESS

C. N. Ward

Bonner Ferry Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **36805**

1. PLACE OF DEATH.

Registration District No. **79**

County of **Boundary**

Primary Registration District No. **21st**

City of **Bonners Ferry**

(No. _____) (St. _____)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Norma Irene Van Etten

Registered No. _____
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

Dec
(Month)

12
(Day)

1920
(Year)

7. AGE

1 yrs. **1** mos. **17** ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Joseph Earl Van Etten

11. BIRTHPLACE OF FATHER

(State or Country)

Nebraska

12. MAIDEN NAME OF MOTHER

Alta Bliss

13. BIRTHPLACE OF MOTHER

(State or Country)

Colo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Joseph Earl Van Etten

(Address)

Bonners Ferry, Ida

15.

Filed

Jan. 30th 1922

E. E. Strick
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan
(Month)

29
(Day)

1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from **Jan. 28th 1922**, to **Jan. 29th 1922**, that I last saw her alive on **Jan. 28 - 1922**, and that death occurred on the date stated above, at **4 P. M.**
The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) _____ yrs. _____ mos. **4** ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

1/31/1922 (Address) **Bonners Ferry, Ida**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bonners Ferry, Ida

1/31 1922

20. UNDERTAKER

ADDRESS

OR Strick

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

✓ CERTIFICATE OF DEATH.

 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

 Registration District No. _____
 County of Canyon Primary Registration District No. 200
 City of Nampa (No. Idaho Sanitarium St.)
File No. 36806

Registered No. _____

 If death occurs away from
usual residence, give facts
called for under special
information.

2. FULL NAME

Ray Melale
 If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

 3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

Male White Single
 (Write the word.)

6. DATE OF BIRTH.

Dec 5 1921
 (Month) (Day) (Year)

7. AGE

 If LESS than 1 day
how many hrs. or
..... min. 2]

 Yrs. 1 Mos. 2.5 ds.

8. OCCUPATION

 (a) Trade, profession or
particular kind of work... None
 (b) General nature of in-
dustry, business, or estab-
lishment in which employ-
ed (or employer).....

9. BIRTHPLACE

 (State or Country) Leaverton Idaho

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

 (State or Country) Unknown

12. MAIDEN NAME OF MOTHER

Anna Berry

13. BIRTHPLACE OF MOTHER

 (State or Country) Berryville Ark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

 (Informant) Dr. B. B. B. B.
 (Address) Nampa Idaho

15.

 Filed Dec. 16 1922
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 30 1922
 (Month) (Day) (Year)

 17. I HEREBY CERTIFY, That I attended deceased from
Jan 3 1922 to Jan 30 1922,
 that I last saw him alive on Jan 30 1922,
 and that death occurred on the date stated above, at 2 A. M.

The CAUSE OF DEATH* was as follows:

Bact. Pneumonia
 (Duration) Yrs. _____ mos. 4 ds.

 Contributory Imperfect closure of
 (Secondary) foramen ovale

(Duration) Yrs. _____ mos. _____ ds.

 (Signed) Dr. B. B. B. B. M. D.

 19. (Address) Nampa Idaho

 *State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
 MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

 At place of death.....yrs.....mos. 27 days In the State.....yrs. 1 mos. 25 days

 Where was disease contracted
 if not at place of death?.....

 Former or usual residence Leaverton Idaho

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Kohlman Cem Feb 1 1922

20. UNDERTAKER ADDRESS

Paul K. Robinson Nampa
Idaho

FORM V. S. No. 5-25 M. 1-19.

V
CERTIFICATE OF DEATH

1. PLACE OF DEATH

Registration District No. 7
 County of Canyon FEB 10 1922
 Primary Registration District No. 2556
 City of Melba (State) ID. (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Dillard William Craner.

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 36807

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

December 7 1902
 (Month) (Day) (Year)

7. AGE

19 Yrs. 1 Mos. 0 ds.

IF LESS than 1 day
 how many..... hrs.
 or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmers.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho, Cassia Co.

10. NAME OF FATHER

William Jasper Craner.

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Luella Tanner.

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

William J. Craner

(Address)

Melba Idaho

15.

Filed

Feb. 10 1922

Pearl Bonds

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

January 17 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

for Head upon arrival 19.....
 that I last saw h..... alive on..... 19.....
 and that death occurred on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH* was as follows: Accidentally
 crushed by water tank.
 Thoracic vertebrae crushed,
 Chest crushed.

(Duration) 10 Yrs. 1 mos. 1 ds.
 ten minutes.

Contributory
 (Secondary)

(Duration) yrs. mos. ds.

(Signed) Samuel A. Sweeney M. D.

1-16-1922 (Address) Melba, Id.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Melba, Id.

DATE OF BURIAL

1-30-1922

20. UNDERTAKER

none

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon Registration District No. 1
City of Nampa Primary Registration District No. 1006
(No. 205-6th Ave St.)File No. 36808
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Hortense Decker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widow
(Write the word.)

6. DATE OF BIRTH

Mar 12 1852
(Month) (Day) (Year)

7. AGE

69 Yrs. 10 Mos. 12 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Housewife

9. BIRTHPLACE

(State or Country)

Kentucky

10. NAME OF FATHER

Wm. Hughes

11. BIRTHPLACE OF FATHER

(State or Country)

Kentucky

12. MAIDEN NAME OF MOTHER

Wells

13. BIRTHPLACE OF MOTHER

(State or Country)

Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wallace Decker

(Address)

Nampa Ida

15.

Filed Feb 11 1922George Jones
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 24, 1922
Oct 20 1921
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Oct 20 1921, to Jan 24, 1922, that I last saw her alive on Jan 24, 1922 and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

General arteriosclerosis with
uniform aneurysm of
a. femoral artery(Duration) Eleven yrs. _____ mos. _____ ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. P. Robinson M. D.

19. (Address) _____

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Kohlstaun Cem

DATE OF BURIAL

1 24 19 22

20. UNDERTAKER

Orin K Robinson

ADDRESS

NampaIda

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of CanyonCity of Haup

Registration District No.

Primary Registration District No.

(No. 521-11th ave St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary Alice Jones

File No.

Registered No. 36809

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED widow
(Write the word.)6. DATE OF BIRTH Apr. 22 1986
(Month) (Day) (Year)7. AGE 61 Yrs. 9 Mos. 5 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)At home

9. BIRTHPLACE

(State or Country)

Ill.

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

John W. Moberley
Kentucky

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Margaret Wright
Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Walter Miller
(Address) 521-11th ave South15. Filed Feb. 18 1922

Local Registrar

16. DATE OF DEATH

Jan 27 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Jan 18 1922 to Jan 27 1922 that I last saw him alive on Jan 27 1922 and that death occurred on the date stated above, at 6 A. M. The CAUSE OF DEATH* was as follows:Pneumonia(Duration) Yrs. mos. 9 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. H. Murray M. D.
1/28 1922 (Address) Haup Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Kohler lawn Cem2-1 1922

20. UNDERTAKER

ADDRESS

Fred K. RobinsonHaup Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Canyon*City of *Nampa*Registration District No. *7*Primary Registration District No. *1555*(No. *3* St.)File No. *36810*Registered No. *36810*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mabel Marie McCaw

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married

6. DATE OF BIRTH

Aug 10 1883

(Month)

(Day)

(Year)

7. AGE

38 Yrs. *5* Mos. *26* ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)*Housewife*

9. BIRTHPLACE

(State or Country)

Ida

10. NAME OF FATHER

C. B. Frost

11. BIRTHPLACE OF FATHER

(State or Country)

Maine

12. MAIDEN NAME OF MOTHER

Mary E. Hazen

13. BIRTHPLACE OF MOTHER

(State or Country)

Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

*J. McCaw
Nampa Ida*

15. FILED

*Feb. 18 1922**1922**Pearl D. Dyer*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 5 1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

✓ 19, to *✓* 19that I last saw her alive on *✓* 19and that death occurred on the date stated above, at *2:00* P. M.

The CAUSE OF DEATH* was as follows:

*Carcinoma
Called to see her after death.
Treated with Dr. Walker Portland Ore.
(Duration) *Oct 3* Yrs. mos. ds.*Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *Horace P. Belknap* M. D.*2/7 1922* (Address) *Nampa Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Kohlman

DATE OF BURIAL

2-8 1922

20. UNDERTAKER

Ed K. Robinson

ADDRESS

Nampa Ida

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
36811

1. PLACE OF DEATH

County of CanyonRegistration District No. 7City of NampaPrimary Registration District No. 1000(No. Pacific Hosp. St.)

File No. _____

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Paul Dwight Howard

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

2

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

B. J. Howard

11. BIRTHPLACE OF FATHER

(State or Country)

Wash.

12. MAIDEN NAME OF MOTHER

Grace Meier

13. BIRTHPLACE OF MOTHER

(State or Country)

Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

B. J. Howard

(Address)

Nampa, Ida

15.

Filed Feb. 16 1922Pearl Jones

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan - 22 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan - 4 1922 to Jan 22, 1922
that I last saw him alive on Jan 22 1922
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) Yrs. mos. ds.

Contributory Gastro Intestinal infection
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Thos E. Mangum M. D.Jan 24 1922 (Address) Nampa, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Kobler Law Co.

DATE OF BURIAL

1-24 1922

20. UNDERTAKER

Fred K Robinson

ADDRESS

Nampa, Idaho

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Canyon
City of Nampa

Registration District No.

Primary Registration District No.

(No. Mercy Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Benjamin Franklin Nott

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36812

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH

Mar. 3d 1862
(Month) (Day) (Year)

7. AGE

59 Yrs. 9 Mos. 11 ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Ill.

10. NAME OF FATHER

Ephriam Nott

11. BIRTHPLACE OF FATHER

(State or Country) Ill.

12. MAIDEN NAME OF MOTHER

Elizabeth Watson

13. BIRTHPLACE OF MOTHER

(State or Country) -----

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs B.F.Nott

(Address) Nampa Ida.

15.

Filed 7/20/22 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan. 15 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 10 1922 to Jan 15 1922
that I last saw him alive on Jan 15 1922
and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Septicaemia

(Duration) Yrs. mos. ds.

Contributory (Secondary) Mastoiditis

(Duration) Yrs. mos. ds. About 3

(Signed) Isaac P. Belknap M. D.

1/15/22 19 (Address) Nampa Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Kohlerlawn Cemetery

DATE OF BURIAL

1/17 1922

20. UNDERTAKER

Frank H. Robinson

ADDRESS

Nampa, Ida.

Belknap

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon
City of NampaRegistration District No. _____
Primary Registration District No. _____
(No. 10th ave N St.)File No. 36813

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Virginia Wilcox

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female White Single
(Write the word.)

6. DATE OF BIRTH

Jan 8 1910
(Month) (Day) (Year)

7. AGE

12 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)In school

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

W. A. Wilcox

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Clara Hart

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. A. Wilcox
(Address) Nampa Idaho

15.

Filed Feb. 16 1922 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan - 9 - 22
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from Jan 7 - 1922 to Jan 9 - 1922
that I last saw her alive on Jan 9 - 1922
and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Diphtheria(Duration) Yrs. mos. 7 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) F. B. Smith M. D.1/11/22 (Address) Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Koppleman Ave

DATE OF BURIAL

1/10 1922

20. UNDERTAKER

Ed H. Robinson

ADDRESS

Nampa

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of CanyonCity of Nampa

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7Primary Registration District No. 244(No. Mercy Hospital St.)File No. 36816

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Anna M. Raine

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female White Married
(Write the word.)

6. DATE OF BIRTH

July 29 1891
(Month) (Day) (Year)

7. AGE

30 Yrs. 6 Mos. 15 ds.
IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Housewife
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Indiana

10. NAME OF FATHER

A. J. McKinsty

11. BIRTHPLACE OF FATHER

(State or Country) Ind

12. MAIDEN NAME OF MOTHER

Eliza Hancock

13. BIRTHPLACE OF MOTHER

(State or Country) Ind

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. E. Raine(Address) Nampa Ida

15.

Filed Dec 16 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 12 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 19 1921, to Jan 12 1922
that I last saw her alive on Jan 12 1922,
and that death occurred on the date stated above, at 9 9 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia(Duration) 5 yrs. 5 mos. 5 ds.Contributory (Secondary) Erysipelas(Duration) 19 yrs. 19 mos. 19 ds.(Signed) M. D. Frank M. D.Jan 19 22 (Address) Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Hudson Kas

DATE OF BURIAL

19

20. UNDERTAKER

Fred K Robison

ADDRESS

Nampa Ida

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of *Canyon*
City of *Parma*Registration District No. *3*
Primary Registration District No. *1007*
(No. *3* St.)File No. *36819*
Registered No. *2*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Grace S Snyder

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *F.* 4. COLOR OR RACE *W.* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. *Married*
(Write the word.)6. DATE OF BIRTH. *November 12th 1899*
(Month) (Day) (Year)7. AGE *22* Yrs. *6* Mos. *28* ds.
IF LESS than 1 day how many hrs. or min. >]

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)*House wife*

9. BIRTHPLACE

(State or Country)

Colorado

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Inf. Habinsley
Parma Ida

15.

Filed

191

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan. 8 19*22*
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *July 10* 19*21* to *Jan 8* 19*22*,
that I last saw him alive on *Jan 8* 19*22*,
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(Duration) *4* Yrs. mos. ds.Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) *W. H. Mitchell* D.19..... (Address) *Parma Ida*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Parma**1-10-1922*

20. UNDERTAKER

ADDRESS

*Peckham Furco**Parma*

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 9County of CanyonPrimary Registration District No. 2007City of Parma

(No. _____ St.)

File No. 36820Registered No. 3

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Margaret Jane Knox Patrick

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

widow

(Write the word.)

6. DATE OF BIRTH.

Sept 27 1845
(Month) (Day) (Year)

7. AGE

86 Yrs. 3 Mos. 14 ds.IF LESS than 1 day
how many _____ hrs. or
_____ min. >]

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).Housewife

9. BIRTHPLACE

(State or Country) Ohio

10. NAME OF FATHER

John Knox Patrick

11. BIRTHPLACE OF FATHER

(State or Country) Do. Ohio

12. MAIDEN NAME OF MOTHER

Mary Vastlander

13. BIRTHPLACE OF MOTHER

(State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) L. K. Knox Patrick

(Address) _____

15.

Filed Jan 12 1922 Lula Waldorf
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 11 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Nov 15 1921 to Jan 11 1922that I last saw him alive on Jan 11 1922

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(Duration) 3 Yrs. _____ mos. _____ ds.Contributory
(Secondary)

(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed) A. M. Mitchell M. D._____ 19____ (Address) Parma, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Parma cemetery

DATE OF BURIAL

Jan 12 1922

20. UNDERTAKER

ADDRESS _____

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Canyon
City of PurbaRegistration District No. 2
Primary Registration District No. 2007
(No. _____ St.)File No. 36821
Registered No. 4

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wilder D Goss

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. m

(Write the word.)

6. DATE OF BIRTH.

June 3 1870
(Month) (Day) (Year)

7. AGE

51 Yrs. 24 Mos. 24 ds.IF LESS than 1 day
how many hrs. or
..... min. 2)

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).Farmer

9. BIRTHPLACE

(State or Country)

Colorado

10. NAME OF FATHER

John W Goss

11. BIRTHPLACE OF FATHER

(State or Country)

N. Y.

12. MAIDEN NAME OF MOTHER

Ellen Olcott

13. BIRTHPLACE OF MOTHER

(State or Country)

N. Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

J. O. Goss
Longmont, Colo.

15.

Filed Jan 29 1922 Huba Haldrop
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 27 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 1 1922, to Jan 27 1922,
that I last saw him alive on Jan 27 1922
and that death occurred on the date stated above, at 8 P. M.
The CAUSE OF DEATH* was as follows:Influenza(Duration) Yrs. _____ mos. 14 ds.Contributory (Secondary) Pleurisy Empyema(Duration) Yrs. _____ mos. 13 ds.(Signed) H. M. Hitchcock M. D.1-30-1922 (Address) Purba

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Purba Jan 29 1922

20. UNDERTAKER

ADDRESS

Peckham Farm Co Purba

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 3County of CanyonPrimary Registration District No. 2007City of Parma

(No. _____ St.)

File No. 36822

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Bryce M Campbell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

MWmarried
(Write the word.)

6. DATE OF BIRTH.

Sept 30
(Month) (Day)1922
(Year)

7. AGE

63

Yrs.

3

Mos.

29

ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....Retired

9. BIRTHPLACE

(State or Country)

Illinois

10. NAME OF FATHER

J. W. Campbell

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Kerstegian

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mary Campbell

(Address)

16. DATE OF DEATH

Jan. 29 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan. 20 1922 to Jan. 29 1922that I last saw him alive on Jan 29 1922

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Cancer of face(Duration) 2 Yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

M. M. Withaker M. D.Address) Parma

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

RoswellJan 31 1922

20. UNDERTAKER

ADDRESS

Pearson Fur CoParma

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

15.

Filed

Jan 29 19221922John Halden
Local Registrar

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Banyon Registration District No. 3
City of Baldwell Primary Registration District No. 2004
(No. Poor Farm St.)File No. _____
Registered No. 18

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Wm Carey Haskins

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male white Single
(Write the word.)

6. DATE OF BIRTH

Apr. 10 1889
(Month) (Day) (Year)

7. AGE

39 Yrs. 9 Mos. 28 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Farmer

9. BIRTHPLACE

(State or Country)

Nebraska

10. NAME OF FATHER

D. O. Haskins

11. BIRTHPLACE OF FATHER

(State or Country)

Iowa

12. MAIDEN NAME OF MOTHER

Ella George

13. BIRTHPLACE OF MOTHER

(State or Country)

Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. J. Haskins
(Address) Wilder Ida15. Filed Feb. 9 - 1922 John H. Mayes
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 8 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Feb. 7, 1922 to Feb. 9, 1922
that I last saw him alive on Feb. 8, 1922
and that death occurred on the date stated above, at _____ M.
The CAUSE OF DEATH* was as follows:Influenza(Duration) Yrs. mos. 8 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

2-9-22 M. D.
(Address) Baldwell Id

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Banyon Hill Feb. 9, 1922

20. UNDERTAKER ADDRESS

base Burn to Baldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon
City of CaldwellRegistration District No. 3
Primary Registration District No. 1005
(No. 10025 St.)File No. 30824
Registered No. 17

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Royal Henry Summers

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married

6. DATE OF BIRTH

Sept 28 1855
(Month) (Day) (Year)

7. AGE

66 Yrs. 4 Mos. 5 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Rancher

9. BIRTHPLACE

(State or Country)

Illinois

10. NAME OF FATHER

John H. Summers

11. BIRTHPLACE OF FATHER

(State or Country)

Illinois

12. MAIDEN NAME OF MOTHER

Charlotte J. Wick

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. W. F. Gentry

(Address)

Caldwell, Idaho

15. Filed

Feb. 4 - 1922John H. Meyers
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 3 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Sept. 14 1921, to Feb. 3 1922, that I last saw him alive on Feb. 3 1922, and that death occurred on the date stated above, at 4:06 P.M.

The CAUSE OF DEATH* was as follows:

barreness of the stomach

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) G. F. Hunt M.D.19 (Address) Caldwell, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Canyon Hill 2-5-1922

20. UNDERTAKER

ADDRESS

C. V. Peckham Caldwell

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Canyon
 City of Caldwell

Registration District No. 3
 Primary Registration District No. 1005
 (No. _____ St.)

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 36825
 Registered No. 16

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William Thompson Claybaugh
 If death occurred in a hospital, institution or camp, give its NAME instead of address and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED married

6. DATE OF BIRTH Oct 9 1847
 (Month) (Day) (Year)

7. AGE 74 Yrs. 3 Mos. 23 ds.
 IF LESS than 1 day
 how many _____ hrs.
 or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

Rancher

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

Lideon Claybaugh

11. BIRTHPLACE OF FATHER

(State or Country)

Pennsylvania

12. MAIDEN NAME OF MOTHER

Jane Thompson

13. BIRTHPLACE OF MOTHER

(State or Country)

Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. B. Claybaugh
Caldwell, Ida.

15. Filed Feb. 4 - 1922 John H. Meyer
 Local Registrar

16. DATE OF DEATH

Feb 2 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 14th 1922 to February 2nd 1922 that I last saw him alive on February 2nd 1922 and that death occurred on the date stated above, at 3 P.M. The CAUSE OF DEATH* was as follows:
Tuberculosis of lungs.
Long standing duration

Contributory
 (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Carl Warner, S.D.

19 _____ (Address) Caldwell, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Canyon Hill 2-4 1922

20. UNDERTAKER

ADDRESS

C. V. Peckham Caldwell, Ida.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of CanyonRegistration District No. 9City of Caldwell (No. Blaine St.)Primary Registration District No. 2005

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Blanche ValeState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 36826Registered No. 15

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED single6. DATE OF BIRTH Sept 12 18977. AGE 24 Yrs. 4 Mos. 19 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. At home
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Kansas10. NAME OF FATHER L. M. Vale

11. BIRTHPLACE OF FATHER

(State or Country) Wisconsin12. MAIDEN NAME OF MOTHER Amanda Myers

13. BIRTHPLACE OF MOTHER

(State or Country) Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. M. Myers(Address) Caldwell, Ida15. Filed Feb. 24 1922Local Registrar John V. Myers

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 31 192217. I HEREBY CERTIFY, That I attended deceased from Jan 31 1922 to Jan 31 1922
that I last saw him alive on Jan 31 1922
and that death occurred on the date stated above, at 10:30 AM.

The CAUSE OF DEATH* was as follows:

Asthma(Duration) Yrs. mos. ds.
Contributory (Secondary) Tuberculosis(Duration) 6 yrs. mos. ds.
(Signed) S. B. Dudley M. D.19. (Address) Caldwell, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Canyon HillDATE OF BURIAL 2-2 192220. UNDERTAKER E. V. PickhamADDRESS Caldwell

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **36827**
Registered No. **14**

1. PLACE OF DEATH

County of **Canyon**City of **Caldwell**Registration District No. **3**Primary Registration District No. **2005**

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jana Nellie McCall

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Jan 31 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from **Jan 10 1922** to **Jan 29 1922**
that I last saw h. & y. alive on **Jan 29 1922**
and that death occurred on the date stated above, at **7:30 AM**.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease(Duration) **2** Yrs. _____ mos. _____ ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

1/31 1922 (Address) **T. D. Garret**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Canyon Hill**1-31 1922**

20. UNDERTAKER

ADDRESS

E. V. Beckham**Caldwell**

V CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Banyon Registration District No. 3
 City of Caldwell Primary Registration District No. 1005
 (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Emeline Ruth Ballinger

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 36828
 Registered No. 13

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED widow
 (Write the word.)

6. DATE OF BIRTH

July 6 1
 (Month) (Day) (Year)

7. AGE

71 Yrs. 6 Mos. 19 ds.

IF LESS than 1 day
 how many _____ hrs.
 or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

Housewife
Nurse

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

David Ray

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Crow

13. BIRTHPLACE OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. J. Ballinger

(Address)

224 Tillmore

15.

Filed

Jan. 27 - 1922

John H. Ingers
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 25 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 19____, to _____ 19____,

that I last saw him _____ alive on _____ 19____, and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis
from report of doctor
attending whose last
call was for a part of
last week of September.

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Paul L. Case M. D.

County Coroner
 (Address) _____

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Banyon Hill

DATE OF BURIAL

1-27-1922

20. UNDERTAKER

CASE FURNITURE CO.

ADDRESS

CALDWELL, IDAHO

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE
CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36829
Registered No. 12

1. PLACE OF DEATH
County of Canyon
City of Baldwell

Registration District No. 3
Primary Registration District No. 20031
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ella Eliza Driscoll

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widow
(Write the word.)

6. DATE OF BIRTH Dec 24 1868
(Month) (Day) (Year)

7. AGE 53 Yrs. - 31 Mos. - 31 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business or establishment in which employed (or employer) Nurse

9. BIRTHPLACE England
(State or Country)

10. NAME OF FATHER Glanville

11. BIRTHPLACE OF FATHER England
(State or Country)

12. MAIDEN NAME OF MOTHER Bessie

13. BIRTHPLACE OF MOTHER England
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank D. Driscoll
(Address) Baldwell Idaho

15. Filed Jan 26 1922 John D. Mayes
Local Registrar

16. DATE OF DEATH Jan 25 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 15 1921 to Jan 25 1922 that I last saw him alive on Jan 25 1922 and that death occurred on the date stated above, at 9:45 P.M.

The CAUSE OF DEATH* was as follows:
Chronic emphysema

(Duration) 1 Yrs. mos. ds.

Contributory (Secondary) (Duration) yrs. mos. ds.

(Signed) Huber M. D.
1/26 1922 (Address) Baldwell Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Boise Idaho DATE OF BURIAL 1-27 1922

20. UNDERTAKER CASE FURNITURE CO. ADDRESS Baldwell

V
CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Canyon.
City of Caldwell

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 3
Primary Registration District No. 2005
(No. St.)State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 36830
Registered No. PP30

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Theodora Irvin Ford

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

Nov. 14 1921
(Month) (Day) (Year)

7. AGE

Yrs. 2 Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).at home

9. BIRTHPLACE

(State or Country)

Idaho.

10. NAME OF FATHER

Mr Clyde Ford.

11. BIRTHPLACE OF FATHER

(State or Country)

Missouri.

12. MAIDEN NAME OF MOTHER

Ida Buffington

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

C. G. Ford

(Address)

Caldwell R#2

15.

Filed

Jan. 21 - 1922 John H. Meyer

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 21 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19

that I last saw him alive on 19

and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

Symptoms - Acute Congestion of lungs.

(Duration) Yrs. mos. ds.

Contributory (Secondary)

Had a cold.No physician saw this case.
(Duration) Yrs. mos. ds.

(Signed)

John H. Meyer M.D.1/22/1922 (Address) Caldwell, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Parma, Ida.1-22-1922

20. UNDERTAKER

ADDRESS

C. V. PeckhamCaldwell, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

PLACE OF DEATH

County of Canyon
City of Wilder

Registration District No. 3
Primary Registration District No. 2005
(No. St.)

File No. 36832
Registered No. 36832

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Adam Lehmann

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married

6. DATE OF BIRTH Dec 9 1878
(Month) (Day) (Year)

7. AGE 43 Yrs. 1 Mos. 10 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Carpenter
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE Pennsylvania
(State or Country)

10. NAME OF FATHER Christian Lehmann

11. BIRTHPLACE OF FATHER Germany
(State or Country)

12. MAIDEN NAME OF MOTHER Elizabeth Maurer

13. BIRTHPLACE OF MOTHER Germany
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm. Lematt Lehmann
(Address) Wilder Ida

15. Filed Jan. 22- 1922 John H. Meyer
Local Registrar

16. DATE OF DEATH Jan 19 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 15 1921 to Dec 19 1921
that I last saw him alive on Jan 19 1922
and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:
Tuberculosis

(Duration) 3 Yrs. mos. ds.
Contributory (Secondary) Pneumonia
(Duration) yrs. mos. 3 ds.
(Signed) Carl H. Mouch M. D.
19 (Address) Wilder Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Wilder Cemetery DATE OF BURIAL 1-22-1922
20. UNDERTAKER E. V. Beckham ADDRESS Caldwell

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon
City of CaldwellRegistration District No. 3Primary Registration District No. 2005

(No. _____ St.)

File No. 36833Registered No. 8

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Goodrow

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-OWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH

Jan 18 1922
(Month) (Day) (Year)

7. AGE

Yrs. _____ Mos. 1 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

E. Goodrow

11. BIRTHPLACE OF FATHER

(State or Country) Idaho

12. MAIDEN NAME OF MOTHER

Luttrude Harris

13. BIRTHPLACE OF MOTHER

(State or Country) Oklahoma

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Eugene Goodrow(Address) Caldwell, Ida

15.

Filed Jan. 20 - 1922Local Registrar John H. Meyer

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 19 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 18 1922 to Jan 19 1922
that I last saw him alive on Jan 19 1922
and that death occurred on the date stated above, at 11:30 AM.

The CAUSE OF DEATH* was as follows:

practically a stillbirth

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed) J. H. Meyer M. D.20 1922 (Address) Caldwell, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Canyon Hill 1-20 1922

20. UNDERTAKER

ADDRESS

C. W. Dickham Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

✓ CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of CanyonCity of Worship

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 9Primary Registration District No. 2005

(No. _____ St.)

File No. 36834Registered No. 7

2. FULL NAME

William Leslie Robison

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDmale white (Write the word.)

6. DATE OF BIRTH

Dec 9 1918
(Month) (Day) (Year)

7. AGE

9 Yrs. 1 Mos. 15 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).At home

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

C. L. Robison

11. BIRTHPLACE OF FATHER

(State or Country)

Illinois

12. MAIDEN NAME OF MOTHER

Maudie McKinley

13. BIRTHPLACE OF MOTHER

(State or Country)

Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

C. L. Robison

(Address)

Worship Ida

15.

Filed Jan. 20 - 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 18 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 14 1922 to Jan 16 1922
that I last saw him alive on Jan 17 1922
and that death occurred on the date stated above, at 9 A.M.
The CAUSE OF DEATH* was as follows:Pneumonia(Duration) _____ Yrs. _____ mos. 9 ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) E. J. Mackey M. D._____ 19____ (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Canyon Hill 1-21 1922

20. UNDERTAKER

ADDRESS

C. J. Beckham Caldwell

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36825

Registered No. 6

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Canyon
City of Lupton, N.H.

Registration District No. 3

Primary Registration District No. 2005
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Eva Gibson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Infant.
(Write the word.)

6. DATE OF BIRTH.

Jan 9 1922
(Month) (Day) (Year)

7. AGE

7 Yrs. Mos. ds.

IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Infant.

9. BIRTHPLACE

(State or Country)

Lupton, N.H.

10. NAME OF FATHER

J. V. Gibson

11. BIRTHPLACE OF FATHER

(State or Country)

Union, Ore.

12. MAIDEN NAME OF MOTHER

Maud Herman

13. BIRTHPLACE OF MOTHER

(State or Country)

La Grande, Ore.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

J. V. Gibson

15.

Filed Jan 16 1922

John V. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 15 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to 191
that I last saw him alive on 191
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Pneumonia
(Pneumonia)

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) W. J. Baker M. D.

Jan 1922 (Address) W. J. Baker
*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

* La Grange Cemetery Jan 16 1922

20. UNDERTAKER

* Geo. P. C. * Lupton #2

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon
City of CaldwellRegistration District No. 3Primary Registration District No. 2009

(No. _____ St.)

File No. 36836Registered No. 5

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Eliza E. Kainey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-OWED OR DIVORCED

Female whitemarried
(Write the word.)

6. DATE OF BIRTH

Jan 10 1879
(Month) (Day) (Year)

7. AGE

43 Yrs. 0 Mos. 3 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Kansas

10. NAME OF FATHER

D. Walton

11. BIRTHPLACE OF FATHER

(State or Country)

Ill.

12. MAIDEN NAME OF MOTHER

Danicks

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

C. W. Kainey

(Address)

Caldwell, Ida

15.

Filed Jan. 15 1922John H. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 13 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct. 18 1921 to Jan 13 1922that I last saw him alive on Jan 13 1922and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) G. F. Hunt M.D.19 _____ (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Canyon Hill

DATE OF BURIAL

1-16 1922

20. UNDERTAKER

C. V. Peckham

ADDRESS

Caldwell, Ida

WRITE PLAINLY, WITH UNFAADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of *Caribou*
City of *Soda Springs*Registration District No. *82*
Primary Registration District No. *2159*
(No. St.)File No. *36837*
Registered No. *233*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Anna Marjory Campbell*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH.

August 6 1921
(Month) (Day) (Year)

7. AGE

6 Yrs. *16* Mos. *16* ds.IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)*None*
Child

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Chas. Campbell

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Stella Patton

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Grace Bence
Soda Spring Id

15.

Filed

Jul 28 1922
E. D. Whelan
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

February 22 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *Feb 21 1922* to *Feb 22 1922* that I last saw her alive on *Feb 21 1922* and that death occurred on the date stated above, at *10 A.* M.
The CAUSE OF DEATH* was as follows:*Acute Intestinal*
hemorrhage(Duration) Yrs. mos. *1* ds.Contributory *Quadruple ulcer (?)*
(Secondary)(Duration) yrs. mos. *12* ds.(Signed) *Russell F. J. M. D.**Jul 22 1922* (Address) *Soda Spring Id*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence *Lava Hot Sp. Id*

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lava Hot Sp. Id *Jul 24 1922*

20. UNDERTAKER

ADDRESS

E. D. Whelan *Soda Spring*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M, 6-15-17

CERTIFICATE OF DEATH

 Rich,
State of Idaho
BOARD OF HEALTH

Bureau of Vital Statistics

File No. 36829

 Registered No. 567
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Cassia

Registration District No. 117

Primary Registration District No. 2196

(No. St.)

 City of Burley
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Albert Samuel Curt.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single (Write the word.)

6. DATE OF BIRTH

 Nov. 15 1922
(Month) (Day) (Year)

7. AGE

18 Yrs. 2 Mos. 16 ds.

 IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Utah

10. NAME OF FATHER

Samuel Hughes Curt.

11. BIRTHPLACE OF FATHER

(State or Country) Ogden Utah

12. MAIDEN NAME OF MOTHER

Celestia M. Short.

13. BIRTHPLACE OF MOTHER

(State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Sam H. Curt.

(Address)

Burley Ida.

15.

Filed

Feb. 2 1922

W. J. C. Patterson

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

 Jan 28 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 17 1922 to Jan 28 1922

that I last saw him alive on Jan 28 1922

and that death occurred on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:

Post diphtheritic paralysis of the heart

(Duration) Yrs. mos. 11 ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) B. A. Rich M. D.

Jan 30 1922 (Address) Burley Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days, State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Burley Ida.

DATE OF BURIAL

Jan 28 1922

20. UNDERTAKER

L. B. Talley

ADDRESS

Burley Ida

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36848
Registered 36848
If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of CassiaRegistration District No. 117Primary Registration District No. 2.196

(No. St.)

City of Burley

If death occurs away from
usual residence, give facts
called for under special
information.

2. FULL NAME Arthur Leslie Thompson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.MaleWhiteSingle (Write the word.)

6. DATE OF BIRTH.

Feb. 1 1921
(Month) (Day) (Year)

7. AGE

2 Yrs. 11 Mos. 24 ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of in-
dustry, business, or estab-
lishment in which em-
ployed (or employer)

At Home

9. BIRTHPLACE

(State or Country) Isiwaika Utah10. NAME OF
FATHERChester R. Thompson11. BIRTHPLACE
OF FATHER(State or Country) Mapleton Utah12. MAIDEN NAME
OF MOTHERNettie Whitting13. BIRTHPLACE
OF MOTHER(State or Country) Mapleton Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chester R. Thompson(Address) Burley, Ida.

15.

Filed Feb. 2 1922Dr. J. E. Patterson

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan. 24 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan. 24, 1921 to Jan. 24, 1922that I last saw him alive on Jan. 24, 1922and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia(Duration) Yrs. mos. 4 ds.Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) J. E. Patterson M. D.2-1 1922 (Address) Burley, Ida.

*State the Disease Causing Death; or in deaths from Violent
Causes, state (1) Means of Injury; and (2) whether Accidental,
Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place In the
of death yrs. mos. days, State yrs. mos. days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Burley Ida.

DATE OF BURIAL

Jan. 27, 1922

20. UNDERTAKER

L. B. Talley

ADDRESS

Burley Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Patterson
State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. *36841*
Registered No. *5866*
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

CERTIFICATE OF DEATH

1. PLACE OF DEATH
County of *Cassia*
City of *Burley*
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME *Murray Henry Norton*
Registration District No. *117*
Primary Registration District No. *2196*
(No. St.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. *Single*
(Write the word.)
6. DATE OF BIRTH. *Jan 13 1922*
(Month) (Day) (Year)
7. AGE *3* IF LESS than 1 day how many hrs. or min.?
..... Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) *Burley Ida*10. NAME OF FATHER *David R. Norton*

11. BIRTHPLACE OF FATHER

(State or Country) *Ariz*12. MAIDEN NAME OF MOTHER *Mabel Burgess*

13. BIRTHPLACE OF MOTHER

(State or Country) *Utah*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *David R. Norton*(Address) *Burley Ida*

15.

Filed *Jan. 26 1922*Local Registrar. *R. J. Patterson*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *Jan 25 1922*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Jan. 23 1922* to *Jan. 25 1922*
that I last saw him alive on *Jan. 24 1922*
and that death occurred on the date stated above, at *4 a.* M.

The CAUSE OF DEATH* was as follows:

Maldevelopment(Duration) Yrs. mos. *2* ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) *J. C. Patterson* M. D.*1-26 1922* (Address) *Burley Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days, State yrs. mos. days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Pleasant View Cemetery

DATE OF BURIAL

Jan. 25 1922

20. UNDERTAKER

R. H. Watt

ADDRESS

Burley Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

1. PLACE OF DEATH
County of Cassia Registration District No. 117
City of Burley Primary Registration District No. 2196
If death occurs away from usual residence, give facts called for under special information.

CERTIFICATE OF DEATH

Patterson
State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36843
Registered No. 36843
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George Arthur Nelson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M **4. COLOR OR RACE** W **5. SINGLE, MARRIED, WIDOWED OR DIVORCED.** Married
6. DATE OF BIRTH. Nov 15 1869
(Month) (Day) (Year)
7. AGE 54 Yrs. 1 Mos. 24 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Ohio

10. NAME OF FATHER Abraam Nelson

11. BIRTHPLACE OF FATHER
(State or Country) Pa

12. MAIDEN NAME OF MOTHER Sarah Maigs

13. BIRTHPLACE OF MOTHER
(State or Country) Pa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. G. A. Nelson
(Address) Burley, Idaho

15. Filed Jan 8 1922 H. J. C. Patterson
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 8 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 8 10 1921 to Jan 8 1922
that I last saw him alive on Jan 7 1922
and that death occurred on the date stated above, at 2:30 P. M.

The CAUSE OF DEATH* was as follows:
Carcinoma of left shoulder and stomach
(Duration) Yrs. several mos. ds.

Contributory (Secondary)
(Duration) Yrs. mos. ds.
(Signed) J. C. Patterson M. D.
1-8-22 (Address) Burley, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days, In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Reese Hill

20. UNDERTAKER R. J. Miller

DATE OF BURIAL

Jan 9 1922

ADDRESS

Burley Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

✓ CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Cassia
City of BurleyRegistration District No. 117
Primary Registration District No. 2196
(No. _____ St.)File No. 36814
Registered No. 36814

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary Alice Osborn

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married

6. DATE OF BIRTH.

April 7 1854
(Month) (Day) (Year)

7. AGE

67 Yrs. 8 Mos. 28 ds.IF LESS than 1 day
how many _____ hrs. or
_____ min. 2)

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....Housewife

9. BIRTHPLACE

(State or Country)

Ind

10. NAME OF FATHER

James Buster

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Martha Huick

13. BIRTHPLACE OF MOTHER

(State or Country)

Ind

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs J. C. Askell

(Address)

Burley

15.

Filed Jan 6 1922Her. J. C. Patterson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 5 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Jan 3 1922 to Jan 4 1922,
that I last saw her alive on Jan 4 1922,
and that death occurred on the date stated above, at _____ M.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage(Duration) _____ Yrs. _____ Mos. _____ ds.
Contributor (Secondary) Arteriosclerosis(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) J. F. Bernstein M. D.
19 _____ (Address) Burley

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Lawrence City - Nebr

DATE OF BURIAL

on arrival 1922

20. UNDERTAKER

R. R. Matt

ADDRESS

Burley Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH. *Clark*
County of *Clark* Registration District No. *125*
City of *Subow* Primary Registration District No. *2203*
St. (No. *125*)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Sarah Elizabeth Burnside*

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. *36844*
Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. *married*
(Write the word.)

6. DATE OF BIRTH *March 24 1853*
(Month) (Day) (Year)

7. AGE *68* yrs. *9* mos. *13* ds.
IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work *Housewife*
(b) General nature of industry business, or establishment in which employed (or employer) _____

9. BIRTHPLACE *Ireland*
(State or Country)

10. NAME OF FATHER *William Funge*

11. BIRTHPLACE OF FATHER *England*
(State or Country)

12. MAIDEN NAME OF MOTHER *Sarah E. Ayer*

13. BIRTHPLACE OF MOTHER *Ireland*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *James Burnside*(Address) *Spencer Idaho*

15. Filed *Jan 11 1922* *W E Jones M D*
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan 11 1922
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from *Jan 2 1922* to *Jan 11 1922*,
that I last saw her alive on *Jan 11 1922*,
and that death occurred on the date stated above, at *11:30 P.M.*

The CAUSE OF DEATH* was as follows:

Bronchopneumonia(Duration) yrs. mos. *10* ds.

Contributory (Secondary) _____

(Duration) yrs. mos. ds.

(Signed) *W E Jones* M. D.*1/11 1922* (Address) *Subow Idaho*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL *Subow Idaho* DATE OF BURIAL *Jan 13 1922*20. UNDERTAKER *none* ADDRESS _____

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **36845**
Registered No. **1**

1. PLACE OF DEATH. Registration District No. **90**
County of **Clearwater** Primary Registration District No. **7168**
City of **Orofino** (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Oscar Anderson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Single**
(Write the word.)

6. DATE OF BIRTH **About** **1875**
(Month) (Day) (Year)

7. AGE **About** **47** yrs. mos. ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work **Tie Maker**
(b) General nature of industry business or establishment in which employed (or employer) **Making R.R. Ties**

9. BIRTHPLACE (State or Country) **Sweden**

10. NAME OF FATHER **Anderson**

11. BIRTHPLACE OF FATHER (State or Country) **Unknown**

12. MAIDEN NAME OF MOTHER **Unknown**

13. BIRTHPLACE OF MOTHER (State or Country) **Unknown**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **J. W. Atteberry**
(Address) **Orofino, Idaho**

15. **Filed** **Feb 1, 1922** **J. W. Atteberry**
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH **January Eighth** **1922**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **July 21st 1913** to **January 8th 1922**
that I last saw him alive on **January 8th 1922**
and that death occurred on the date stated above, at **8:45 A. M.**

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. ds.

Contributory (Secondary) **Insanity**

(Duration) yrs. mos. ds.

(Signed) **John W. Stevens** M. D.

January 8th 1922 (Address) **Orofino, Idaho**
*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place **8** yrs. **5** mos. **19** ds. In the **over** **8** yrs. **5** mos. **19** ds.

Where was disease contracted, If not at place of death?

Former or usual residence. **Bonner County, Idaho**

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
The Northern Idaho Sanitarium **1/1/1922**
Orofino, Idaho **1922**

20. UNDERTAKER ADDRESS

J. W. Atteberry **Orofino, Idaho**

RECEIVED CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 36850
Registered No. 36850

1. PLACE OF DEATH

County of Blaine
City of Mt HomeRegistration District No. 34.
Primary Registration District No. 2020.
(No. St.)If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

John Wilson

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH

April 9 1884
(Month) (Day) (Year)

7. AGE

77 Yrs. 9 Mos. 29 ds.
IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer).

Miner

9. BIRTHPLACE

(State or Country)

Unknown

10. NAME OF
FATHER11. BIRTHPLACE
OF FATHER

(State or Country)

12. MAIDEN NAME
OF MOTHER13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank Jackson

(Address) Mt Home Ida

15.

Filed 2-1-1922

J E Evans
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan. 7 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
11-1-1921, to Jan 7-1922
that I last saw him alive on Jan 6-1922
and that death occurred on the date stated above, at 2 A.M.
The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 2 Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J E Evans M. D.

1-8-1922 (Address) Mt Home Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Mt Home - Idaho

DATE OF BURIAL

19

20. UNDERTAKER

Fred K. Robinson

ADDRESS

Pampa Ida

RECEIVED CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

Registration District No.

Primary Registration District No.

(No.

St.)

File No.

Registered No. 36851

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF
FATHER11. BIRTHPLACE
OF FATHER

(State or Country)

12. MAIDEN NAME
OF MOTHER13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

1 - 23 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1 - 16 - 1922, to 1 - 22 - 1922

that I last saw him alive on 1 - 22 - 1922

and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Acute Articular Rheumatism

(Duration) yrs. mos. 7 ds.

Contributory Endocarditis

(Duration) yrs. mos. 2 ds.

(Signed) J. E. Evans M. D.

1-24-1922 (Address) Mtn Home Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mtn Home Ida 1-25-1922

20. UNDERTAKER

ADDRESS

A. H. Connor Mtn Home

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH
in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH

County of *Elmore*City of *Mountain*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED CERTIFICATE OF DEATH

Registration District No. *34*Primary Registration District No. *2020*(No. *3*)St. *Idaho*State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

36852

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

*Female**White**Married*
(Write the word.)

6. DATE OF BIRTH

(Month) *July*(Day) *7*(Year) *1961*

7. AGE

60 Yrs*5* Mos*19* ds

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Kansas

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

Marky, Phelps
New York

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Ramie McDonald
Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mrs. A. W. Cottner*(Address) *mt. Home Idaho*

15.

Filed *1-25-1922**J. E. Evans*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan

(Month)

24

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

1-10-1922 to *19*that I last saw him alive on *1-27-1922*and that death occurred on the date stated above, at *4:30 P.M.*

The CAUSE OF DEATH* was as follows:

Dementia(Duration) *2* Yrs. *1* mos. *1* ds.Contributory
(Secondary)(Duration) *1* yrs. *1* mos. *1* ds.(Signed) *J. E. Evans*

M. D.

1-23-1922 (Address) *Mountain Home Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death *1* yrs. *1* mos. *1* day In the State *1* yrs. *1* mos. *1* day

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Mountain Home Cemetery**1/26/22*

20. UNDERTAKER

ADDRESS

*Wm. McBratney**Boise Idaho*

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Franklin
City of Clifton, Ft.

Registration District No. 27
Primary Registration District No. 2119
(No. St.)

File No. 36853
Registered No. 8

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Hula Varnas Harmon

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-OWED OR DIVORCED

Female White

single
(Write the word.)

6. DATE OF BIRTH

Sept 7 1874
(Month) (Day) (Year)

7. AGE

46 Yrs. 5 Mos. 18 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

House work

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Henry Martin Harmon

11. BIRTHPLACE OF FATHER

(State or Country)

Penn

12. MAIDEN NAME OF MOTHER

Susan Marler

13. BIRTHPLACE OF MOTHER

(State or Country)

Miss

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs Marion Henderson

(Address)

Clifton, Ida

15.

Filed 7-10

1922

J. P. Cutler

Local Registrar

16. DATE OF DEATH

Jan 27 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 25 1922 to Jan 27 1922

that I last saw her alive on Jan 25 1922

and that death occurred on the date stated above, at 8:00 P.M.

The CAUSE OF DEATH was as follows:

acute bacterial endocarditis

(Duration) Yrs. 2 mos. ds.

Contributory (Secondary) Chronic cardio valvular disease

(Duration) 5 yrs. mos. ds.

(Signed) A. P. Cutler M. D.

127 1922 (Address) Preston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Clifton, Ida

Jan 31 1922

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Franklin Registration District No. 27
City of Dayton Primary Registration District No. 2119
(No. _____ St.)File No. 36854Registered No. 5

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Stephen James Callan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH

December 16 1871
(Month) (Day) (Year)

7. AGE

50 Yrs. 21 Mos. 1 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Farming & stock raising
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Utah

10. NAME OF FATHER

Stephen Callan

11. BIRTHPLACE OF FATHER

(State or Country) Ireland

12. MAIDEN NAME OF MOTHER

Mary Bodew

13. BIRTHPLACE OF MOTHER

(State or Country) Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) M. L. Perkins(Address) Dayton Idaho

15.

Filed 2-11 1922 Mrs. Ida J. J. J.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 6 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 15 1921, to Jan 6 1922
that I last saw him alive on Jan 3 1922
and that death occurred on the date stated above, at 8:45 A.M.

The CAUSE OF DEATH* was as follows:

Insane gun shot through temporal region
(Duration) _____ Yrs. _____ mos. _____ ds.Contributory Diabetes mellitus
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) P. R. Cutler, Jr. M. D.1-7 1922 (Address) Preston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Dayton

DATE OF BURIAL

Jan 7 1922

20. UNDERTAKER

W. A. Skidmore

ADDRESS

Preston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36855

1. PLACE OF DEATH. Registration District No. 27
County of Franklin Primary Registration District No. 119
City of Preston (No. , St.)

Registered No. 4

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jennie Mae Martin

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH April 24 1912
(Month) (Day) (Year)

7. AGE 9 yrs. 9 mos. 12 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer).

9. BIRTHPLACE Idaho
(State or Country) Franklin County

10. NAME OF FATHER Wm Burton Martin

11. BIRTHPLACE OF FATHER Bear Lake Idaho
(State or Country)

12. MAIDEN NAME OF MOTHER Bessie Casperson

13. BIRTHPLACE OF MOTHER Logan Utah
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Bert Martin

(Address)

15.

Filed 2-11-1912 Mrs. Ida Lippert

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Jan 5 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug-28 1921, to Jan 5 1922 that I last saw her alive on Jan 5 1922 and that death occurred on the date stated above, at 1:30 PM.

The CAUSE OF DEATH* was as follows:

Pneumonia with mitral disease of heart.

(Duration) 1 yrs. 9 mos. ds.

Contributory (Secondary) Pneumonia

(Duration) yrs. mos. ds.

(Signed) J. W. States M. D.

Jan 5 - 1922 (Address) Preston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Preston Ida Jan 7 1922

20. UNDERTAKER ADDRESS

W. C. Hedgemon Preston Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36856

Registered No. 3

1. PLACE OF DEATH

County of Franklin
City of PrestonRegistration District No. 27Primary Registration District No. 2119

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Samuel A. Merrill

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the words)

6. DATE OF BIRTH

April 2 1846
(Month) (Day) (Year)

7. AGE

73 Yrs. 8 Mos. 30 ds.
IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

United States

10. NAME OF FATHER

Samuel Merrill

11. BIRTHPLACE OF FATHER

(State or Country)

U. S.

12. MAIDEN NAME OF MOTHER

Elizabeth Runyon

13. BIRTHPLACE OF MOTHER

(State or Country)

U. S.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Elvira T. Merrill(Address) Preston Idaho.

15.

Filed Jan 4 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 1 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 26 1921, to Jan 1 1922that I last saw him alive on Jan 1 1921,and that death occurred on the date stated above, at Preston Idaho

The CAUSE OF DEATH* was as follows:

Chronic Coronary

(Duration) Yrs. mos. ds.

Contributory (Secondary) Coronary dilatationChronic myocarditis

(Duration) Yrs. mos. ds.

(Signed) W. A. Skidmore M. D.1-3 1922 (Address) Preston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 13 yrs. 8 mos. 6 days. In the State 37 yrs. 9 mos. 9 days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Smithfield Utah Jan 4 1922

20. UNDERTAKER

ADDRESS

W. A. Skidmore Preston

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Franklin
City of PrestonRegistration District No. 27Primary Registration District No. 2119

(No. _____ St.)

File No. 36857Registered No. 36857

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

George H. Blair

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WID-OWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

June 27 1891
(Month) (Day) (Year)

7. AGE

30 Yrs. 6 Mos. 6 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Farmer

9. BIRTHPLACE

(State or Country)

Lewiston, Id.

10. NAME OF FATHER

Wm. M. Blair

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Lovina Haynes

13. BIRTHPLACE OF MOTHER

(State or Country)

Eng.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Samuel Blair

(Address)

Lewiston, Id.

15. Filed

Jan 4 19 22

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 2 19 22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 24 19 21, to Jan 2 19 22
that I last saw him alive on Jan 1 19 22,
and that death occurred on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(Duration) Yrs. 3 mos. 6 ds.Contributor Spontaneous
(Secondary)(Duration) yrs. 10 mos. 10 ds.(Signed) A. R. Cutler M. D.1-3 19 22 (Address) Preston, Id.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Lewiston, Utah

DATE OF BURIAL

Jan 13 19 22

20. UNDERTAKER

W. A. Shridmon

ADDRESS

1-3

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics1. PLACE OF DEATH **RECEIVED**County of *Franklin*City of *Preston*Registration District No. *27*Primary Registration District No. *2419*

(No. _____ St.)

File No. *36858*Registered No. *4*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Arabella Lillian Fyfe

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *Female* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *single*

(Write the word.)

6. DATE OF BIRTH

June 6 1883
(Month) (Day) (Year)

7. AGE

38 Yrs. *6* Mos. *29* ds.IF LESS than 1 day
how many *6* hrs.
or *6* min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)*General house work*
Home of parents

9. BIRTHPLACE

(State or Country)

Utah Cache

10. NAME OF FATHER

Willard Samuel Fyfe

11. BIRTHPLACE OF FATHER

(State or Country)

Denmark

12. MAIDEN NAME OF MOTHER

Lurah Caroline Hanson

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. Fyfe
Blackfoot Idaho

15.

Filed *2-11* 19 *22*

Local Registrar

16. DATE OF DEATH

1 (Month) *4* (Day) 19 *22* (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 27 19 *21*, to *Jan 4* 19 *22*that I last saw her alive on *Jan 4* 19 *22*and that death occurred on the date stated above, at *6 A.M.*

The CAUSE OF DEATH* was as follows:

Acidosis(Duration) Yrs. *2* mos. *2* ds.

Contributory (Secondary)

(Duration) yrs. *4* mos. *4* ds.

(Signed)

P. R. Cutler M. D.*1-7-1922* (Address) *Preston Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Preston Idaho**Jan 7 1922*

20. UNDERTAKER

ADDRESS

*W. C. Skidmore**Preston Idaho*

K
CERTIFICATE OF DEATHState of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36859
Registered No. 7

1. PLACE OF DEATH

County of Franklin
City of PrestonRegistration District No. 27
Primary Registration District No. 2119
(No. _____ St. _____)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Della Burton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Oct 8 1910
(Month) (Day) (Year)

7. AGE

11 Yrs. 2 Mos. 6 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

school pupil

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Treasureton Idaho

10. NAME OF FATHER

George Burton

11. BIRTHPLACE OF FATHER

(State or Country)

Bonanza Utah

12. MAIDEN NAME OF MOTHER

Mary Ransom

13. BIRTHPLACE OF MOTHER

(State or Country)

Treasureton Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Rev. J. J. J. J.(Address) Treasureton Idaho

15.

Filed 2-1119 22Mrs. Ida L. J. J.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

January 14 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan - 3 1922, to Jan 14 1922that I last saw him alive on Jan 12 1922and that death occurred on the date stated above, at 8:27 P.M.

The CAUSE OF DEATH* was as follows:

Phrenation of heart
Endocarditis(Duration) Yrs. _____ mos. 15 ds.

Contributory (Secondary)

Phrenation(Duration) 1 yrs. _____ mos. 4 ds.

(Signed)

G. W. States

M. D.

19

(Address)

Preston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Cleveland Ida

DATE OF BURIAL

Jan 17 1922

20. UNDERTAKER

W. B. Skidmore

ADDRESS

Preston

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 30860
Registered No.

1. PLACE OF DEATH

Registration District No. 19
County of Bremont Primary Registration District No. 127
City of Pauler BUREAU (No. 1111) St. ()

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

STATISTICS

John Austin Belnap

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

married

(Write the word.)

6. DATE OF BIRTH

May 9th 1887
(Month) (Day) (Year)

7. AGE

34 Yrs. 8 Mos. 9 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Instructor in School

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Hopew Utah

10. NAME OF FATHER

Wm J. Belnap

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Eliza Ann Watts

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wm J. Belnap

(Address)

Hopew Utah

15.

Filed

2 101922W. J. Belnap

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 28 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan. 13, 1922 to Jan 28 1922
that I last saw him alive on Jan 28 1922
and that death occurred on the date stated above, at 3 A.M.

The CAUSE OF DEATH* was (as follows)

Meningitis(Duration) Yrs. mos. 7 ds.

Contributory (Secondary)

Acute Chronic Dis. Media
and La grippe(Duration) Yrs. mos. 14 ds.

(Signed)

J. E. Melton M. D.2/31 1922 (Address) Stanley, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Benton

DATE OF BURIAL

Jan 31st 1922

20. UNDERTAKER

W. M. Hansen

ADDRESS

St. Anthony Idaho

FORM V. S. No. 5-A-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36861

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of *Fremont*
City of *St. Anthony*Registration District No. *99*Primary Registration District No. *317*

(No. St.)

If death occurs away from usual residence, give information for under special in-

2. FULL NAME

Norma Hobbs

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female *White* *Single*
(Write the word.)

6. DATE OF BIRTH

February *11* *1905*
(Month) (Day) (Year)

7. AGE IF LESS than 1 day

16 Yrs. *11* Mos. *29* ds. how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. *Student at High School*
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) *Cache, Idaho*

10. NAME OF FATHER

Earnest Hobbs

11. BIRTHPLACE OF FATHER

(State or Country) *London England*

12. MAIDEN NAME OF MOTHER

Rosalie Bruders

13. BIRTHPLACE OF MOTHER

(State or Country) *Marseilla France*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Earnest Hobbs*

(Address)

15.

Filed *2* *10* *1922* *W. S. W. S. W.*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan *13* *1922*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan. 6 *1922* to *Jan. 13* *1922*that I last saw her alive on *Jan. 13* *1922*and that death occurred on the date stated above, at *4:30* P.M.

The CAUSE OF DEATH* was as follows:

Peritonitis (general)(Duration) Yrs. mos. *7* ds.Contributory (Secondary) *Ruptured appendix*(Duration) Yrs. mos. *2* ds.(Signed) *J. E. Mettler* M. D.*Jan. 14* *1922* (Address) *St. Anthony, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Riverview Cemetery St. A.

20. UNDERTAKER

W. M. Hansen

DATE OF BURIAL

Jan 16 1922

ADDRESS

St. Anthony

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36862
Registered No. _____

1. PLACE OF DEATH

Registration District No. 49County of FremontPrimary Registration District No. 2177City of Teton

(No. _____)

St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lucy Atkinson Stewart

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female

White

Married

(Write the word.)

6. DATE OF BIRTH

July

25th

1880

(Month)

(Day)

(Year)

7. AGE

41 Yrs. 5 Mos. 16 ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Alfred H. Atkinson

11. BIRTHPLACE OF FATHER

(State or Country)

Not Known

12. MAIDEN NAME OF MOTHER

Matilda Petersen

13. BIRTHPLACE OF MOTHER

(State or Country)

Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed 2 1119 22

W. S. W. S.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

January 11th 1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from December 3rd, 1921, to Dec. 6th, 1921 that I last saw her alive on Dec. 7th, 1921 and that death occurred on the date stated above, at 8 P. M. The CAUSE OF DEATH* was as follows:

Valvular disease chronic cardiac

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

M. D.

(Address) Stanching Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Newton, Utah

Jan. 15, 1922

20. UNDERTAKER

ADDRESS

David R. Young
Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of

Registration District No.

Primary Registration District No.

City of

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED
(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many.....hrs.
or.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him..... alive on.....
and that death occurred on the date stated above, at.....M.

The CAUSE OF DEATH* was as follows:

(Duration) Yrs..... mos..... ds.
Contributory (Secondary)

(Duration) Yrs..... mos..... ds.
(Signed) M. D.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **36864**

1. PLACE OF DEATH

County of *Fremont*City of *St. Anthony*

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
MAR 4 1922
BUREAU OF VITAL
STATISTICS

Registration District No. *44*Primary Registration District No. *211*

St.)

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

unmarried

(Write the word.)

6. DATE OF BIRTH

5 - 28 - 1849
(Month) (Day) (Year)

7. AGE

77 Yrs *9* Mos. *26* ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

1 newspaper

(b) General nature of industry, business or establishment in which employed (or employer)

do

9. BIRTHPLACE

(State or Country)

Fremont

10. NAME OF FATHER

Wm. Nielsen

11. BIRTHPLACE OF FATHER

(State or Country)

Denmark

12. MAIDEN NAME OF MOTHER

Porter

13. BIRTHPLACE OF MOTHER

(State or Country)

Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

St. Anthony
St. Anthony

15.

Filed *2 11* 19*22**W. B. Smith*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

1 *2* 19*22*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 19*22* to *Dec* 19*22*
that I last saw her alive on *Dec* 19*22*

and that death occurred on the date stated above, at *2 AM*.

The CAUSE OF DEATH* was as follows:

Paralysis(Duration) *1* Yrs. *6* mos. — ds.

Contributory (Secondary)

apoplexy(Duration) *1* yrs. *6* mos. — ds.

(Signed)

19*22* (Address)

Dr. C. E. M. D.
St. Anthony

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Parker

DATE OF BURIAL

5 19*22*

20. UNDERTAKER

Wm. Hansen

ADDRESS

St. Anthony

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH
Fremont
County of **SUBURBAN** Primary Registration District No. **6**
City of **Ashton** (No. **STATISTICS**) St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **36866**
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME
Laurel Elenore Parks,

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Single**
(Write the word.)

6. DATE OF BIRTH
June 8 1919
(Month) (Day) (Year)

7. AGE **3** **8** **26** IF LESS than 1 day
Yrs. Mos. ds. how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) **Ashton Idaho**

10. NAME OF FATHER
Raymond Parks

11. BIRTHPLACE OF FATHER
(State or Country) **Utah**

12. MAIDEN NAME OF MOTHER
Phillis. E Rodgers

13. BIRTHPLACE OF MOTHER
(State or Country) **Salt Lake City Utah.**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) **Raymond. Parks**
(Address) **Ashton Idaho**

15. Filed **2-4-22** 19 **22** **Ashton**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
2/3/22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **2-1-22** to **2-3-22**
that I last saw **her** alive on **2-2-22** 19 **22**
and that death occurred on the date stated above, at **10 A.M.**
The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration) Yrs. mos. **8** ds.
Contributory **NA.**
(Secondary)

(Duration) yrs. mos. ds.
(Signed) **Ashton** M. D.
2-4-1922 (Address) **Ashton, Ida.**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **Ashton Idaho** DATE OF BURIAL **3/5/22** 19 **22**

20. UNDERTAKER **Lewis Kiser** ADDRESS **Ashton Idaho.**

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Ben*
City of *Emmett*Registration District No.
Primary Registration District No.
(No. St.)File No. *36867*
Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

George Robert Haley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *single*
(Write the word.)

6. DATE OF BIRTH

Sept 10 19*16*
(Month) (Day) (Year)

7. AGE

5 Yrs. *4* Mos. *12* ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).*child*

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

George B. Haley

11. BIRTHPLACE OF FATHER

(State or Country)

New Jersey

12. MAIDEN NAME OF MOTHER

Emma Johnson

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Geo B Haley

(Address)

Emmett Idaho

15.

Filed *2/9* 19*22**J. D. Reynolds*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 22 19*22*
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *Sept 26* 19*21*, to *Jan 22* 19*22* that I last saw him alive on *Jan 22* 19*22*, and that death occurred on the date stated above, at *12* M. The CAUSE OF DEATH* was as follows:
Hogkins disease(Duration) Yrs. *4* mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *R. H. Emmett* M. D.1/23 1922 (Address) *Emmett*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Emmett Ida

DATE OF BURIAL

1/24 19*22*

20. UNDERTAKER

C. Buckner

ADDRESS

Emmett Ida

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Gen*City of *Emmett*

If death occurs away from usual residence, give facts called for under special information.

Registration District No. *6*Primary Registration District No. *6*(No. *30*)

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *36868*Registered No. *36868*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Infant son Geo Jeffries

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

*white*5. SINGLE, MARRIED, WID-
OWED OR DIVORCED*infant*
(Write the word.)

6. DATE OF BIRTH

(Month) *Jan*(Day) *8*(Year) *1922*

7. AGE

new Born

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

Infant

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Geo Jeffries

11. BIRTHPLACE OF FATHER

(State or Country)

not known

12. MAIDEN NAME OF MOTHER

Ladie Stowell

13. BIRTHPLACE OF MOTHER

(State or Country)

North Dakota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

R. J. Chadwick

(Address)

15.

Filed *1/11/22* 19*J. L. Reynolds*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month) *Jan*(Day) *8*19 *22* (Year)

17. I HEREBY CERTIFY, That I attended deceased from

at birth, to *Jan 8* 19 *22*that I last saw him alive on *Jan 8* 19 *22*and that death occurred on the date stated above, at *11 a.m.*

The CAUSE OF DEATH* was as follows:

Premature birth
6 1/2 mo

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. L. Reynolds M. D.*1/11/1922* (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Emmett Idaho

DATE OF BURIAL

1/8 19 *22*

20. UNDERTAKER

C. D. Buckner

ADDRESS

Emmett Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

Registration District No.

Primary Registration District No.

St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED
(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

2/8

1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

1922
(Year)17. I HEREBY CERTIFY, That I attended deceased from
Feb 1 1922 to Feb 5 1922
that I last saw him alive on Feb 5 1922
and that death occurred on the date stated above, at 1 P. M.
The CAUSE OF DEATH* was as follows:

myocardial insufficiency

(Duration) yrs. mos. ds.
Contributory (Secondary) Syphilitic Pneumonia(Duration) yrs. mos. ds.
(Signed) R. N. Cunningham M. D.

Feb 6 1922 (Address) Emmett Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cascade Ida

2/8 1922

20. UNDERTAKER

ADDRESS

C. D. Duckman

Emmett

Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. _____
County of Jern Primary Registration District No. 4
City of Near-Letha (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Bessie E. StradleyFile No. 36870

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDInfant
(Write the word.)

6. DATE OF BIRTH

December 9 1920
(Month) (Day) (Year)

7. AGE

2 Yrs. 1 Mos. 7 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Infant

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Yakima Co Wash.

10. NAME OF FATHER

Grant Stradley

11. BIRTHPLACE OF FATHER

(State or Country)

Phillips Co Kansas

12. MAIDEN NAME OF MOTHER

Bessy E Greenfield

13. BIRTHPLACE OF MOTHER

(State or Country)

Phillips Co Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. L. Rose(Address) R#1 Emmett

15.

Filed 1/16 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

January 16 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 15 1922, to Jan 16 1922
that I last saw her alive on Jan 16 1922,
and that death occurred on the date stated above, at 5 P.M.
The CAUSE OF DEATH* was as follows:Ileo-Cecitis(Duration) _____ Yrs. _____ mos. 7 ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) R. R. Emmett M. D.1/16 1922 (Address) Emmett

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Caldwell, Ida.

DATE OF BURIAL

Jan 18 1922

20. UNDERTAKER

O. Buckner

ADDRESS

Emmett Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Gem*
City of *Emmett*

Registration District No. *9*

Primary Registration District No. *3*

(No. *3*)

St.)

File No. *30871*

Registered No. *30871*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary Obermeyer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female white

widow
(Write the word.)

6. DATE OF BIRTH

Dec 11 1855
(Month) (Day) (Year)

7. AGE

66 Yrs. *1* Mos. *11* ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

Liny

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Not known

13. BIRTHPLACE OF MOTHER

(State or Country)

" "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Louis A. Gregory
Emmett Idaho

(Address)

15.

Filed *1/24* *1922*

J. L. Reynolds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 22 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 20 1922 to Jan 22 1922
that I last saw him alive on *Jan 21 1922*
and that death occurred on the date stated above, at *12:30 PM*.

The CAUSE OF DEATH* was as follows:

Percutaneous aneurysm

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Barton O. Clark M. D.

1/24 1922 (Address) *Emmett Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Emmett Idaho

DATE OF BURIAL

1/24 1922

20. UNDERTAKER

C. D. Buckner

ADDRESS

Emmett Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Ben*
City of *Emmett*Registration District No. *6*
Primary Registration District No. *6*
(No. *6* St.)File No. *30872*
Registered No. *30872*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Elden El Roy Mc Gee

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

Sept 27 1893
(Month) (Day) (Year)

7. AGE

28 Yrs. *3* Mos. *19* ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).*Farmer*

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Alvin Mc Gee

11. BIRTHPLACE OF FATHER

(State or Country)

Penn

12. MAIDEN NAME OF MOTHER

Margaret E. Johnson

13. BIRTHPLACE OF MOTHER

(State or Country)

Neb.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Alvin Mc Gee

(Address)

Parma Idaho

15.

Filed *1/19* 19 *22*Local Registrar *J. L. Reynolds*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 15 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19....., to 19.....
that I last saw h..... alive on 19.....
and that death occurred on the date stated above, at..... M.
The CAUSE OF DEATH* was as follows:*Suicide*
Gun shot wound

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *W. M. Brown-Corner M. D.**1/19 1922* (Address) *Emmett Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Emmett Idaho

DATE OF BURIAL

1/19 1922

20. UNDERTAKER

O. B. Buckner

ADDRESS

Emmett Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Bem*
City of *Emmett*

Registration District No.

Primary Registration District No.

(No. St.)

File No.

Registered No. *36873*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Samuel W. Davenport

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-OWED OR DIVORCED

Male *White* *Married*
(Write the word.)

6. DATE OF BIRTH

Dec. 22, 18*97*
(Month) (Day) (Year)

7. AGE

54 Yrs. *24* ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)*Farmer*

9. BIRTHPLACE

(State or Country) *Manti, Utah*

10. NAME OF FATHER

Samuel Davenport

11. BIRTHPLACE OF FATHER

(State or Country) *England*

12. MAIDEN NAME OF MOTHER

Sarah Mackey

13. BIRTHPLACE OF MOTHER

(State or Country) *Idaho*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *C. L. Davenport*
(Address) *Idaho*

15.

Filed *1/27* 19*23* *J. L. Reynolds*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 19*22*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar 10 19*21*, to *Jan 17* 19*22*
that I last saw him alive on *Jan 28* 19*22*,
and that death occurred on the date stated above, at *9 a.m.*

The CAUSE OF DEATH* was as follows:

Chronic Nephritis(Duration) *2 wks.* mos. ds.Contributory (Secondary) *uremia*

(Duration) yrs. mos. ds.

(Signed) *J. L. Reynolds* M. D.*1/17* 19*22* (Address) *Emmett, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Manti Utah

DATE OF BURIAL

.....19.....

20. UNDERTAKER

C. Bucknum

ADDRESS

Emmett Idaho

FORM V. S. No. 5-A—25 M. T-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Gem*
City of *Emmett*Registration District No. *6*

Primary Registration District No. _____

(No. _____ St.)

File No. *36874*

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Michael Gilbride

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WID-

married

(Write the word.)

6. DATE OF BIRTH

Feb 25 1872
(Month) (Day) (Year)

7. AGE

*49 Yrs 11 Mos 14 ds.*IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

Stone Cutter

9. BIRTHPLACE

(State or Country)

Ireland

10. NAME OF FATHER

Michael Gilbride

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Not known

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mrs M. Gilbride*
(Address) *Emmett Ida*

15.

Filed *2/10* 19 *22* *J L Reynolds*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 9 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 4 1922 to *Feb 9 1922*
that I last saw him alive on *Feb 9 1922*
and that death occurred on the date stated above, at *1:30* M.

The CAUSE OF DEATH* was as follows:

Thrombosis of coronary artery?
Was recovering from acute attack of
appendicitis.

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) *R S Cummings* M. D.*2/10 1922* (Address) *Emmett Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Emmett Ida

DATE OF BURIAL

2/10 1922

20. UNDERTAKER

C. Duckman

ADDRESS

*Emmett**Idaho*

WHITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 24

County of Bonanza

Primary Registration District No. _____

City of Bliss

(No. _____)

St.)

Registered No. 36876

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Marion L Roberts

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Sept
(Month)

13
(Day)

1859
(Year)

7. AGE

62 yrs. 3 mos. 24 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Penn

10. NAME OF FATHER

Leary

11. BIRTHPLACE OF FATHER

(State or Country)

—

12. MAIDEN NAME OF MOTHER

Sarah Billington

13. BIRTHPLACE OF MOTHER

(State or Country)

—

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Bliss Ida

15.

Filed

1-24-1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan
(Month)

6
(Day)

1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec. 29 1921, to Jan. 6 1922

that I last saw him alive on Jan 6 1922

and that death occurred on the date stated above, at 8:25 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia, Pleurisy

(Duration) _____ yrs. _____ mos. 8 ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

H. E. Paul M. D.

Jan. 7 1922 (Address) Bonanza

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

A. E. Thompson 1-7-1922

20. UNDERTAKER

ADDRESS

A. E. Thompson Bonanza

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Gooding
City of Gooding

Registration District No. 24

Primary Registration District No. _____

(No. & V.) _____

St.) _____

File No. _____

Registered No. _____

If death occurs away from
usual residence, give facts
called for under special
information.

2. FULL NAME

Edna Lee Williams

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.Single
(Write the word.)

6. DATE OF BIRTH

Dec 6 1896
(Month) (Day) (Year)

7. AGE

26 Yrs. 1 Mos. 21 ds.

If LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work...
(b) General nature of in-
dustry, business, or estab-
lishment in which employ-
ed (or employer).....

at home

9. BIRTHPLACE

(State or Country)

Tenn.10. NAME OF
FATHERHenry Williams11. BIRTHPLACE
OF FATHER

(State or Country)

Tenn.12. MAIDEN NAME
OF MOTHERJackson13. BIRTHPLACE
OF MOTHER

(State or Country)

Tenn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

W. B. Brooks

(Address)

Gooding Idaho

15.

Filed

1-16-22

191

J. H. Raynor

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

January 27 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

not at all 191 to 191

that I last saw h..... alive on 191

and that death occurred on the date stated above, at 1 A.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

H. E. Lamb

M. D.

19 (Address)

Gooding Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

191

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
36883

1. PLACE OF DEATH
County of *Looding*
City of *Wendell*

Registration District No. *192*
Primary Registration District No. *192*
(N. BUREAU OF VITAL STATISTICS)

File No. *36883*
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME *John Ward*

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Widowed*
(Write the word.)

6. DATE OF BIRTH *Apr 29 1893*
(Month) (Day) (Year)

7. AGE *89* Yrs. *10* Mos. *7* ds.
IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION *Farming*
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE *Ohio*
(State or Country)

10. NAME OF FATHER *Edward Ward*

11. BIRTHPLACE OF FATHER _____
(State or Country)

12. MAIDEN NAME OF MOTHER *Mary Morris*

13. BIRTHPLACE OF MOTHER _____
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *M. M. Ward*
(Address) _____

15. Filed *Mar 4 1922* *E. P. Simonton*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *March 4 1922*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Feb 26 1922* to *Mar 4 1922*
that I last saw him alive on *Feb 26 1922*
and that death occurred on the date stated above, at *5 A. M.*

The CAUSE OF DEATH* was as follows:
Cerebral Cerebral Hemorrhage

(Duration) _____ Yrs. _____ mos. *6* ds.

Contributory (Secondary) _____
(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed) *E. P. Simonton*
3-4 1922 (Address) *Wendell Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL *Calvin Crest* DATE OF BURIAL _____ 19 _____

20. UNDERTAKER *Jauchman* ADDRESS *Looding*

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 105
County of Idaho Primary Registration District No. 2183
City of Cottonwood (No. _____ St.)File No. 38884

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

May Haywood Shultz
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Boy 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)6. DATE OF BIRTH May 17 1921
(Month) (Day) (Year)7. AGE 1 Yrs. _____ Mos. _____ ds. IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Haywood L. Shultz

11. BIRTHPLACE OF FATHER

(State or Country) W. Va.

12. MAIDEN NAME OF MOTHER

Elmer Rachel

13. BIRTHPLACE OF MOTHER

(State or Country) Montana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H. L. Shultz
(Address) Cottonwood, Ida.15. Filled Feb 6 1922 W. F. Orr
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 21 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Jan 12 1922 to Jan 21 1922
that I last saw him alive on Jan 21 1922
and that death occurred on the date stated above, at 9:00 A.M.
The CAUSE OF DEATH* was as follows:
Bronchial pneumonia(Duration) _____ Yrs. _____ mos. 9 ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Wesley F. Orr M. D.
2/21 1922 (Address) Cottonwood, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Cottonwood DATE OF BURIAL Jan 1-22 1922

20. UNDERTAKER

ADDRESS

Annan Cottonwood, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **38885**
Registered No. _____

1. PLACE OF DEATH

County of **Idaho**
City of **Kenterville**

Registration District No. **105**

Primary Registration District No. **2183**

(No. _____) (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Herman Henry Upton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

Dec. 16 1880
(Month) (Day) (Year)

7. AGE

72 Yrs. **30** ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Peotopolis, Ill.

10. NAME OF FATHER

Herman Henry Upton

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

B. H. Buchbald

(Address) **Kenterville Idaho**

15.

Feb. 6 1922

W. F. Orr
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan. 14 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 8 1922 to Jan 14 1922
that I last saw him alive on **Jan 14 1922**
and that death occurred on the date stated above, at **11:45 P.**

The CAUSE OF DEATH* was as follows:

**Post operative Pneumonia
Operative Cystitis for calculus
rectal obstruction**

(Duration) Yrs. mos. ds.

Contributory (Secondary)

Cystitis due to calculus
Feb. 10 1922 (Duration) yrs. mos. ds.

(Signed)

Wesley F. Orr

1/16 1922

(Address) **Ottawa, Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Kenterville Idaho 1-17-1921

20. UNDERTAKER

ADDRESS

H. A. Orr **Cottmanwood, Idaho**

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

1. PLACE OF DEATH.

County of Idaho
City of KosciuskoRegistration District No. 106
Primary Registration District No. 2184
(No. _____ St.)State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36886
Registered No. 117

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Alonzo E. Davis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH.

(Month)

(Day)

1877
(Year)

7. AGE

45 Yrs.

Mos.

ds.

IF LESS than 1 day
how many hrs. or
..... min. 2]

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....General Work

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

F. W. Davis

11. BIRTHPLACE OF FATHER

(State or Country)

Iowa

12. MAIDEN NAME OF MOTHER

Mary E. Smith

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

John Davis
Kosciusko - Idaho

15.

Filed

Jan 141922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

January
(Month)13
(Day)1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 10 1922 to Jan 12 1922that I last saw him alive on Jan 10 1922and that death occurred on the date stated above, at 5:20 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(Duration) 10+ Yrs. mos. ds.Contributory
(Secondary)(Duration) 10+ yrs. mos. ds.(Signed) J. M. Dubach M. D.Jan 22 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Kosciusko Cemetery

DATE OF BURIAL

Jan 14 1922

20. UNDERTAKER

ADDRESS

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Idaho
City of KooskiaRegistration District No. 106Primary Registration District No. 2184

(No. _____ St.)

File No. 36888Registered No. 118

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Louisa Pablo

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

IndianSingle
(Write the word.)

6. DATE OF BIRTH.

August 5 1921
(Month) (Day) (Year)

7. AGE

Yrs. _____ Mos. _____ ds. _____

IF LESS than 1 day
how many _____ hrs. or
_____ min. 2

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....Infant

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

John Pablo

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Julia Webb

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

John Pablo

15.

Filed

Jan 271922J. M. Webb
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 27 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to 191that I last saw h. alive on 191and that death occurred on the date stated above, at 6:25 M.

The CAUSE OF DEATH* was as follows:

No medical attention
Death probably due to
pneumonia

(Duration) Yrs. _____ mos. _____ ds. _____

Contributory
(Secondary)

(Duration) yrs. _____ mos. _____ ds. _____

(Signed) J. M. Webb M. D.Jan 27, 1922 (Address) Kooskia Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

SepulchreJan 27, 1922

20. UNDERTAKER

ADDRESS

JohnsonKamiah

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13.

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Idaho
City of StitesRegistration District No. 106
Primary Registration District No. 2184
(No. _____ St.)File No. 36889
Registered No. 119

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Rodney Huffman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.Single
(Married or divorced.)

6. DATE OF BIRTH.

Aug 19 1911
(Month) (Day) (Year)

7. AGE

10 Yrs. 5 Mos. 9 ds.IF LESS than 1 day
how many _____ hrs. or
_____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....Child

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Red Huffman

11. BIRTHPLACE OF FATHER

(State or Country)

Missouri

12. MAIDEN NAME OF MOTHER

Constance Brown

13. BIRTHPLACE OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Red Huffman

(Address)

Stites Idaho

15.

Filed

Jan 30 1922J. M. Winkler
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 28 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Jan 26 1922 to Jan 28 1922, that I last saw him alive on Jan 28 1922 and that death occurred on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:

Blow in frontal portion head from kick of horse
Death sudden without previous signs or symptoms
Contributory (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) W. W. Wentworth M. D.
Jan 29 1922 (Address) Stites Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Stites

DATE OF BURIAL

Jan 30 1922

20. UNDERTAKER

G. J. J. J.

ADDRESS

Rocky

FORM V. S. No. 5-25 M. 1-16-13

1. PLACE OF DEATH.

County of Idaho
City of Brangerville

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Frank Pickolick

CERTIFICATE OF DEATH.

Registration District No. 103Primary Registration District No. 1001

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 36890Registered No. 11

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married

(Write the word.)

6. DATE OF BIRTH.

Sept

(Month)

9

(Day)

1885

(Year)

7. AGE

5 Yrs.

Mos.

ds.

IF LESS than 1 day
how many hrs. or
..... min.?)

8. OCCUPATION

(a) Trade, profession or particular kind of work...

(b) General nature of industry, business, or establishment in which employed (or employer).....

mining

9. BIRTHPLACE

(State or Country)

Novy Vinodol Austria
Hungary

10. NAME OF FATHER

Andrew Pickolick

11. BIRTHPLACE OF FATHER

(State or Country)

Austria

12. MAIDEN NAME OF MOTHER

Sokolick

13. BIRTHPLACE OF MOTHER

(State or Country)

Austria

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Harry L. Griffith

(Address)

15.

Filed

Mar 11922J. S. Stockton

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Perhaps Feb.

(Month)

6

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

..... 191..... to 191.....

that I last saw him 191.....

and that death occurred on the date stated above at M.

The CAUSE OF DEATH was as follows:

Found in 13.Strained in snowslide, accidental

.....

.....

.....

.....

Contributory

(Secondary)

.....

(Signed) P. J. Mangg Cornet19..... (Address) Brangerville

.....

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1)

MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

.....

.....

.....

19. PLACE OF BURIAL OR REMOVAL

Prairie View2-17 1923

20. UNDERTAKER

E. Hancock

ADDRESS

Brangerville

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **36891**
Registered No. **36891**

1. PLACE OF DEATH

County of **Idaho**
City of **Brangerville**

Registration District No. **103**Primary Registration District No. **2181**

(No. _____)

(St.) _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Thomas Surridge

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widowed
(Write the word.)

6. DATE OF BIRTH

Aug 7 1849
(Month) (Day) (Year)

7. AGE

72 Yrs. **4** Mos. **15** ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Farmer Retired

9. BIRTHPLACE

(State or Country)

London England

10. NAME OF FATHER

John Surridge

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Mary Cochran

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

James Surridge
Harper Ida

15.

Filed

March 1 1922 **98 Stockton**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb. 22 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 1 1921, to **Feb 22 1922**

that I last saw him alive on **Feb 6 1922**

and that death occurred on the date stated above, at **1230 A.M.**

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

Valvular lesion & arteriosclerosis

(Duration) Yrs. mos. ds.

(Signed)

G. S. Stockton M. D.

2/23 1922 (Address) **Brangerville Ida**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Harper Idaho**Feb 22 1922**

20. UNDERTAKER

ADDRESS

A. J. Maugh**Brangerville**

N. B.—Every item of information should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

1. PLACE OF DEATH.

County of Idaho Registration District No. 103
City of Brangerville Primary Registration District No. 1001
(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mabel Barker

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36892
Registered No. 6

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH.

Feb 21 1922
(Month) (Day) (Year)

7. AGE

11 Yrs. Mos. ds.

IF LESS than 1 day
how many 11 hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country)

Brangerville

10. NAME OF FATHER

Jesse Barker

11. BIRTHPLACE OF FATHER

(State or Country)

Ellowess

12. MAIDEN NAME OF MOTHER

Edna Howell

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs E. W. Richey(Address) Lapwai Idaho

15.

Filed March 1 1922 E S Stucklen

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 21 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 21 1922, to Feb 21 1922, that I last saw her alive on Feb 21 1922, and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Premature birth

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) E S Stucklen M. D.2/249 27 (Address) Brangerville Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Prairie View21 23 1922

20. UNDERTAKER

ADDRESS

E S HancockBrangerville

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

1. PLACE OF DEATH.

County of Idaho Registration District No. 103
City of Granger Primary Registration District No. 2181
(No. 5 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Halford

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36893
Registered No. 5

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
widower
(Write the word.)

6. DATE OF BIRTH.

Don't know
(Month) (Day) (Year)

7. AGE

82 Yrs. — Mos. — ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

Farmer

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

2
1

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Geo C. Porter
Granger Idaho

15.

Filed

March 1 1922

G. S. Storken
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 19 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 13 1922 to Feb 19 1922

that I last saw him alive on Feb 13 1922
and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) Yrs. 6 mos. — ds.

Contributory Arteriosclerosis
(Secondary)

(Duration) yrs. — mos. — ds.

(Signed) G. S. Storken M. D.

2/19 1922 (Address) Granger Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Winona Idaho 2/20 1922

20. UNDERTAKER

ADDRESS

None

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Jerome*City of *Eden*

If death occurs away from usual residence, give facts called for under special information.

Registration District No. *23*Primary Registration District No. *1017-2017*

(No. _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *36907*

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Lloyd John Price

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Infant
(Write the word.)

6. DATE OF BIRTH

Jan 18 19*22*
(Month) (Day) (Year)

7. AGE

____ Yrs. ____ Mos. ____ ds.

IF LESS than 1 day
how many *10* hrs.
or ____ min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
-
- (b) General nature of industry, business or establishment in which employed (or employer)

Infant

9. BIRTHPLACE

(State or Country)

Eden Idaho

10. NAME OF FATHER

Lloyd David Price

11. BIRTHPLACE OF FATHER

(State or Country)

Colorado

12. MAIDEN NAME OF MOTHER

Grace Elizabeth M. Farland

13. BIRTHPLACE OF MOTHER

(State or Country)

Texas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mrs. E. J. Jernico*(Address) *Eden Idaho*15. Filed *Feb 8* 19*22* *E.D. Piper M.D.*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 19 19*22*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 18 19*22* to *Jan 19* 19*22*
that I last saw him alive on *Jan 19* 19*22*and that death occurred on the date stated above, at *6:00* P. M.

The CAUSE OF DEATH* was as follows:

Weakling(Duration) ____ Yrs. ____ mos. *10* hrs.Contributory
(Secondary)

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) *Mrs. E. J. Jernico - midwife**1/19/22* (Address) *Eden Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Eden

DATE OF BURIAL

Jan 19 19*22*

20. UNDERTAKER

Lloyd David Price

ADDRESS

Eden Idaho

(Father)

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **36909**
Registered No. **91**

1. PLACE OF DEATH.

County of Kootenai
City of Harrison

Registration District No. 126Primary Registration District No. 2204

St.)

If death occurs away from
usual residence, give facts
called for under special
information.

2. FULL NAME

Fred A. Ryser

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

Single

(Write the word.)

6. DATE OF BIRTH.

Oct 25 1904
(Month) (Day) (Year)

7. AGE

18 Yrs. 2 Mos. 29 ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work...
(b) General nature of in-
dustry, business, or estab-
lishment in which employ-
ed (or employer).....

9. BIRTHPLACE

(State or Country)

Kansas

10. NAME OF
FATHER

C. Ryser

11. BIRTHPLACE
OF FATHER

(State or Country)

Switzerland

12. MAIDEN NAME
OF MOTHER

Marie Baerker

13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Marie Ryser

(Address)

Harrison Ida

15.

Filed

2-1

1912

J. H. Herring

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 24 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Jan 21 1922, to Jan 25 1922,
that I last saw him alive on Jan 23 1922,
and that death occurred on the date stated above, at 1 A M.
The CAUSE OF DEATH¹ was as follows:

Apoplexy

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. H. Herring M. D.

124 1922 (Address) Harrison Ida

¹State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Harrison

DATE OF BURIAL

1-25 1922

20. UNDERTAKER

M. Ketchum

ADDRESS—

Harrison

1. PLACE OF DEATH.

County of Boyle Registration District No. 126
City of Chatcolet Primary Registration District No. 2204
(No. _____ St.)File No. 36910Registered No. 70

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Reed

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widower
(Write the word.)

6. DATE OF BIRTH.

August 9th 1838
(Month) (Day) (Year)

7. AGE

83 Yrs. 5 Mos. 11 ds.IF LESS than 1 day
how many _____ hrs. or
_____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...

Farmer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

Edmond Reed

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Missie Mitchell

(Address)

Chatcolet Idaho

15.

Filed Jan 21 1922W. B. B. B.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 20 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 18 1922 to Jan 21 1922that I last saw him alive on Jan 21 1922and that death occurred on the date stated above, at 6 M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) Yrs. _____ mos. _____ ds.

Contributory
(Secondary)Myocarditis

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W. B. B. B. M. D.1-21-22 (Address) Spokane Id.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Spokane Wash

DATE OF BURIAL

Jan 24 1922

20. UNDERTAKER

Hazen and Leager

ADDRESS

Spokane

FORM V. S. No. 5-A-25 M. 1-19.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED

FEB 21 1922

BUREAU OF

STATE

CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

(No. 3)

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED
(Write the word.)

6. DATE OF BIRTH

7. AGE

Yrs. 10 Mos. 1 ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15. Filed

16. 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 7th 1922 to Jan. 15 1922 that I last saw him alive on Jan 15 1922 and that death occurred on the date stated above, at 7:15 P.M. The CAUSE OF DEATH* was as follows:

Erysipelas

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

Chas. L. Gutman M. D.

1/16 1922 (Address) Moscow, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH **RECEIVED**
 County of Latah Registration District No. 61
 City of Moscow Primary Registration District No. 1011
 No. 61 St. 1011

 File No. 36413
 Registered No. 36413

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Norma Angeline Finston

PERSONAL AND STATISTICAL PARTICULARS

 3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
 (Write the word.)

6. DATE OF BIRTH

September 18 1922
 (Month) (Day) (Year)

7. AGE

42 Yrs. 4 Mos. — ds.

 IF LESS than 1 day
 how many..... hrs.
 or..... min.?

8. OCCUPATION

 (a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).
Housewife

9. BIRTHPLACE

(State or Country)

Washington

10. NAME OF FATHER

George W Butts

11. BIRTHPLACE OF FATHER

(State or Country)

Oregon

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. Scott Finston(Address) Moscow, Idaho

15. Filed

Jan 18 1922
M. H. Carithers
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 18 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 18 1922 to Jan 18 1922
 that I last saw her..... alive on Jan 18 1922.
 and that death occurred on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:

Heart Disease
 (Duration) Not known Yrs. mos. ds.
 Contributory (Secondary) Confinement (at home)

 (Duration) Not known Yrs. mos. ds.

 (Signed) W. A. G. Davis M. D.

 (Address) Moscow Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Line City, Idaho 1922

20. UNDERTAKER

ADDRESS

Em. Brown Lincoln Idaho

1. PLACE OF DEATH

County of *Idaho*City of *Moscow*

If death occurs away from usual residence, give facts called for under special information.

RECEIVED

FEB 21 1922

BUREAU OF VITAL

STATISTICS

CERTIFICATE OF DEATH

Registration District No. *61*Primary Registration District No. *1011*State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *36914*

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Grace H. Richardson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

Jan 14 1922
(Month) (Day) (Year)

7. AGE

8
Yrs. Mos. ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Otis D Richardson

11. BIRTHPLACE OF FATHER

(State or Country)

Nebraska

12. MAIDEN NAME OF MOTHER

William H. Kellam

13. BIRTHPLACE OF MOTHER

(State or Country)

Washington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Otis D Richardson

(Address)

Moscow

15.

Filed

Jan 24 19.....*M. H. Baithers*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 22 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 14 1922 to Jan 22 1922
that I last saw h. *alive* on *Jan 22 1922*and that death occurred on the date stated above, at *7:00 P.M.*

The CAUSE OF DEATH* was as follows:

*Pneumonia
Twenty six weeks*

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

Chas. L. Gritman M. D.*1922* (Address) *Moscow, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Moscow, Idaho

19.....

20. UNDERTAKER

ADDRESS

Blair J. McCall

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED
CERTIFICATE OF DEATH

Registration District No.

Bureau of Vital Statistics

(Not a Statistic)

36917

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15. Filed

1-4

19

22

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

birth 19 to 19

that I last saw him alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Stillborn.

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

1-4

(Duration) Yrs. mos. ds.

(Signed)

1/4 19 22

(Address) Deary

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

1 Avon Cem.

1-4 19 22

20. UNDERTAKER

ADDRESS

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Idaho
City of Genesee

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No. 12
Primary Registration District No. 2142
No. 1 St.)BUREAU
STATAnn E. WilloughbyState of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36918
Registered No. 1

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

Oct 5 1922
(Month) (Day) (Year)

7. AGE

81 Yrs. 3 Mos. 2 ds. X
IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Little Beaver Penn

10. NAME OF FATHER

Joseph Taylor

11. BIRTHPLACE OF FATHER

(State or Country) Penn

12. MAIDEN NAME OF MOTHER

Minerva Shroat
Wm E Taylor

13. BIRTHPLACE OF MOTHER

(State or Country) Darlington Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ann E. Willoughby
(Address) Genesee Idaho15. Filed 1-9- 1922 W. E. Her
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 7 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 1 1922 to Jan 4 1922
that I last saw him alive on Jan 4 1922,
and that death occurred on the date stated above, at 59 M.
The CAUSE OF DEATH* was as follows:Pneumonia(Duration) Yrs. mos. 3 ds.Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) W. E. Her M. D.19-1922 (Address) Genesee

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Colfax Wash

DATE OF BURIAL

1-11 1922

20. UNDERTAKER

J. E. Lambert Genesee

1. PLACE OF DEATH.

County of Latah Registration District No. 68
 City of Julesburg Primary Registration District No. 192
 (No. 192 St.)

File No. 36919

Registered No. _____

If death occurs away from
usual residence, give facts
called for under special
information.

2. FULL NAME

David Carson Hamill

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

Male White Widower
(Write the word.)

6. DATE OF BIRTH.

2 7 1882
(Month) (Day) (Year)

7. AGE 89

89 Yrs. 11 Mos. 19 ds.

IF LESS than 1 day
how many hrs. or
min.

8. OCCUPATION

(a) Trade, profession or
particular kind of work...
(b) General nature of in-
dustry, business, or estab-
lishment in which employ-
ed (or employer).....

Farmer.

9. BIRTHPLACE

(State or Country) Blunt Co Tenn

10. NAME OF FATHER

Geo Hamill

11. BIRTHPLACE OF FATHER

(State or Country) Blunt Co Tenn.

12. MAIDEN NAME OF MOTHER

do not know

13. BIRTHPLACE OF MOTHER

(State or Country) do not know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15.

Filed

Jan 26 1922 R. F. Pepper
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

1 26 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 16 1922 to Jan 26 1922

that I last saw him alive on Jan 26 1922

and that death occurred on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:

General Paralysis +
Arterial Sclerosis

(Duration) — Yrs. 2 mos. — ds.

Contributory
(Secondary)

(Duration) — yrs. — mos. — ds.

(Signed) J. H. Kelly M. D.

1-26-1922 (Address) Wendricks Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted
if not at place of death?.....

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Washington Iowa1-27 1922

20. UNDERTAKER

ADDRESS

Lebranchy no 88 Julesburg

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **36921**

1. PLACE OF DEATH

County of *Kootenai* Registration District No. _____
City of *Coeur d'Alene* Primary Registration District No. _____
(No. *312*, S. *15th* St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Christian Carlson

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

M.

4. COLOR OR RACE

N.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

single
(Write the word.)

6. DATE OF BIRTH

Jan *12* *1922*
(Month) (Day) (Year)

7. AGE

Yrs. *1 1/2* ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Jens Carlson

11. BIRTHPLACE OF FATHER

(State or Country)

Norway

12. MAIDEN NAME OF MOTHER

Paulina Olson

13. BIRTHPLACE OF MOTHER

(State or Country)

Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Jens Carlson

(Address)

15.

Filed _____ 19 _____

Local Registrar

16. DATE OF DEATH

January *13* *1922*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan *12* *1922* to *Jan* *13* *1922*
that I last saw him alive on *Jan* *13* *1922*
and that death occurred on the date stated above, at *10:30* M.

The CAUSE OF DEATH* was as follows:

Premature birth

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

Jan 14 1922

(Address) *Coeur d'Alene, Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Forest Cem. Coeur d'Alene

DATE OF BURIAL

1-14 1922

20. UNDERTAKER

C. Carney

ADDRESS

Coeur d'Alene.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Tooten*
City of *Cornudas*Registration District No. *30*
Primary Registration District No. *1051*
(No. *French Gulch* St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*William A Kelly*State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *36923*Registered No. *1821*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*
(Write the word.)

6. DATE OF BIRTH

Oct 8 1854
(Month) (Day) (Year)

7. AGE

65 Yrs. *3* Mos. *1* ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

Rancher

9. BIRTHPLACE

(State or Country)

Ireland

10. NAME OF FATHER

James Kelly

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Mary Flynn

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mrs J. P. Garrison*
(Address) *Edmond, Mont.*

15.

Filed *Feb. 3 1922*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 9 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan. 11 1922 to *Jan 8 1922*
that I last saw him alive on *Jan 8 1922*
and that death occurred on the date stated above, at *9:30 A.M.*

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) Yrs. mos. ds.

Contributory (Secondary) *Cardiac disease in fibrosis*

(Duration) yrs. mos. ds.

(Signed) *J. P. Garrison* M. D.(Address) *Edmond, Mont.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Thomas Cemetery *1-11-1922*

20. UNDERTAKER

ADDRESS

W. B. Doney *Edmond, Mont.*

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Kootenai Registration District No. 30
 City of Coeur d'Alene Primary Registration District No. 1067
 (No. 1012 2nd St.)

If death occurs away from
usual residence, give facts
called for under special in-
formation.

File No. 36934
 Registered No. 36934

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

2. FULL NAME

Frank Russett

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

M.

4. COLOR OR RACE

W.5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDmarried
(Write the word.)

6. DATE OF BIRTH

Feb 2 1875
 (Month) (Day) (Year)

7. AGE

106 Yrs. 11 Mos. 4 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

Retired

9. BIRTHPLACE

(State or Country)

Canada10. NAME OF
FATHERRussett11. BIRTHPLACE
OF FATHER

(State or Country)

12. MAIDEN NAME
OF MOTHER13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Wm. Lefler

(Address)

Coeur d'Alene

15.

Filed Feb 3 1922 D. W. Dremar
 Local Registrar

16. DATE OF DEATH

January 6 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov. 1921, to Jan. 6 1922
 that I last saw him alive on November 1921,
 and that death occurred on the date stated above, at 6 P. M.
 The CAUSE OF DEATH* was as follows:

Senility.

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

John O'Leary M. D.
Jan 9 1922 (Address) Coeur d'Alene, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Thomas1-8 1922

20. UNDERTAKER.

ADDRESS

C. CassidyIdaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
 N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH
 in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Footen*
City of *Power & Dale*

Registration District No. *30*Primary Registration District No. *1051*(No. *709* Empire one St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Sarah Hodgson

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. *36925*Registered No. *1023*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widow

(Write the word.)

6. DATE OF BIRTH

Oct 8 1848
(Month) (Day) (Year)

7. AGE

73 Yrs. *2* Mos. *25* ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

Retired

9. BIRTHPLACE

(State or Country) *Conn.*

10. NAME OF FATHER

Olige White

11. BIRTHPLACE OF FATHER

(State or Country) *U. S.*

12. MAIDEN NAME OF MOTHER

Francis Reed

13. BIRTHPLACE OF MOTHER

(State or Country) *U. S.*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mrs. Frank Nease*(Address) *Power & Dale 2da*

15. Filed *Feb 3* 19 *22* *DD Drema*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 7 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 1921 to *Jan. 7 1922*
that I last saw him alive on *Dec. 10 1921*

and that death occurred on the date stated above, at *5 A.M.*

The CAUSE OF DEATH* was as follows:

Hemiplegia.(Duration) *1* Yrs. *6* mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

John Wood M. D.(Address) *Power & Dale 2da*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State *25* yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Forest Cemetery

DATE OF BURIAL

1-9 1922

ADDRESS

Power & Dale 2da

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Booleman*

City of *Cornwall*

If death occurs away from usual residence, give facts called for under special information.

Registration District No. *30*

Primary Registration District No. *1051*

(No. St.)

2. FULL NAME

Mary Cook

State of Idaho
BOARD OF HEALTH

Bureau of Vital Statistics

File No. *369264*
Registered No. *7894*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WID-OWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH.

Jan 24 1891
(Month) (Day) (Year)

7. AGE

30 Yrs. *11* Mos. *20* ds.

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

House-wife

9. BIRTHPLACE

(State or Country)

Post Falls, Idaho

10. NAME OF FATHER

Thos E. Holm

11. BIRTHPLACE OF FATHER

(State or Country)

Norway

12. MAIDEN NAME OF MOTHER

Caroline Johnson

13. BIRTHPLACE OF MOTHER

(State or Country)

Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Husband) Earl L. Cook
Plummer, Idaho

(Address)

15. Filed

Feb 3 1922

D. H. Greene
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 4 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 3 1921 to *Jan 4 1921*
that I last saw her alive on *Jan 4 1921*

and that death occurred on the date stated above, at *2:30 P.M.*

The CAUSE OF DEATH* was as follows:

Peritonitis

(Duration) Yrs. mos. *14* ds.

Contributory (Secondary)

Salpingitis

(Duration) *4* Yrs. mos. ds.

(Signed)

J. L. McCauley
Jan 4 1921 (Address) *Post Falls, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days, State yrs. mos. days

Where was disease contracted if not at place of death? *Cornwall & Cleme*

Former or usual residence

Plummer Idaho

19. PLACE OF BURIAL OR REMOVAL

Post Falls Idaho

DATE OF BURIAL

1-6 1922

20. UNDERTAKER

R. B. Money

ADDRESS

Cornwall

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Routt*
 City of *Coeur d'Alene*

Registration District No. *30*
 Primary Registration District No. *1061*
 (No. St.)

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. *36927*
 Registered No. *1025*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mrs W. Hogensson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *F.* 4. COLOR OR RACE *W.* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *married*
 (Write the word.)

6. DATE OF BIRTH

Nov *5* *1843*
 (Month) (Day) (Year)

7. AGE

72 Yrs. *1* Mos. *26* ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

House wife

9. BIRTHPLACE

(State or Country)

Norway

10. NAME OF FATHER

Lars Christensen

11. BIRTHPLACE OF FATHER

(State or Country)

Norway

12. MAIDEN NAME OF MOTHER

Curris Larsen

13. BIRTHPLACE OF MOTHER

(State or Country)

Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mrs Anna Neander*
 (Address) *Coeur d'Alene Ida*

15. *Feb. 3* *1922* *D. Drennan*
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan *4* *1922*
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 30 *1921*, to *Jan 6* *1922*
 that I last saw *her* alive on *Jan 5* *1922*,
 and that death occurred on the date stated above, at *9 P.* M.
 The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) Yrs. mos. ds.

Contributory (Secondary) *Age*

(Duration) yrs. mos. ds.

(Signed) *D. Drennan* M. D.

1/6 *1922* (Address) *Coeur d'Alene*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Forest L. Cem. Co. A. *1-6* *1922*

20. UNDERTAKER

Curried *Idaho*

ADDRESS

FORM V. S. No. 5-25 M. 1-19.

REC-11-11-11
CERTIFICATE OF DEATH

1. PLACE OF DEATHCounty of RoutenauCity of Corn & Alene

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 30Primary Registration District No. 1051

(No. _____ St.)

2. FULL NAMEAlbert Brown

State of Idaho
BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 36928Registered No. 1026

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS**3. SEX**male**4. COLOR OR RACE**white**5. SINGLE, MARRIED, WIDOWED OR DIVORCED**Widowed
(Write the word.)**6. DATE OF BIRTH**

July 17th 1845
 (Month) (Day) (Year)

7. AGE76 Yrs. 6 Mos. 12 ds.

IF LESS than 1 day
 how many _____ hrs.
 or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Farmer

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Guilford, N.Y.**10. NAME OF FATHER**Billings F Brown**11. BIRTHPLACE OF FATHER**

(State or Country)

Plainfield, N.Y.**12. MAIDEN NAME OF MOTHER**Emeline Hale**13. BIRTHPLACE OF MOTHER**

(State or Country)

Victor, N.Y.**14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant)

Charles F Brown

(Address)

Belmont, Idaho**15.**

Filed

Feb 4 1922D D Drema

Local Registrar

MEDICAL CERTIFICATE OF DEATH**16. DATE OF DEATH**

January 26 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 22 1922 to Jan 26 1922
 that I last saw him alive on Jan 22 1922
 and that death occurred on the date stated above, at 7:30 A.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia(Duration) _____ Yrs. _____ mos. 12 ds.Contributory
(Secondary)Malaga

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Frank (Wm) M. D.1/26/1922 (Address) Rathol, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 2 yrs. 5 mos. 2 days. In the State 3 yrs. 4 mos. 3 days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVALRathol, Idaho**DATE OF BURIAL**Jan 27 1922**20. UNDERTAKER****ADDRESS**C Cassidy, Rathol, Idaho

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Kootenai*
City of *Bozeman*
Thomas Gardens

If death occurs away from usual residence, give facts called for under special information.

Registration District No. *20*Primary Registration District No. *1007*(No. *1007*)

(St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. *262329*Registered No. *262329*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Merrin Norwood Bailey

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

*W.*5. SINGLE, MARRIED, WID-
OWED OR DIVORCED*Single*
(Write the word.)

6. DATE OF BIRTH

March *28* *1892*
(Month) (Day) (Year)

7. AGE

9 Yrs. *10* Mos. *6* ds.
IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

School boy

9. BIRTHPLACE

(State or Country)

N.C.

10. NAME OF FATHER

Paul Bailey

11. BIRTHPLACE OF FATHER

(State or Country)

Vir.

12. MAIDEN NAME OF MOTHER

Genevieve McGraw

13. BIRTHPLACE OF MOTHER

(State or Country)

Vir.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Paul Bailey

(Address)

15. Filed

Feb. 4 *1922* *D. D. Drennan*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan. *4* *1922*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan. *1921*, to *Jan. 4* *1922*
that I last saw him alive on *Jan. 4* *1922*

and that death occurred on the date stated above, at *6 P.M.*

The CAUSE OF DEATH* was as follows:

Acute endocarditis.(Duration) Yrs. *2* mos. ds.

Contributory (Secondary)

Chronic endocarditis(Duration) *1* yrs. mos. ds.

(Signed)

John D. Wood M. D.*Jan. 6* *1922* (Address) *Bozeman, Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Forest Cem. Bozeman

DATE OF BURIAL

1-6 *1922*

20. UNDERTAKER

Classey

ADDRESS

Bozeman

1. PLACE OF DEATH *RECEIVED*
 County of *Kootenai* Registration District No. *30*
 City of *Laurel* Primary Registration District No. *1051*
 (St.)

File No. *36931*
 Registered No. *1012*

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

John Cunningham

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*

(Write the word.)

6. DATE OF BIRTH

March 10 1855
 (Month) (Day) (Year)

7. AGE

63 Yrs. *9* Mos. *22* ds.

IF LESS than 1 day
 how many... hrs.
 or... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Miner

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Canada

10. NAME OF FATHER

Sam Cunningham

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Mary Dougherty

13. BIRTHPLACE OF MOTHER

(State or Country)

Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

William Cunningham
Coeur d'Alene, Ida.

15. Filed

Feb. 3 1922

D. D. Bremer
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 9 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec. 13 1921 to *Jan 2 1922*
 that I last saw him alive on *Dec. 21 1921*
 and that death occurred on the date stated above, at *8 A.* M.
 The CAUSE OF DEATH* was as follows:

Tracheitis

(Duration) Yrs. mos. ds.

Contributory
 (Secondary)

(Duration) yrs. mos. ds.

(Signed)

Jan 3 1922

(Address)

Coeur d'Alene, Ida.

M. D.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State 1 yrs. 6 mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Thomas Cemetery 1-4 1922

20. UNDERTAKER

ADDRESS

R. B. Moroney, Coeur d'Alene

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36932
Registered No. 1013

1. PLACE OF DEATH

County of Kootenai
City of Coeur d'Alene

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

James H. Shoerlucke

Registration District No. 30

Primary Registration District No. 1027

(No. 1027 Bay St.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

Feb 24 1848
(Month) (Day) (Year)

7. AGE

73 Yrs. 10 Mos. 25 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

Retired

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. J. S. Duckert

(Address) Coeur d'Alene Ida

15.

Filed Feb. 3 1922 DD Brennan

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 16 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 15 1922, to Jan 15 1922
that I last saw him alive on Jan 15 1922
and that death occurred on the date stated above, at 10 A. M.
The CAUSE OF DEATH* was as follows:

Myocardial degeneration

(Duration) Not known mos. ds.

Contributory (Secondary) Intermittent Nephritis

(Duration) Not known mos. ds.

(Signed) J. C. Meyer M. D.

(Address) Coeur d'Alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State 5 yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Spokane Ida Jan 19 1922

20. UNDERTAKER

ADDRESS

R. B. Mooney Coeur d'Alene

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36933
Registered No. 1014

1. PLACE OF DEATH

Registration District No. 30
County of Bolemai FEB 8 1922
City of Grand Alameda (No. 1051 St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lawrence Francis O'Toole

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Male White Single
(Write the word.)

6. DATE OF BIRTH

8 16 1911
(Month) (Day) (Year)

7. AGE

10 Yrs. 5 Mos. 12 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Student

9. BIRTHPLACE

(State or Country)

Ida.

10. NAME OF FATHER

Jas. O. Toole

11. BIRTHPLACE OF FATHER

(State or Country)

Wis.

12. MAIDEN NAME OF MOTHER

Mary Jecquer

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

M. J. O'Toole

15.

Filed Feb-3 19 22 D. D. Prema
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 28 19 22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 20 19 21, to Jan 28 19 22
that I last saw him alive on Jan 26 19 22
and that death occurred on the date stated above, at 10:09 A.M.

The CAUSE OF DEATH* was as follows:

Acute Albuminuria

(Duration) Yrs. 3 mos. ds.

Contributory Parasitosis
(Secondary)

(Duration) 2 yrs. mos. ds.

(Signed) W. H. Kolderup M. D.

Jan 29 19 22 (Address) Coverd Alameda

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

St. Thomas Cem. Co. Alameda

DATE OF BURIAL

1-30 19 22

20. UNDERTAKER

C. Carney

ADDRESS

Alameda

36934

FORM V. S. No. 5-A-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Foster Registration District No. 30
 City of Coeur d'Alene Primary Registration District No. 1007
 BUREAU OF VITAL STATISTICS No. 224 Foster St.)

File No. 1018Registered No. 1018

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Harry J. Stenvik

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Male White Single
 (Write the word.)

6. DATE OF BIRTH

Sept 7 1898
 (Month) (Day) (Year)

7. AGE

23 Yrs. 4 Mos. 17 ds.

If LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work. Accountant
 (b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer) in Minn.

9. BIRTHPLACE

(State or Country) Minn

10. NAME OF
FATHERO. J. Stenvik11. BIRTHPLACE
OF FATHER

(State or Country) Norway

12. MAIDEN NAME
OF MOTHEREmma Nelson13. BIRTHPLACE
OF MOTHER

(State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Olson Nelson
 (Address) Coeur d'Alene 2da

15. Feb. 3 1922 DD Deema
 Filed Local Registrar

SYN-YORK CO. PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

January 24 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 29 1921, to Jan 24 1922
 that I last saw him alive on Jan 24 1922
 and that death occurred on the date stated above, at 2:57 P.
 The CAUSE OF DEATH* was as follows:

Tuberculosis of the lungs

(Duration) Two Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Jan 24 1922 (Address) Louise H. Most M. D.
Coeur d'Alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state
 (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. 1 mos. 20 days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Forest Cemetery

DATE OF BURIAL

1-25 1922

20. UNDERTAKER

B. B. Dwyer Coeur d'Alene

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
 N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH
 in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

36935

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Boonville
City of Boonville

Registration District No. 30

Registration District No. 105-1

File No. 1016

Registered No. 1016

If death occurs away from usual residence, give facts called for under special information.

BUREAU OF VITAL STATISTICS

2. FULL NAME

Lugene M. Moulden

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

7

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widow
(Write the word.)

6. DATE OF BIRTH

September 1 1838
(Month) (Day) (Year)

7. AGE

83 Yrs. 4 Mos. 21 ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

Nothing

9. BIRTHPLACE

(State or Country)

Norway

10. NAME OF FATHER

Deak Kaur

11. BIRTHPLACE OF FATHER

(State or Country)

Deak Kaur

12. MAIDEN NAME OF MOTHER

X

13. BIRTHPLACE OF MOTHER

(State or Country)

Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

My Sister

(Address)

Boonville

15.

Filed

Feb 3 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 29 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1921 to Jan 22 1922

that I last saw her alive on Jan 22 1922

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Heart Fatigue

(Duration) 4 Yrs. mos. ds.

Contributory (Secondary) Coronary Arteriosclerosis

(Duration) 1 yrs. mos. ds.

(Signed) J. H. Duncan M. D.

1/27 1922 (Address) Boonville, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Forest Cemetery

DATE OF BURIAL

1-24-1922

20. UNDERTAKER

E. Cassidy

ADDRESS

Boonville

36936

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.
Registered No. 1017

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

FORM V. S. No. 5-A-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Kootenai Registration District No. 30
City of Paer dale Primary Registration District No. 1051
(No. 16 and St Marie St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Thomas J Bunker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH

July 13 1840
(Month) (Day) (Year)

7. AGE

81 Yrs. 6 Mos. 6 ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Retired

9. BIRTHPLACE

(State or Country)

Maine

10. NAME OF FATHER

Noble Bunker

11. BIRTHPLACE OF FATHER

(State or Country)

Maine

12. MAIDEN NAME OF MOTHER

Sarah Brier

13. BIRTHPLACE OF MOTHER

(State or Country)

Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs J. J. Bunker
(Address) Paer dale, Ida.

15.

Filed Feb 3 19 22 D. D. Druman
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 19 19 22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 16 19 22 to Jan 19 - 19 22
that I last saw him alive on 19 Jan 19 22
and that death occurred on the date stated above, at 4 A M.
The CAUSE OF DEATH* was as follows:
apoplexy

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) D. D. Druman M. D.

1/21 19 22 (Address) Paer dale

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State 18 yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

First Cemetery

DATE OF BURIAL

1-21 19 22

20. UNDERTAKER

P. B. Mooney

ADDRESS

Paer dale

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH

County of Footwall
City of Post Falls, Idaho

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED CERTIFICATE OF DEATH

Registration District No. 30

Primary Registration District No. 1051

(No. STATISTICS)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No. 1018

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED
married
(Write the word.)

6. DATE OF BIRTH.

Mar 12 1858
(Month) (Day) (Year)

7. AGE

63 Yrs. 10 Mos. 1 ds.

IF LESS than 1 day
how many ... hrs. or
... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

House wife

9. BIRTHPLACE

(State or Country)

Cedar Rapids Iowa

10. NAME OF FATHER

S. Graves

11. BIRTHPLACE OF FATHER

(State or Country)

Don't know

12. MAIDEN NAME OF MOTHER

Nellie

13. BIRTHPLACE OF MOTHER

(State or Country)

Don't know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Chris Passons
Post Falls, Idaho

15. Filled

Feb 3 1922

S. D. Druma
Local Registrar.

16. DATE OF DEATH

January 13th 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Dec 21st 1921 to Jan 22 1922

that I last saw her alive on Dec 23rd 1921
and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Cancer of Uterus & Bladder

(Duration) 1 Yrs. 2 mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) J. L. McCaulup M. D.

(Address) Post Falls, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days, State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Riverside Park, Spokane, Wn

20. UNDERTAKER

SMITH & CO.

DATE OF BURIAL

Jan 16 1922

ADDRESS

CERTIFICATE OF DEATH

30 36938

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Kootenai Registration District No. 30
City of Coeur d'Alene Primary Registration District No. 1057
(No. 1915 Sherman St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Martin Underland

File No.

Registered No. 1028

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED single

(Write the word.)

6. DATE OF BIRTH

June 5 1889
(Month) (Day) (Year)

7. AGE

22 Yrs. 6 Mos. 22 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Lumberman

9. BIRTHPLACE

(State or Country)

Norway

10. NAME OF FATHER

Gilbert Underland

11. BIRTHPLACE OF FATHER

(State or Country)

Norway

12. MAIDEN NAME OF MOTHER

Christina Olson

13. BIRTHPLACE OF MOTHER

(State or Country)

Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Gilbert Underland
(Address) 1915 Sherman

15.

Filed Feb. 7 1922 D. Thuma
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 1 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec. 27 1921 to Jan 1 1922
that I last saw him alive on Dec. 27 1921,
and that death occurred on the date stated above, at 4 A. M.
The CAUSE OF DEATH* was as follows:P. m. Tuberculosis(Duration) 1 Yrs. mos. ds.Contributory
(Secondary)(Duration) 1 yrs. mos. ds.

(Signed)

Jan 2 1922 (Address) Coeur d'Alene, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Forest Cem. Coeur d'Alene 1-4 1922

20. UNDERTAKER

ADDRESS

C. CarstedtCoeur d'Alene

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Latah Registration District No. 64
City of Troy Primary Registration District No. 36939
St. 2144

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mrs Emma Slaff

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

widowed
(Write the word.)

6. DATE OF BIRTH

September 28 1872
(Month) (Day) (Year)

7. AGE

49 Yrs. 4 Mos. 12 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

House wife

9. BIRTHPLACE

(State or Country)

Michigan

10. NAME OF FATHER

Nils Mangue Johnson

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME OF MOTHER

Christina Johnson

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. A. P. Lewis(Address) Troy, Idaho

15.

Filed March 1 1922 Lucy M. Pickard
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb. 9th 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 30 1922 to Feb 8 1922that I last saw her alive on Feb 8 1922and that death occurred on the date stated above, at 11³⁰ P.M.

The CAUSE OF DEATH* was as follows:

Paralysis - Bulbar

(Duration) Yrs. mos. ds.

Contributory (Secondary) Nephritis

(Duration) Yrs. mos. ds.

(Signed) R. Nelson M. D.410 1922 (Address) Troy, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Allagan Mich unknown

20. UNDERTAKER ADDRESS

John J. Pickard Troy Ida

CERTIFICATE OF DEATH

36940

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Latah
City of BozillRegistration District No. 66Primary Registration District No. 2146(No. Bozill Hospital St.)File No. 1

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Helen Flaig

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDFemaleWhiteSingle
(Write the word.)

6. DATE OF BIRTH

February 10- 1922
(Month) (Day) (Year)

7. AGE

Yrs. 4 Mos. 4 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

none

(b) General nature of industry, business or establishment in which employed (or employer).

none

9. BIRTHPLACE

(State or Country)

Latah Co

10. NAME OF FATHER

Samuel Flaig

11. BIRTHPLACE OF FATHER

(State or Country)

Washington

12. MAIDEN NAME OF MOTHER

Hilda Brude

13. BIRTHPLACE OF MOTHER

(State or Country)

Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Don Flaig

(Address)

Bozill Idaho

15.

Filed 2/15 1922Wm. R. Gibson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb. 13 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 10- 1922, to Feb 13- 1922that I last saw her alive on Feb 13 1922,and that death occurred on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Interne Memoratorium

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

H. Gibson

M. D.

7/14/1922 (Address) Bozill Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. 4 days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Don Flaig

DATE OF BURIAL

2/14 1922

20. UNDERTAKER

ADDRESS

Helmer Sida

4136941

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Lemhi*
City of *Leadore*

Registration District No. _____

Primary Registration District No. *1116*

(No. _____)

St. _____

File No. _____

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Charles F. Barnes

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

August 9
(Month) (Day) (Year)*1867*
(Year)

7. AGE

55
Yrs. _____ Mos. _____ ds. _____IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Day Labor.

(b) General nature of industry, business or establishment in which employed (or employer)

Cutting Railroad ties.

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

Thomas Barnes

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Not known

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mrs Pearl Barnes*(Address) *Leadore Idaho.*

15.

Filed *Feb 10* 19 *22* *Chas Bellamy*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 6
(Month) (Day) (Year)*1922*
(Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 19 _____, to _____ 19 _____,

that I last saw him _____ alive on _____ 19 _____,

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Natural Causes due to Valvular heart disease

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) *W C Taehle, Coroner M.D.**2-7-23* (Address) *Salmon Idaho.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Junction Cemetery**2-12-1922*

20. UNDERTAKER

ADDRESS

*W C Taehle**Salmon Ida*

FORM V. S. No. 5-25 M. 1-19.

V
CERTIFICATE OF DEATH

36942

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Laramie*City of *Salmon*

If death occurs away from usual residence, give facts called for under special information.

Registration District No. *41*Primary Registrar District No. *2 116*

(No. _____ St.)

File No. _____

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME *Earl Walker*

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Feb 3

(Month)

(Day)

1899
(Year)

7. AGE

23

Yrs.

Mos.

ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Day farm laborer

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

William J. Walker

11. BIRTHPLACE OF FATHER

(State or Country)

Missouri

12. MAIDEN NAME OF MOTHER

Bertie Burris

13. BIRTHPLACE OF MOTHER

(State or Country)

Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

William J. Walker

(Address)

Plato, Missouri

15.

Filed

*Feb 10 - 1922**Chas Bellamy*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 5th

(Month)

(Day)

1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 19 _____, to _____ 19 _____

that I last saw him _____ alive on _____ 19 _____

and that death occurred on the date stated above, at *2:30 AM*.

The CAUSE OF DEATH* was as follows:

Gun shot wound inflicted by the hand of Officer entering right side

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed) *W. C. Doehle, Coroner**2-6-22*(Address) *Salmon Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ Yrs. _____ mos. _____ days. In the State _____ Yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Plato Missouri

19 _____

20. UNDERTAKER

ADDRESS

*W. C. Doehle**Salmon Ida*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

1. PLACE OF DEATH.

County of Lamhi
City of Salmon Ida

Registration District No. 41

Primary Registration District No. 3694
(No. 2176 St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. _____
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Helen Robins

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH.

Aug 17 1906
(Month) (Day) (Year)

7. AGE

15 Yrs. _____ Mos. _____ ds.

If LESS than 1 day
how many _____ hrs. or
_____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

High School

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Wm Robins

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Bertrude Elliott

13. BIRTHPLACE OF MOTHER

(State or Country)

Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

P J Brown

(Address)

Salmon Idaho

15.

Filed

Feb 101922Chas Bellomy

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 25

(Month)

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 17 1922, to Jan 21 1922.

that I last saw h. er alive on Jan 22 1922

and that death occurred on the date stated above, at 1 P M.

The CAUSE OF DEATH* was as follows:

Typhoid feverAbout 5 weeks

(Duration)

Yrs.

mos.

ds.

Contributory

(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

Chas F. Hammer M. D.

(Address)

Salmon Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death.

Where was disease contracted

if not at place of death?

Former or

usual residence

In the

State.

yrs. mos. days

19. PLACE OF BURIAL OR REMOVAL

Junction Cemetery

DATE OF BURIAL

1-26 1922

20. UNDERTAKER

W C Joebler

ADDRESS

Salmon Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 25 M. 1-16-13

CERTIFICATE OF DEATH.

36946

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Lewis

City of Hamlet

Registration District No. 47

Primary Registration District No. 2428

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jefferson Wood

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.Married
(Write the word.)

6. DATE OF BIRTH.

June 19 1844
(Month) (Day) (Year)

7. AGE

77 Yrs. 7 Mos. 19 ds.

IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

Retired farmer

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

John H. Wood

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Elizabeth Blugh

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

H. E. Wagon
Hamlet Idaho

15.

Filed

2/8 1922 C. J. Johnson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 7 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 7 1922 to August 19 1922
that I last saw him alive on Feb 6 1922
and that death occurred on the date stated above, at 9:15 P.M.

The CAUSE OF DEATH* was as follows:

Influenza complicated
by pneumonia

(Duration) 2 Yrs. 4 mos. ds.

Contributory (Secondary) chronic disease

(Duration) yrs. mos. 1 ds.

(Signed) C. J. Bryan M. D.

1922 (Address) Hamlet Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Woodland Ida

DATE OF BURIAL

7/9 1922

20. UNDERTAKER

C. J. Johnson

ADDRESS

Hamlet Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

36947

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Idaho*

City of *Kamiah*

Registration District No. *49*

Primary Registration District No. *2728*

(No. *2728*)

St.)

File No. _____

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Balburn Hill

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single

(Write the word.)

6. DATE OF BIRTH.

Nov

7

1917

(Month)

(Day)

(Year)

7. AGE

4 Yrs.

2 Mos.

4 ds.

IF LESS than 1 day
how many.....hrs. or
.....min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)

Chief

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

McCoy Hill

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Martha Oakman

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

McCoy Hill

(Address)

Kamiah Ida.

15.

Filed

1/11

1922

C. Johnson

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

January

(Month)

11

(Day)

1917

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

1-8

1922

to *1-10*

1922

that I last saw him alive on *1-10*

and that death occurred on the date stated above, at *Idaho*

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

Influenza

(Duration)

Yrs.

mos.

ds.

(Signed)

W. J. Johnson

M. D.

1-11-1922 (Address) *McCoy Hill, Idaho*

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Idaho, No. 202, South of Id.

DATE OF BURIAL

1-11-1922

20. UNDERTAKER

W. J. Johnson

ADDRESS

Kamiah, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13.

✓ CERTIFICATE OF DEATH.

36948

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 47

County of Idaho
City of Kamiah

Primary Registration District No. 2427

File No.

(No. St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

FULL NAME

Isabel Margaret Matlock

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-OWED OR DIVORCED.

White

Married

(Write the word.)

6. DATE OF BIRTH.

Apr 11 1889

(Month)

(Day)

(Year)

7. AGE

02 Yrs. 9 Mos. 14 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)

housewife

9. BIRTHPLACE

(State or Country)

Knoxington

10. NAME OF FATHER

James Margaret

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Julia Houston

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

J. C. Johnson
Kamiah, Ida

15. Filed

Jan 25 1922

1922

C. J. Johnson

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 25 1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 18 1922 to Aug 21 1922

that I last saw her alive on Jan 21 1922

and that death occurred on the date stated above, at 3:30 P.M.

The CAUSE OF DEATH* was as follows:

curious stomach

(Duration) ? Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

C. J. Johnson

M. D.

1/25/22 Address

Kamiah, Ida

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

St. Ann's Cemetery, Kamiah, Ida

DATE OF BURIAL

Jan 26 1922

20. UNDERTAKER

C. J. Johnson

ADDRESS

Kamiah, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

36949

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Idaho

Registration District No.

49

County of

Kamiah

Primary Registration District No.

2428

File No.

City of

Kamiah

(No.)

St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Willie Powers

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single

(Write the word.)

6. DATE OF BIRTH.

June 13 1907
(Month) (Day) (Year)

7. AGE

14 Yrs. 7 Mos. 1 ds.

IF LESS than 1 day how many hrs. or min. >

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

Schoolboy

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Willie Powers

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Agnes H. St. John-Kimpt

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Camille Williams
Kamiah

(Address)

15.

1/16

1922

J. Johnson
Local Registrar

Filed

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

January 14 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan. 10 1922 to about 1922
that I last saw him alive on Jan. 13 1922
and that death occurred on the date stated above, at 4:05 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) 3 Yrs. 1 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. Johnson M. D.

1116 1922 (Address) Kamiah

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death.....yrs.....mos.....days State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Just Cen No 1 Kamiah Ida

DATE OF BURIAL

1/16 1922

20. UNDERTAKER

J. Johnson

ADDRESS

Kamiah

MARGIN RESERVE

WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

1. PLACE OF DEATH.

County of Idaho
City of Namiah Ids

Registration District No. 49

Registration District No. 2428

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Asa Powers

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36950

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

Irish

5. SINGLE, MARRIED, WID-OWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH.

May 12 1905
(Month) (Day) (Year)

7. AGE

16 Yrs. 8 Mos. 6 ds.

If LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

School boy

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Frank Powers

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Agnes El Stow a Knopf

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Samuel Williams
Namiah Ids

(Address)

15.

Filed

1/18 1922

W. J. Johnson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

January 18 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 14 1922 to Jan 17 1922
that I last saw him alive on Jan 17 1922
and that death occurred on the date stated above, at 9:30 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) 7 Yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W. J. Johnson M. D.

1/20 1922 (Address) Namiah Ids

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Ind. Cen. No 1 Namiah Ids Jan 20 1922

20. UNDERTAKER

W. J. Johnson

ADDRESS

Namiah

V CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. *48*
County of *Lewis* Primary Registration District No. *2127*
City of *Rimbou* (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

BUREAU OF VITAL STATISTICS

2. FULL NAME

*Rosa Paul*File No. *36951*Registered No. _____
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *Red* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*
(Write the word.)6. DATE OF BIRTH *March 2nd 1903*
(Month) (Day) (Year)7. AGE *18* Yrs. *9* Mos. *30* ds.
IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)*Student*
Home

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Jesse Paul

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Lydia Condit

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Family Record - J. H. Laughlin*
(Address) *Winchester*15. Filed *Feb 1* 19*22* *J. H. Laughlin*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 1st 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *Jan 30 1922* to *Jan 31 1922*
that I last saw her alive on *Jan 31 1922*
and that death occurred on the date stated above, at *10 A.M.*

The CAUSE OF DEATH* was as follows:

Pericarditis with effusion(Duration) *2* Yrs. *5* mos. *5* ds.

Contributory (Secondary)

General debility(Duration) *2* yrs. *2* mos. *5* ds.

(Signed)

*J. H. Laughlin, M. D.**Feb 1 1922* (Address) *Winchester*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Winchester 19*22*

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH *Lincoln* Registration District No. *16*
 County of *Shoshone* Primary Registration District No. *1016*
 City of *Shoshone* (No. _____ St.)

File No. *36963*
 Registered No. *3*

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME *Eli Wherley*

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *married*
 (Write the word.)

6. DATE OF BIRTH *7 of May 1836*
 (Month) (Day) (Year)

7. AGE *85* Yrs. *8* Mos. *23* ds. IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

John J. Wherley
Penn a

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Margaret Wherley
Penn a

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

M. J. Wherley
Shoshone

15.

Filed

January 30 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan *30* *1922*
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 26 *1922* to *Jan 30* *1922*
 that I last saw him alive on *Jan 29* *1922*
 and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Senility.

(Duration) Yrs. _____ mos. _____ ds.
 Contributory (Secondary) *Hard work*

(Duration) Yrs. _____ mos. _____ ds.
 (Signed) *E. J. Davis* M. D.

Jan 30 1922 (Address) *Shoshone Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Shoshone *1-31 1922*

20. UNDERTAKER

ADDRESS

O. J. Newman *Shoshone*

CERTIFICATE OF DEATH.

1. PLACE OF DEATH.

Registration District No. 16
 County of Lincoln Primary Registration District No. 2016
 City of McEwensville St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

unmanned

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 36964Registered No. 2

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Fe 4. COLOR OR RACE wh. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single

6. DATE OF BIRTH.

1 (Month) 12 (Day) 1922 (Year)

7. AGE

1 hour If LESS than 1 day how many... (i.e. hrs. or min.)
 Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work...
 (b) General nature of industry, business, or establishment in which employed (or employer)...

NoneNone

9. BIRTHPLACE

(State or Country)

Idaho.

10. NAME OF FATHER

William Fectner

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Mada Gragor

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15.

Filed January 16 1922

J. L. Tuma
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

1 (Month) 12 (Day) 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-12-1922 to 1-12-1922 that I last saw him alive on 1-12-1922 and that death occurred on the date stated above, at 1:52 P.M.

The CAUSE OF DEATH* was as follows:

Cyanosis Muscularum

(Duration) 1 hour Yrs. Mos. ds.

Contributory Premature Birth (Secondary) 7 mos

(Duration) 7 mos Yrs. Mos. ds.

(Signed) Arthur C. Deane M. D.

19 (Address) Shoshone Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death... yrs... mos... days In the State... yrs... mos... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

On Ranch at Shoshone 1922

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

1. PLACE OF DEATH

County of LincolnCity of Shoshone (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mr. Thomas Fay

CERTIFICATE OF DEATH

Registration District No. 16Primary Registration District No. 1016State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 36965Registered No. 1

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

white5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDmarried
(Write the word.)

6. DATE OF BIRTH

March
(Month)17
(Day)1850
(Year)

7. AGE

71 Yrs.Mos. 10 ds. 4IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Housewife

9. BIRTHPLACE

(State or Country)

Ireland

10. NAME OF FATHER

Thomas Farrell

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Mary Farrell

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

James T. Fay

(Address)

Shoshone Idaho

15.

Filed

July 14 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July
(Month)13
(Day)1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 5 1922, to July 13 1922
that I last saw him alive on July 13 1922
and that death occurred on the date stated above, at 6:40 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy(Duration) _____ Yrs. _____ mos. 9 ds.Contributory
(Secondary)Senility

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

W. R. Baugh M. D.1/13 1922 (Address) Shoshone Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Shoshone

DATE OF BURIAL

1-14 1922

20. UNDERTAKER

O. J. Hummer

ADDRESS

Shoshone

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Madison Registration District No. 100
City of Rexburg Primary Registration District No. 2178
(No. St.)File No. 36966
Registered No. 1

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ellen Norwood Forsyth

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Married
(Write the word.)6. DATE OF BIRTH
August 1st 1863
(Month) (Day) (Year)7. AGE 58 Yrs. 5 Mos. 8 ds. IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Housewife

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Utah

10. NAME OF FATHER

Richard Norwood

11. BIRTHPLACE OF FATHER

(State or Country) Tennessee

12. MAIDEN NAME OF MOTHER

Elizabeth Stevenson

13. BIRTHPLACE OF MOTHER

(State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) T. R. Forsyth
(Address) Rexburg, Ida.15. Filed 1/10 1922
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

January 7, 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
.....19....., to19.....that I last saw h..... alive on.....19.....
and that death occurred on the date stated above, at.....M.

The CAUSE OF DEATH* was as follows:

gastric carcinoma

.....(Duration).....Yrs.....mos.....ds.

Contributory
(Secondary)

.....(Duration).....Yrs.....mos.....ds.

(Signed) G. E. Espe M. D.

.....19..... (Address).....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....Yrs.....mos.....days. In the State.....Yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Burton, Ida.

DATE OF BURIAL

1/11 1922

20. UNDERTAKER

David R. Young Rexburg, Ida.

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36967
Registered No. 2

1. PLACE OF DEATH

County of MadisonCity of SalemRegistration District No. 100Primary Registration District No. 2178

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary Ann Barker Virgin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.) Widowed

6. DATE OF BIRTH

July

(Month)

25th

(Day)

1832

(Year)

7. AGE

89

Yrs.

5

Mos.

19

ds.

IF LESS than 1 day

how many _____ hrs.

or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

None

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

Thomas Barker

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Elizabeth Thompson

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1/161922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

1-13-1922, to 1-13-1922that I last saw h. aw alive on 1-13-1922and that death occurred on the date stated above, at 6 am M.

The CAUSE OF DEATH* was as follows:

gastritis

(Duration)

Yrs.

mos.

7 ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

1/16 1922 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death.

yrs.

mos.

days.

In the

State.

yrs.

mos.

days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Sugar City

DATE OF BURIAL

1/171922

20. UNDERTAKER

David R. Young

ADDRESS

Rexburg, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 6-12 M. 6-15-17.

CERTIFICATE OF DEATH

36969

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Blaine*Registration District No. *100*Primary Registration District No. *2178*City of *Blaine*

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Hekoria Ogawa*

File No.

Registered No. *4*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M*4. COLOR OR RACE *Japanese*5. SINGLE, MARRIED, WIDOWED OR DIVORCED. *single*

(Write the word.)

6. DATE OF BIRTH. *Unknown*

(Month)

(Day)

(Year)

7. AGE *59*

Yrs.

Mos.

ds.

IF LESS than 1 day
how many hrs. or
min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Farm Laborer

9. BIRTHPLACE

(State or Country)

Japan

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

Japan

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Japan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *S. J. G. G. G.*(Address) *Blaine*15. *1/11*Filed *1922**1922*Local Registrar. *G. G. G.*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *January 10, 1922*

(Month)

(Day)

1912

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

1912

to

1912

that I last saw h. alive on 1912

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Labor Pneumonia

(Duration) Yrs. mos. ds.

Contributory

(Secondary)

(Duration) Yrs. mos. ds.

(Signed) *G. G. G.* M. D.

1922 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days, State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Blaine*DATE OF BURIAL *1/12 1922*20. UNDERTAKER *G. G. G.*ADDRESS *Blaine*

CERTIFICATE OF DEATH

10036970

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Madison Registration District No. 2178
City of Recluse Primary Registration District No. 2178
(No. 2178 St.)File No. 5If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Norah A. BakerIf death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH

June 15 1863
(Month) (Day) (Year)

7. AGE

58 Yrs. 7 Mos. 16 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)House wife

9. BIRTHPLACE

(State or Country)

Idaho10. NAME OF
FATHERRobert Rowdell11. BIRTHPLACE
OF FATHER

(State or Country)

Alabama12. MAIDEN NAME
OF MOTHERHarrist M. Mearns13. BIRTHPLACE
OF MOTHER

(State or Country)

New Jersey

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Jesse M. Baker
Recluse

15.

Filed 2/3 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

February 2 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 1919 to Feb 1 1922
that I last saw h. er alive on Jan 31 1922
and that death occurred on the date stated above, at 2:40 am M.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver(Duration) 2 Yrs. 0 mos. 0 ds.Contributory Carcinoma of pancreas
(Secondary)(Duration) 1 yrs. 0 mos. 0 ds.2/6 (Signed) Louis L. Rich M. D.1922 (Address) Recluse Idaho*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho7/4 1922

20. UNDERTAKER

ADDRESS

W. YoungRecluse

CERTIFICATE OF DEATH

36971

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Madison*
City of *Rebur*Registration District No. *100*Primary Registration District No. *2178*

(No. _____) (St.) _____

File No. _____

Registered No. *6*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Kathryn P. Nielsen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*
(Write the word.)

6. DATE OF BIRTH

March 26 1922
(Month) (Day) (Year)

7. AGE

*1 Yrs. 10 Mos. 13 ds.*IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)*Child*

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

James A. Nielsen

11. BIRTHPLACE OF FATHER

(State or Country)

Denmark

12. MAIDEN NAME OF MOTHER

Helene Paul

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

*Walter G. Paul
Rebur Idaho*

15.

Filed *2/9* *1922*Local Registrar *G. E. G.*

16. DATE OF DEATH

2 8 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

2/8 1922 to *2/8 1922*
that I last saw her alive on *2/8 1922*and that death occurred on the date stated above, at *10 PM*

The CAUSE OF DEATH* was as follows:

gastroenteritis

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory (Secondary)

Convulsions

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

G. E. G.

M. D.

19 _____ (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Rebur**2/10 1922*

20. UNDERTAKER

ADDRESS

David Young Rebur

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of MadisonCity of BurtonIf death occurs away from
usual residence, give facts
called for under special in-
formation.Registration District No. 100Primary Registration District No. 2178

(No. _____ St.)

File No. _____

Registered No. 7If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.2. FULL NAME Esther Lewis Gunnell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDFemale WhiteWidowed

(Write the word.)

6. DATE OF BIRTH

November 15th 1848
(Month) (Day) (Year)

7. AGE

73 Yrs. 2 Mos. 20 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)House Wife

9. BIRTHPLACE

(State or Country) Wales10. NAME OF
FATHERThomas Lewis11. BIRTHPLACE
OF FATHER(State or Country) Wales12. MAIDEN NAME
OF MOTHERMary Ann Griffiths13. BIRTHPLACE
OF MOTHER(State or Country) Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Evans Lewis Jr.(Address) Rehburg, Id.15. 2/6Filed 19Local Registrar G. G. Espe

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

February 5 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19that I last saw h. _____ alive on 19

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed) G. G. Espe M. D.19 (Address) _____*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted
if not at place of death?Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho, Utah 19

20. UNDERTAKER

ADDRESS

David R. Young Rehburg, Id.

CERTIFICATE OF DEATH

36973

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH **RECEIVED**
 Registration District No. **100**
 County of **Madison** **FEB 20 1922**
 Primary Registration District No. **2178**
 City of **Sugar** **BUREAU OF VITAL STATISTICS** (No. **100**) St.)

File No. _____
 Registered No. **8**

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME **Lillie Elizabeth Harrison**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Married**
 (Write the word.)

6. DATE OF BIRTH

December 30th 1882
 (Month) (Day) (Year)

7. AGE

39 Yrs. **1** Mos. **7** ds.

IF LESS than 1 day
 how many _____ hrs.
 or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Salt Lake City, Utah

10. NAME OF FATHER

Jabez W. West

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Jesse Hoggan

13. BIRTHPLACE OF MOTHER

(State or Country)

Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

2/919 **22**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

February 7, 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, that I attended deceased from **Feb. 7, 1922** to **Feb. 7, 1922**
 that I last saw her alive on **Feb. 7, 1922**
 and that death occurred on the date stated above, at **4 A.M.**
 The CAUSE OF DEATH* was as follows:

Addison Disease

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

F. B. Evans

M. D.

2/8 1922

(Address)

Sugar City

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sugar City**2/10 1922**

20. UNDERTAKER

ADDRESS

David Young**Rexburg**

CERTIFICATE OF DEATH

36990 *Johnson*
State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Boise*City of *Lewiston*Registration District No. *96*Primary Registration District No. *1009*(No. *1009*)

St.)

File No. *746*Registered No. *746*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Stillborn Ragon*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male*4. COLOR OR RACE *White*5. SINGLE, MARRIED, WID-OWED OR DIVORCED *Widow (the word.)*6. DATE OF BIRTH *Jan 22nd 1922*

(Month)

(Day)

(Year)

7. AGE

Yrs. *6 1/2*Mos. *—*ds. *—*IF LESS than 1 day
how many *6 1/2* hrs.
or *—* min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work *Stillborn*

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) *Idaho*10. NAME OF FATHER *H. J. Ragon*

11. BIRTHPLACE OF FATHER

(State or Country) *Wash*12. MAIDEN NAME OF MOTHER *Elizabeth Hornad*

13. BIRTHPLACE OF MOTHER

(State or Country) *Idaho*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *H. J. Ragon*(Address) *Lewiston, Idaho*

15.

Filed *2. 10 - 1922**Norm E. Bruce*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *Jan 22nd 1922*

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from *Jan 1 1922* to *Jan 2 1922*that I last saw him alive on *Jan 1 1922*and that death occurred on the date stated above, at *1:30 A.M.*

The CAUSE OF DEATH* was as follows:

Premature birth, (7 mos 1

(Duration)

Yrs. *6 1/2*mos. *—*ds. *—*Contributory *Transition*
(Secondary)

(Duration)

Yrs. *—*mos. *—*ds. *—*(Signed) *Paul W. Johnson*

M. D.

1/3 1922 (Address) *Lewiston, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death *—* yrs. *—* mos. *—* days. In the State *—* yrs. *—* mos. *—* days

Where was disease contracted if not at place of death?

Former or usual residence *—*19. PLACE OF BURIAL OR REMOVAL *Lewiston Idaho*DATE OF BURIAL *1/22 1922*20. UNDERTAKER *Vassar and Co*ADDRESS *Lewiston, Idaho*

V
CERTIFICATE OF DEATHState of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Boise
City of LewistonRegistration District No. 96Primary Registration District No. 1009

(No. _____ St.)

File No. _____

Registered No. 747

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary H. Stilwell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widow
(Write the word.)

6. DATE OF BIRTH

Jan 2nd 1862
(Month) (Day) (Year)

7. AGE

61 Yrs. — Mos. — ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)At Home

9. BIRTHPLACE

(State or Country)

Ontario Canada

10. NAME OF FATHER

Thomas Stinson

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Isabell Galbraith

13. BIRTHPLACE OF MOTHER

(State or Country)

Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

L. S. Stinson

(Address)

Winchester Idaho

15.

Filed

2-10-1922 Man E. Brun
Local Registrar

16. DATE OF DEATH

Jan 2nd 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19____ to 19____
that I last saw him alive on Jan 9th 1922

and that death occurred on the date stated above, at ____ M.

The CAUSE OF DEATH* was as follows:

Tuberculosis, chronic
Pulmonary

(Duration) ____ Yrs. ____ mos. ____ ds.

Contributory
(Secondary)

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed)

F. T. Hamer M. D.(Address) Lewiston

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days. In the ____ State ____ yrs. ____ mos. ____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lewiston Idaho

19____

20. UNDERTAKER

ADDRESS

Dessau and Co. Lewiston Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Perce
City of LewistonRegistration District No. 9636992Primary Registration District No. 1009

(No. _____ St.)

File No. _____

Registered No. 748

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Charles E. Helm

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

6. DATE OF BIRTH

Nov 15 1875
(Month) (Day) (Year)

7. AGE

46 Yrs. 1 Mos. 18 ds.
IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Farmer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ill.

10. NAME OF FATHER

Samuel H. Helm

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Martha J. Neville

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. M. Osower

(Address)

Leavitt, Idaho

15.

Filed 2 11 - 1922 Super E. Brown

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 3rd 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____ 19____, to _____ 19____

that I last saw him _____ alive on _____ 19____

and that death occurred on the date stated above, at 2:45 A.M.

The CAUSE OF DEATH was as follows:

Acute Heart Failure(Duration) _____ Yrs. _____ mos. One ds.Contributory
(Secondary)No Blue

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) M. B. Williamson Coroner M. D.Jan 9, 1922 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Lewiston, Idaho

DATE OF BURIAL

11 1922

20. UNDERTAKER

ADDRESS

Lewiston Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Boise
City of LewistonRegistration District No. 9636993
Primary Registration District No. 1009
(No. _____ St.)File No. _____
Registered No. 749

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jas W. Chittenden

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married

6. DATE OF BIRTH

Jan 21st 1875
(Month) (Day) (Year)

7. AGE

46 Yrs. 11 Mos. 17 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Salesman

9. BIRTHPLACE

(State or Country)

Kansas

10. NAME OF FATHER

Jas W. Chittenden

11. BIRTHPLACE OF FATHER

(State or Country)

Ind

12. MAIDEN NAME OF MOTHER

Ann Beckenbaugh

13. BIRTHPLACE OF MOTHER

(State or Country)

Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs J. W. Chittenden
(Address) Lewiston Idaho15. Filed 2-10-1922 Anna E Bruce
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 8th 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 26 1921 to Jan 8 1922
that I last saw him alive on Jan 5 1922
and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH was as follows:

General Tuberculosis(Duration) 3 Yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Jan 9 1922 (Address) Lewiston 2nd
Edgar White M.D.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Lewiston Idaho

DATE OF BURIAL

1/10 1922

20. UNDERTAKER

ADDRESS

Lewiston Idaho

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Nez Perce
City of Lewiston, Ida.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jacob Reidhaar

CERTIFICATE OF DEATH

Registration District No. 9636994Primary Registration District No. 1009(No. 1009 St.)State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. _____

Registered No. 750

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-OWED OR DIVORCED

Male White

Married

(Write the word.)

6. DATE OF BIRTH

December 31st 1945
(Month) (Day) (Year)

7. AGE

76 Yrs. 0 Mos. 18 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Zug Switzerland

10. NAME OF FATHER

M.C. Reidhaar

11. BIRTHPLACE OF FATHER

(State or Country) Switzerland

12. MAIDEN NAME OF MOTHER

Not Known

13. BIRTHPLACE OF MOTHER

(State or Country) Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Jacob Reidhaar(Address) Cottonwood, Ida.

15.

Filed 2-10-1922 Rusan E Bruce

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

1 18 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 11 1921 to Jan 18 1921
that I last saw him alive on Jan 17 1921
and that death occurred on the date stated above, at 2:30 A.M.

The CAUSE OF DEATH* was as follows:

Neural hernia (strangulated)
followed by paralysis
of bowels(Duration) _____ Yrs. _____ mos. 1 ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) John N. Alby, M. D.1-17-1922 (Address) Lewiston, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL
Cottonwood, Ida.DATE OF BURIAL
1/20/2220. UNDERTAKER
H.R. MerchantADDRESS
Clarkston, Wash

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Nezperce*City of *Lewiston*

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. *317 First Ave* St.)

2. FULL NAME

Elizabeth Powell

926995

1009

File No.

Registered No. *751*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

Nov 4 1851
January 17 1922
(Month) (Day) (Year)

7. AGE

*70 Yrs. 2 Mos. 18 ds.*IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION.

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)*Farmer's Wife*
Retired 16 years

9. BIRTHPLACE

(State or Country)

Wales

10. NAME OF FATHER

Evan Jenkins

11. BIRTHPLACE OF FATHER

(State or Country)

Wales

12. MAIDEN NAME OF MOTHER

Elizabeth Thomas

13. BIRTHPLACE OF MOTHER

(State or Country)

Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

H. D. Powell

(Address)

Lewiston Ida

15.

Filed

*Jan Feb 10 1921**Ernest E. Pounce*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 22 1922
At home for the past year
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19..... to *Jan 22 1922*
that I last saw him alive on *Jan 22 1922*
and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Gradual decline as result of Chronic Bronchitis

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

19..... (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Clarkston Wash

DATE OF BURIAL

Jan 25 1922

20. UNDERTAKER

H. A. Merchant

ADDRESS

Clarkston

CERTIFICATE OF DEATH

36996

McMahon
State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Ada*City of *Lewiston*Registration District No. *96*Primary Registration District No. *1009*(No. *1009* St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Rennie Carsson*File No. *75-2*Registered No. *75-2*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widowed
(Write the word.)

6. DATE OF BIRTH

Jan 10 1847
(Month) (Day) (Year)

7. AGE

75 Yrs. 11 ds.

If LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

At Home

9. BIRTHPLACE

(State or Country)

Mo.

10. NAME OF FATHER

Schwartz

11. BIRTHPLACE OF FATHER

(State or Country)

Alsace Lorraine

12. MAIDEN NAME OF MOTHER

Melbean

13. BIRTHPLACE OF MOTHER

(State or Country)

Alsace Lorraine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Dr. C. Carsson

(Address)

Lewiston Ida

15.

Filed

*2-10*19 *22**Dwan E. Bruce*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 21st 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 21st 1922 to *same* *1922*
that I last saw him *dead* *Jan 21st 1922*
and that death occurred on the date stated above, at *7-10 P.M.*

The CAUSE OF DEATH* was as follows:

Sudden attack of asthma

(Duration) Yrs. mos. ds.

Contributory (Secondary) *Cardiovascular renal disease*(Duration) *several* yrs. mos. ds.(Signed) *W. F. McMahon* M. D.*1-26 1922* (Address) *Lewiston Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Lewiston Ida

DATE OF BURIAL

1/27 1922

20. UNDERTAKER

Wosar and Co. Lewiston Ida

CERTIFICATE OF DEATH

36997

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. _____
County of Idaho Primary Registration District No. 1009
City of Lewiston (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Sister Maria TheresaFile No. _____
Registered No. 753

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDFemale White Single
(Write the words)

6. DATE OF BIRTH

Jan 27th 1874
(Month) (Day) (Year)

7. AGE

47 Yrs. 11 Mos. 27 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Sister of St Joseph

9. BIRTHPLACE

(State or Country)

Phil. Penn

10. NAME OF FATHER

Thomas Minaghan

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Mary Coyne

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mother M. Adelaide
(Address) Lewiston Idaho15. 3-10-1921 Susan E Bruce
Filed _____ Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 24th 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
Jan 20th 1922 to Jan 24th 1922that I last saw him alive on Jan 23rd 1922and that death occurred on the date stated above, at 1 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia(Duration) _____ Yrs. _____ mos. 4 ds.Contributory
(Secondary)Influenza(Duration) _____ yrs. _____ mos. 6 ds.

(Signed)

J. C. Vassar

M. D.

19. _____ (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Lewiston Ida

DATE OF BURIAL

1/15 1922

20. UNDERTAKER

Vassar and Co.

ADDRESS

Lewiston

V
CERTIFICATE OF DEATHwhite
State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Nezperce
City of LewistonRegistration District No. 9636998Primary Registration District No. 1009

(No. _____, _____ St.)

File No. _____

Registered No. 754

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Arville Adams

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDMale white Single
(Write the word.)

6. DATE OF BIRTH

Aug 20 1907
(Month) (Day) (Year)

7. AGE

14 Yrs. 5 Mos. 5 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)School boy

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

L. C. Adams

11. BIRTHPLACE OF FATHER

(State or Country)

Oregon

12. MAIDEN NAME OF MOTHER

Rosie Teats

13. BIRTHPLACE OF MOTHER

(State or Country)

Ilu

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

L. C. Adams

15.

Filed

2-10-1922 Dwan E. Price
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 25 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
Jan 1 1922 to Jan 25 1922that I last saw him alive on Jan 25 1922and that death occurred on the date stated above, at 2 A.M.

The CAUSE OF DEATH* was as follows:

Septicemia with resultant liver abscess.(Duration) Yrs. 1 mos. 20 ds.

Contributory (Secondary)

Infection from bruise(Duration) yrs. 1 mos. 2 ds.

(Signed)

Edgar L. White, M. D.Jan 25 1922 (Address) Lewiston, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. _____ mos. _____ days. In the State yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rural Ida19

20. UNDERTAKER

ADDRESS

W. E. TAYLOR & COLewiston, Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Mayhem Registration District No. 96 36999
City of Quincy Primary Registration District No. 1009
(No. _____ St.)File No. _____
Registered No. 753

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Archie James Brinkley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH

Jan 24 1922
(Month) (Day) (Year)

7. AGE

4 Yrs. 4 Mos. 4 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Infant

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Robt C. Brinkley

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Ethel Watson

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. P. Watson

(Address) _____

15.

Filed 2-16-22 Susan E. Bruce
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 28 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 24 1922 to Jan 28 1922
that I last saw him alive on Jan 25 1922
and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia(Duration) _____ Yrs. _____ mos. 4 ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) John N. Alley M. D.

19. (Address) _____

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Leviestown Ida 7-29-19

20. UNDERTAKER

ADDRESS

Vassar Medical Co. Leveistown

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Jefferson
City of Lafayette

Registration District No. _____

Primary Registration District No. 1009

(No. _____ St.)

File No. _____

Registered No. 756

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Clarence Lincoln

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

(Month) _____ (Day) _____ (Year) _____

7. AGE

23

Yrs. _____ Mos. _____ ds. _____

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

Student

9. BIRTHPLACE

(State or Country)

N.D.

10. NAME OF FATHER

Not Known

11. BIRTHPLACE OF FATHER

(State or Country)

Not Known

12. MAIDEN NAME OF MOTHER

Not Known

13. BIRTHPLACE OF MOTHER

(State or Country)

Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. H. Hume
Lafayette Idaho

15.

Filed

2-101922Susan E. Bruce

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month) 1 (Day) 30 (Year) 1922

17. I HEREBY CERTIFY, That I attended deceased from

1-1-1922 to 1-30-1922that I last saw him alive on Jan 29 19and that death occurred on the date stated above, at 50 M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
chronic(Duration) 2 Yrs. _____ mos. _____ ds.
Contributory (Secondary) Pulmonary Tuberculosis

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) John H. Alley M.D.1-31-1922 (Address) Lewiston, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Waltham N.D.

DATE OF BURIAL

2-1-1922

20. UNDERTAKER

H. B. Hume

ADDRESS

Lewiston, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Write Plainly, with Unfading Ink—This is a Permanent Record. Every item of information should be carefully supplied. Age should be stated Exactly. Physicians should state Cause of Death in plain terms, so that it may be properly classified. Exact statement of Occupation is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

State of North Dakota
Bureau of Vital Statistics

1 Place of Death Ft Lapwai Sanatorium State Idaho Registered No. _____
County _____ Township _____ or Village _____ or
City _____ No. _____ St., _____ Ward _____
(If death occurred in a hospital or institution, give its name instead of street and number.)

2 Full Name Clarence Lincoln *Dec 1922*
(a) Residence. No. _____ St., _____ Ward. _____
(Usual place of abode) (If nonresident give city or town and State.)
Length of residence in city or town where death occurred _____ years, _____ months, _____ days
How long in United States, if of foreign birth _____ years, _____ months, _____ days

PERSONAL AND STATISTICAL PARTICULARS

3 Sex Male 4 Color or Race Indian 5 Single, Married, Widowed, or Divorced (write the word) Single
5a If Married, Widowed, or Divorced HUSBAND of _____ (or) WIFE of _____ Single
6 Date of Birth (month, day, and year) 11.20.1895
7 Age 26 Years 2 Months 10 Days 1 If less than 1 day, ... hrs. ... min.
8 Occupation of Deceased
(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) None
(c) Name of employer _____
9 Birthplace (city or town) (State or country) Ft Berthold Reserve

10 Name of Father Robert Lincoln
11 Birthplace of Father (city or town) (State or country) Ft Berthold Reserve
12 Maiden Name of Mother Zora Spotted Bear
13 Birthplace of Mother (city or town) (State or country) Ft Berthold Reserve

14 Informant _____
(Address) Elbowoods, N.D.

15 Filed FEB 6 1924 Registrar _____

MEDICAL CERTIFICATE OF DEATH

16 Date of Death (month, day, and year) 1.30.22 19
17 I HEREBY CERTIFY, That I attended deceased from 7.4.21, 19... to 10.1.21, 19... that I last saw him alive on 10.1.21, 19... and that death occurred, on the date stated, at 4.30 Pm.
The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonary
(duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY (Secondary) _____
(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted if not at place of death? _____
Did an operation precede death. _____ Date of _____
Was there an autopsy? _____
What test confirmed diagnosis? clinical
(Signed) Harry H. McKee M. D.
(Address) Elbowoods, N.D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental or Homicidal. (See reverse side for Add. space.)

19 Place of Burial, Cremation or Removal Ft Berthold Reserve Date of Burial 19
20 Undertaker _____ Address _____

✓ CERTIFICATE OF DEATH

37001

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Nez Perce
City of Lewiston, Ida.Registration District No. 96
Primary Registration District No. 1009
(No. _____ St.)File No. _____
Registered No. 74-8

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Agnes Krause

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widowed
(Write the word.)6. DATE OF BIRTH January 1st 1854
(Month) (Day) (Year)7. AGE 68 Yrs. 30 Mos. ds.
IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work At Home
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) France

10. NAME OF FATHER

Not Known

11. BIRTHPLACE OF FATHER

(State or Country) Not Known

12. MAIDEN NAME OF MOTHER

Not Known

13. BIRTHPLACE OF MOTHER

(State or Country) Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Mary Hanson
(Address) Kamiah, Ida.15. Filed 2-10-1922 Susan E. Bruce
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan. 30th, 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Jan. 24th 1922 to Jan 30th 1922
that I last saw her alive on Jan 30th 1922
and that death occurred on the date stated above, at 8 P.M.The CAUSE OF DEATH* was as follows:
Influenza(Duration) 8 Yrs. mos. ds.
Contributory (Secondary) Flu Pneumonia (Lobular)(Duration) 6 yrs. mos. ds.
(Signed) Paul W. Johnson M. D.2/1-19-22 (Address) Lewiston, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Clarkston, Wash DATE OF BURIAL 2/2/22 19____20. UNDERTAKER B.R. Merchant ADDRESS Clarkston, Wn/

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

37003

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 43

County of *Owyhee*

Primary Registration District No. 2120

City of *Salmon*

(No. _____)

(St. _____)

File No. _____

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

A. L. Mann

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male

Yellow

Single
(Write the word.)

6. DATE OF BIRTH

Jan

13

1832

(Month)

(Day)

(Year)

AGE

40 yrs. *0* mos. *13* ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

China

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

China

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

China

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. L. Mann

(Address)

177 Salmon City Idaho

15.

Filed

Jan 27

19*22*

John A. G. [Signature]

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191... to 191...

that I last saw him alive on 191...

and that death occurred on the date stated above at M.

The CAUSE OF DEATH* was as follows

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

19... (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death... yrs... mos... days. In the State... yrs... mos... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

China Cemetery

Jan 27 1922

20. UNDERTAKER

John A. G. [Signature]

ADDRESS

Salmon City

CERTIFICATE OF DEATH

37007

State of Idaho
BOARD OF HEALTH

Bureau of Vital Statistics

File No. 3

Registered No. 141

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

1. PLACE OF DEATH

County of Power

Registration District No.

Primary Registration District No.

City of American Falls

If death occurs away from

usual residence, give facts

called for under special

information.

2. FULL NAME

William S. Booth

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

Single

6. DATE OF BIRTH.

Aug

31

1872

(Month)

(Day)

(Year)

7. AGE

49

4

13

Yrs.

Mos.

ds.

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work

Stockman

(b) General nature of in-
dustry, business, or estab-
lishment in which em-
ployed (or employer)

9. BIRTHPLACE

(State or Country)

Kas

10. NAME OF

FATHER

E.F. Booth

11. BIRTHPLACE

OF FATHER

(State or Country)

Ills

12. MAIDEN NAME

OF MOTHER

Lucie E. Bennett

13. BIRTHPLACE

OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Burling Box 305

15.

Filed 191

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

January

13

22

(Month)

(Day)

191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 10 1922 to Jan 10 1922

that I last saw him alive on Jan 10 1922

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Nephritis

(Duration)

Yrs.

mos.

ds.

Contributory

(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

V. G. Lagan

M. D.

19 (Address)

Am Falls

*State the Disease Causing Death; or in deaths from Violent
Causes, state (1) Means of Injury; and (2) whether Accidental,
Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place

In the

of death yrs. mos. days, State yrs. mos. days

Where was disease contracted

if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Am Falls

Jan 10 1922

20. UNDERTAKER

ADDRESS

A. W. Davis

Am Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

1. PLACE OF DEATH. Home
Registration District No. 2072
County of Power Primary Registration District No. 2072
City of American Falls, Idaho Bethany Hospital St.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lee Walton

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 3
Registered No. 172

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE Black 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH.

XXM Not known

(Month) (Day) (Year)

7. AGE

52

Yrs. Mos. ds.

If LESS than 1 day
how many hrs. or
min. 2

8. OCCUPATION

(a) Trade, profession or particular kind of work. Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Not Known

10. NAME OF FATHER

Not Known

11. BIRTHPLACE OF FATHER

(State or Country) Not Known

12. MAIDEN NAME OF MOTHER

Not Known

13. BIRTHPLACE OF MOTHER

(State or Country) Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

American Falls, Idaho

15.

Filed 1 - 7 1922 Richard F. Roth
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 27/22 1912
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1st 1922, to Jan 27 1922,

that I last saw him alive on Jan 27 1922

and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Myocardial infarction of heart

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) J. G. Fagan M. D.

19. (Address) American Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

American Falls Jan 27 1922

20. UNDERTAKER

ADDRESS

Arvidson

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

37010 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Payette*
City of *New Plymouth*Registration District No. *5*Primary Registration District No. *2009*

File No. _____

Registered No. *1*

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Fannie Johnson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

Feb 2 1895
(Month) (Day) (Year)

7. AGE

*66 Yrs. — Mos. 25 ds.*IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).*Housewife*

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

Cyrus Talley

11. BIRTHPLACE OF FATHER

(State or Country)

Kentucky

12. MAIDEN NAME OF MOTHER

Edwards

13. BIRTHPLACE OF MOTHER

(State or Country)

Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Lott Johnson

(Address)

Ontario Oregon

15.

Filed *Feb 28* 1922*Wm J. Drysdale*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 27 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 1919 19 to *Feb 11* 1922
that I last saw him alive on *Feb 11* 1922
and that death occurred on the date stated above, at *1 P.M.*

The CAUSE OF DEATH* was as follows:

Apoplexy -(Duration) *2* Yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Y. R. Edwards M. D.*2/27* 1922 (Address) *Payette Ida -*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Payette Idaho

DATE OF BURIAL

March 1, 1922

20. UNDERTAKER

Glenn C. Landon

ADDRESS

Payette Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

37011

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.

County of *Boise*

Primary Registration District No.

City of *Boise*

St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

BUREAU OF VITAL STATISTICS

2. FULL NAME

Lena Taylor

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1927

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at 2:30 M.

The CAUSE OF DEATH* was as follows:

*Organic Heart Disease*Contributory *Inflammatory Phlebitis*(Signed) *Geo. Jennings* M. D.1-7-1922 (Address) *Boise, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

37012

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 39
County of Twin Falls Primary Registration District No. 2087
City of Buhl (No. 39) St.

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Marion Converse

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male White (Write the word.)

6. DATE OF BIRTH

July 25 1922
(Month) (Day) (Year)

7. AGE

5 27
Yrs. Mos. ds. IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Buhl Idaho, T. Falls Co.

10. NAME OF FATHER

Marion Converse

11. BIRTHPLACE OF FATHER

(State or Country) Iowa

12. MAIDEN NAME OF MOTHER

Catherine Wadell

13. BIRTHPLACE OF MOTHER

(State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Marion Converse(Address) BuhlFiled Jan. 17 1922 J. H. Murphy

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan. 16 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan. 16 1922 to Jan. 16 1922
that I last saw him alive on Jan. 16 1922and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Bronchitis

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) James M. D.19 (Address) Buhl, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Buhl

DATE OF BURIAL

Jan 17 1922

20. UNDERTAKER

Armer B Evans

ADDRESS

Buhl Ida

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH
BUREAU OF VITAL STATISTICS

37013 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. _____
Registered No. _____

1. PLACE OF DEATH

County of Ada
City of Buhl

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Kenneth Dale Morris

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

6. DATE OF BIRTH

Dec 29 1921
(Month) (Day) (Year)

7. AGE

20 yrs. 20 mos. 0 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Buhl

10. NAME OF FATHER

Richard Morris

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Oma Keck

13. BIRTHPLACE OF MOTHER

(State or Country)

Okla.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Richard Morris
Buhl

(Address)

15.

Filed Jan 19 1922

J. H. Murphy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 18 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

18 1922, to 18 1922
that I last saw him alive on 18 1922,
and that death occurred on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:

Capillary Bronchitis

One day (Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) James Monroe M. D.

Jan 29 1922 (Address) Buhl, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Repp Cemetery 1/19 1922

20. UNDERTAKER

ADDRESS

Lowell D. Rupp Buhl, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH
County of Blaine Registration District No. 39
City of Blaine Primary Registration District No. 2081 File No. _____
St. _____ Registered No. _____
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME Donald Eugene Rogers
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS
3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
6. DATE OF BIRTH Feb 13 1921
(Month) (Day) (Year)
7. AGE 11 Yrs. 9 Mos. 9 ds. IF LESS than 1 day how many hrs. or min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work. ✓
(b) General nature of industry, business or establishment in which employed (or employer). ✓
9. BIRTHPLACE Washington
(State or Country)
10. NAME OF FATHER Bryan E. Rogers
11. BIRTHPLACE OF FATHER Idaho
(State or Country)
12. MAIDEN NAME OF MOTHER Nora Whitaker
13. BIRTHPLACE OF MOTHER Mo
(State or Country)
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Bryan E. Rogers
(Address) Blaine Idaho
15. Filed 1-23 1922 J. H. Murphy
Local Registrar

MEDICAL CERTIFICATE OF DEATH
16. DATE OF DEATH 1 - 22 - 1922
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from 1 - 19 - 1922 to 1 - 22 - 1922
that I last saw him alive on 1 - 22 - 1922
and that death occurred on the date stated above, at 1:30 PM.
The CAUSE OF DEATH* was as follows:
Streptococcus Septicemia from the throat.
(Duration) Yrs. 4 mos. 4 ds.
Contributory (Secondary) _____
(Duration) yrs. 4 mos. 4 ds.
(Signed) Geo. Jennings M. D.
1-22 1922 (Address) Blaine, Ida.
*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.
18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. 4 mos. 4 days. In the State yrs. 4 mos. 4 days.
Where was disease contracted if not at place of death? _____
Former or usual residence _____
19. PLACE OF BURIAL OR REMOVAL Blaine Cemetery DATE OF BURIAL Jan 23 1922
20. UNDERTAKER Howell & Sons ADDRESS Blaine Ida

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

37015

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 37.

County of *Irving*

Primary Registration District No. 1085.

City of *Irving*

(No. 1)

St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Edangler Bass

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED*Male**White**Married*
(Write the word.)

6. DATE OF BIRTH

Jan 22
(Month)

(Day)

19 22
(Year)

7. AGE

Yrs. Mos. *3* ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Irving Falls

10. NAME OF FATHER

Raymond Bass

11. BIRTHPLACE OF FATHER

(State or Country)

Hawaii

12. MAIDEN NAME OF MOTHER

Kathleen Spangler

13. BIRTHPLACE OF MOTHER

(State or Country)

Irving Falls

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. C. Spangler
319. 5th Ave north

15.

Filed

*Feb 7 1922**John F. Connelley*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 24
(Month)

(Day)

19 22
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 22 1922 to *Jan 24 1922*
that I last saw him alive on *Jan 24 1922*
and that death occurred on the date stated above, at *9 P.M.*

The CAUSE OF DEATH* was as follows:

Melena Neanatorum

(Duration)

Yrs.

mos.

3 hours
ds.Contributory
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

Chas. R. Scott M. D.*1-25-1922*

(Address)

Irving Falls - Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Irving Falls**Jan 25 1922*

20. UNDERTAKER

ADDRESS

*Ed. A. Scott**Irving Falls*

37016

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Lincoln*City of *Idaho Falls*If death occurs away from
usual residence, give facts
called for under special in-
formation.

RECEIVED CERTIFICATE OF DEATH

Registration District No. *37*Primary Registration District No. *1085*

(No. St.)

File No.

Registered No.

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

2. FULL NAME

Myrtle Croft

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

*White*5. SINGLE, MARRIED, WID-
OWED OR DIVORCED*Single*

6. DATE OF BIRTH

Jan 7 1922
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many *12* hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)*Lab.*

9. BIRTHPLACE

(State or Country)

*Ida.*10. NAME OF
FATHER*Ephraim Croft*11. BIRTHPLACE
OF FATHER

(State or Country)

*Utah*12. MAIDEN NAME
OF MOTHER*Anna May Blankenship*13. BIRTHPLACE
OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *E. H. Croft*(Address) *Idaho Falls*15. Filed *Feb 7 1922*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 8 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1/8 1922 to *1/8 1922*that I last saw him alive on *1/8 1922*and that death occurred on the date stated above, at *11:00* M.

The CAUSE OF DEATH* was as follows:

Prima facie
(Duration) Yrs. mos. ds.Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

H. N. Latta M. D.
1/12 1922 (Address) *Idaho Falls**State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Idaho Falls

DATE OF BURIAL

1-10 1922

20. UNDERTAKER

ADDRESS

J. H. Brown
Idaho Falls

37017

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Lincoln*Register District No. *37*Primary Registration District No. *1083*City of *Lincoln*(No. *Lincoln* St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Virginia Ruth Richmond

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female white(Write the word.) *Single*

6. DATE OF BIRTH

*June**4**1*

(Month)

(Day)

(Year)

7. AGE

5

Yrs.

Mos.

da.

IF LESS than 1 day
how many Yrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Thomas Richmond

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

May Robinson

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Thomas Richmond

(Address)

Lincoln, Idaho

15.

Filed *Feb 7* 19 *22*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 8

(Month)

(Day)

19 *22*
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 4 19 *22*, to *Jan 8* 19 *22*.that I last saw him alive on *Jan 8* 19 *22*.and that death occurred on the date stated above, at *9:28* P.M.

The CAUSE OF DEATH* was as follows:

Peritonitis

(Duration)

Yrs.

mos.

ds. *4*

Contributory

ruptured appendix

(Duration)

Yrs.

mos.

ds. *4*

(Signed)

H. A. K. Wright M. D.*Jan 9* 19 *22*. (Address) *Lincoln, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Lincoln**1-10* 19 *22*

20. UNDERTAKER

ADDRESS

*J. J. Groverman**Lincoln*

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Laramie Falls*
City of *" "*Registration District No. *37*Primary Registration District No. *1085-37020*
(No. *County Hospital* St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Ivor T. Edwards

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male white Single (Write in word.)

6. DATE OF BIRTH

Dec. 1 1878
(Month) (Day) (Year)

7. AGE

*43 Yrs. 1 Mos. 12 ds.*IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).*Farmer*

9. BIRTHPLACE

(State or Country)

Cardiff, England

10. NAME OF FATHER

Richard Edwards

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

C. J. Pringle

(Address)

Laramie Falls

15.

Filed *Feb 9* 19 *22* *John T. Long* Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan. 19 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 24 1921 to *Jan 19 1922*
that I last saw him alive on *Jan 19 1922*
and that death occurred on the date stated above, at *11 am* M.

The CAUSE OF DEATH* was as follows:

Septic Endocarditis(Duration) Yrs. *7* mos. - ds.Contributory (Secondary) *Exophthalmic Goiter, nephritis, album of prostate.*

(Duration) Yrs. - mos. - ds.

(Signed) *H. W. Wilson* M. D.(Address) *Laramie Falls, Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Laramie Falls

DATE OF BURIAL

Jan. 22 1922

20. UNDERTAKER

J. J. Grossman

ADDRESS

Laramie Falls

MARGIN RESERVED FOR BINDING PURPOSES - THIS IS A PERMANENT RECORD

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-1-25 M. 1-19.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No. 37

Primary Registration District No. 1085

S. No.

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male

White

Married
(Write the word.)

6. DATE OF BIRTH

April

4

1850
(Month) (Day) (Year)

7. AGE

72 Yrs. 9 Mos. 25 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

Retired.

Farmer.

9. BIRTHPLACE

(State or Country)

Ire.

10. NAME OF FATHER

Isaac Goodrich

11. BIRTHPLACE OF FATHER

(State or Country)

N. Y.

12. MAIDEN NAME OF MOTHER

Margaret Garmelle

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Lloyd Goodrich

(Address)

Ivins Falls, Ida.

15.

Filed

Feb. 9- 1922

John F. Laughlin

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan - 29

(Month)

29

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan. 19- 1922, to Jan. 29 1922.
that I last saw him alive on Jan. 29 1922.
and that death occurred on the date stated above, at 10:00 P.M.
The CAUSE OF DEATH* was as follows:

Edwin J. Long

(Duration)

Yrs.

mos.

ds.

Contributors
(Secondary)

Gibson & Co.

(Duration)

Yrs.

mos.

ds.

(Signed)

John F. Laughlin M. D.

1922

(Address) Ivins Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Ivins Falls

Jan 31 1922

20. UNDERTAKER

P. J. Grossman

ADDRESS

Ivins Falls

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Twin Falls*

Registration District No. *37023*

Primary Registration District No. *37023*

City of *Idaho*

(No. *Idaho* St.)

File No. *37023*

Registered No. *37023*

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

John E. Milligan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married

6. DATE OF BIRTH

Oct. 31 1848
(Month) (Day) (Year)

7. AGE

73 Yrs. *2* Mos. *9* ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

Anthony Milligan

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Sarah Randles

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mrs. John E. Milligan*

(Address) *Idaho*

15. *Filed* *Dec. 7* 19 *22* *John E. Milligan*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 10 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1730 1921, to *Jan 10* 1922

that I last saw him alive on *Jan 9* 1922

and that death occurred on the date stated above, at *40* M.

The CAUSE OF DEATH* was as follows:

Angina pectoris

(Duration) Yrs. *20*3 mos. ds.

Contributory (Secondary) *Bladder drainage for enlarged prostate*

(Duration) yrs. mos. *8* ds.

(Signed) *W. G. Pike* M. D.

1/11/22 (Address) *Twin Falls, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Twin Falls

DATE OF BURIAL

Jan 14 1922

20. UNDERTAKER

J. J. Roseman

ADDRESS

Twin Falls

FORM V. S. No. 5-A-25 M. 1-19.

CERTIFICATE OF DEATH

37025

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Twin Falls*Registration District No. *37*Primary Registration District No. *1085*City of *Idaho*

(No. St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give NAME instead of street and number.

2. FULL NAME

Gys E Junius van Hammet

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WID-OWED OR DIVORCED *Married*

(Write the word.)

6. DATE OF BIRTH

June 16th 1886
(Month) (Day) (Year)

7. AGE

36 Yrs. *7* Mos. *21* ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)*Accountant*

9. BIRTHPLACE

(State or Country)

Atlantic Iowa

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

Gys E Junius van Hammet
Halland

12. MAIDEN NAME OF MOTHER

Cheryl A Rank

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Mary Junius van Hammet

15.

Filed *Feb 27* 19 *22*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 5th 1922

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb. 22 1921 to *Feb. 5 1922*
that I last saw him alive on *Feb. 5 1922*
and that death occurred on the date stated above, at *7:45* M.

The CAUSE OF DEATH* was as follows:

Arterial poisoning(Duration) Yrs. *11* mos. *14* ds.Contributory (Secondary) *Septic endocarditis*
Chronic Nephritis
Splenectomy(Duration) Yrs. *11* mos. *—* ds.(Signed) *H. Wilson* M. D.*Feb. 7 1922* (Address) *Twin Falls, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Twin Falls *37* 19 *22*

20. UNDERTAKER

ADDRESS

Edwert *Twin Falls*

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A-25 M. 1-19.

CERTIFICATE OF DEATH

37026

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Twins FallsRegistration District No. 37City of Idaho FallsPrimary Registration District No. 1085

(No.)

(St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William H. Greenlow

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married

6. DATE OF BIRTH

Jan. 9 1846
(Month) (Day) (Year)

7. AGE

76 Yrs. — 25 Mos. — 25 ds.

IF LESS than 1 day
how many hrs.
or min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Weigh master

(b) General nature of industry, business or establishment in which employed (or employer).

T. F. City

9. BIRTHPLACE

(State or Country)

Indiana

10. NAME OF FATHER

James W. Greenlow

11. BIRTHPLACE OF FATHER

(State or Country)

Virginia

12. MAIDEN NAME OF MOTHER

Augusta Russell

13. BIRTHPLACE OF MOTHER

(State or Country)

Miss.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Anna Greenlow842 Ave. N. T. F.

15. FILED

Feb. 91922John F. Thompson

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb. 3 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb. 2nd 1922 to Feb. 3 1922
that I last saw him alive on Feb. 2nd 1922
and that death occurred on the date stated above, at 6 p.m.
The CAUSE OF DEATH* was as follows:

Angina Pectoris(Duration) Yrs. mos. 3 ds.

Contributory (Secondary)

Arterio Sclerosis

(Duration) ? yrs. mos. ds.

(Signed)

James L. Thompson4/3 1922(Address) Twins Falls, Id.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Twins FallsJan. 7, 1922

20. UNDERTAKER

ADDRESS

J. ThompsonTwins Falls

CERTIFICATE OF DEATH

37027

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Quinn-Talbot*Registration District No. *37*City of *Kimberly* (No. *307*)Primary Registration District No. *2085*

St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary L. Summers

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed *Feb 9 - 1922*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

January 10 19*22*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov. 5 19*21*, to *Jan 10* 19*22*
that I last saw her alive on *January 10* 19*22*
and that death occurred on the date stated above, at *3:40 p.m.*

The CAUSE OF DEATH* was as follows:

Abscess of left lung.(Duration) Yrs. *1* mos. *15* ds.Contributory *Infected tonsils*
(Secondary)(Duration) *(?)* yrs. mos. ds.(Signed) *H. B. Payne*

M. D.

19*22* (Address) *Quinn Falls, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Quinn Falls**Jan. 12, 1922*

20. UNDERTAKER

ADDRESS

*J. J. Harrison, Quinn Falls*WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

37029

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Twin Falls

City of Kimberly,

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 36

Primary Registration District No. _____

(No. _____ St.)

File No. _____

Registered No. 1

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Leola Irene Rice

PERSONAL AND STATISTICAL PARTICULARS

3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

female | white | single
(Write in word.)

6. DATE OF BIRTH

October, 20, 1894
(Month) (Day) (Year)

7. AGE

26 Yrs. 2 Mos. 14 ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. school teacher
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Missouri

10. NAME OF FATHER

William M. Rice

11. BIRTHPLACE OF FATHER

(State or Country) Mo.

12. MAIDEN NAME OF MOTHER

Lula Robinson

13. BIRTHPLACE OF MOTHER

(State or Country) Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Clarence Rice

(Address) Kimberly, Idaho

15.

Filed Jan. 4, 1922

J. M. Davis
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

January, 3, 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan. 1, 1922, to Jan. 3, 1922

that I last saw her alive on Jan. 3, 1922

and that death occurred on the date stated above, at 11:20 A.M.

The CAUSE OF DEATH* was as follows:

Acute dilatation of heart,

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory Influenza
(Secondary)

(Duration) _____ yrs. 1 mos. _____ ds.

(Signed) J. M. Davis M. D.

1/4/1922 (Address) Kimberly, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Butler, Missouri

DATE OF BURIAL

Jan. 4

20. UNDERTAKER

P. J. Grossman Twin Falls,

ADDRESS

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
MAR 6 1922

CERTIFICATE OF DEATH

37031

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Lyon Falls District No. 39
City of Lyon Falls (No. 7087) St.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John HoggFile No.
Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married

6. DATE OF BIRTH

Dec 18 1877
(Month) (Day) (Year)

7. AGE

44 Yrs. 1 Mos. 15 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ireland

10. NAME OF FATHER

James Hogg

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Mary Gilmore

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John Hogg

(Address)

15.

Filed Feb. 4 1922J. H. Murphy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 3 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Dec 10 1922 to Feb 2 1922that I last saw him alive on Feb 2 1922and that death occurred on the date stated above, at 7 A. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(Duration) 1 Yrs. mos. ds.Contributory
(Secondary)(Duration) yrs. mos. ds.

(Signed)

C. J. McGinnis M. D.19. (Address) Lyon Falls Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Rock Cemetery

DATE OF BURIAL

Feb 3 1922

20. UNDERTAKER

Howell & Pugh Rock Ida.

ADDRESS

37032

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Blaine*
City of *Buhl*Registration District No. *39*Primary Registration District No. *2087*(No. *100*)

St.)

File No.

Registered No.

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

*Glenn Howard Luce*If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

*White*5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

*Oct**13**1918*

(Month)

(Day)

(Year)

7. AGE

3

Yrs.

3

Mos.

21

ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country)

*Neiser Idaho*10. NAME OF
FATHER*Harmer Luce*11. BIRTHPLACE
OF FATHER

(State or Country)

*Harrington Wash.*12. MAIDEN NAME
OF MOTHER*Edna Averett*13. BIRTHPLACE
OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Harmer Luce

(Address)

Buhl Ida.

15.

Filed

*Feb. 4**1922*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

*Feb.**3rd**1922*

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

2-2-1922 to *2-3-1922*that I last saw him alive on *2-3-1922*and that death occurred on the date stated above, at *7 P.* M.

The CAUSE OF DEATH* was as follows:

Streptococcus Septicemia

(Duration)

Yrs.

mos. *2*

ds.

Contributory
(Secondary)*Tonsillitis*

(Duration)

yrs.

mos.

ds.

(Signed)

Geo. Jennings

M. D.

2-3-1922

(Address)

*Buhl, Ida.**State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Buhl Ida**Feb. 6 1922*

20. UNDERTAKER

ADDRESS

*Harmer B. Evans**Buhl Ida*

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

37033

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Lincoln*Registration District No. *39*City of *Buhl*Primary Registration District No. *2087*(No. *1* St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Andrew Lewis Kallmeyer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

Aug. 26. 1921
(Month) (Day) (Year)

7. AGE

— Yrs. *5* Mos. *11* ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed *Feb. 8. 1922*

Local Registrar

16. DATE OF DEATH

Feb. 8th 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

2-1-1922, to *2-8-1922*that I last saw him alive on *2-5-1922*and that death occurred on the date stated above, at *7 A. M.*

The CAUSE OF DEATH* was as follows:

Acute Nephritis(Duration) Yrs. mos. *8* ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *Geo. J. Jennings* M. D.*28-1922* (Address) *Buhl, Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Buhl *27 9 22*

20. UNDERTAKER

Stromer B. Evans *Buhl*

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37034
Registered No.

1. PLACE OF DEATH

County of Linn
City of Castleton

Registration District No. 59
Primary Registration District No. 2087
(No.) (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Shu Soo Taketa

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

yellow

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

Feb 6 1922
(Month) (Day) (Year)

7. AGE

3 Yrs. 3 Mos. 3 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Castleton

10. NAME OF FATHER

G. Taketa

11. BIRTHPLACE OF FATHER

(State or Country)

Japan

12. MAIDEN NAME OF MOTHER

Chieko Maruwaki

13. BIRTHPLACE OF MOTHER

(State or Country)

Japan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

G. Taketa
Castleton

15.

Filed 2-10 1922

J. H. Murphy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 9 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

2/6 1922 to 2/9 1922
that I last saw him alive on 2/6 1922

and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

(Duration) 1 yrs. 2 mos. 2 ds.

Contributory
(Secondary)

(Duration) 1 yrs. 2 mos. 2 ds.

(Signed) A. J. H. Clark M. D.

2/10 1922 (Address) Buhl Bldg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Buhl Bldg Feb 10 1922

20. UNDERTAKER

ADDRESS

Armen Berens Buhl Bldg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
37035

1. PLACE OF DEATH
County of Adair
City of Adair

Registration District No. 39
Primary Registration District No. 2087
(No. St.)

File No.
Registered No.

If death occurs away from usual residence, give facts called for under special information.

BURIAL

2. FULL NAME Alfred Meryl Clemens

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Single

6. DATE OF BIRTH Oct 9 1904
(Month) (Day) (Year)

7. AGE 17 Yrs. 4 Mos. 5 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION Laborer
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE Idaho
(State or Country)

10. NAME OF FATHER C. H. Clemens

11. BIRTHPLACE OF FATHER Idaho
(State or Country)

12. MAIDEN NAME OF MOTHER Nancy E. Hughes

13. BIRTHPLACE OF MOTHER Kansas
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. H. Murphy
(Address) Adair, Ida.

15. Filed 2-15 1922
Local Registrar J. H. Murphy

16. DATE OF DEATH Feb. 14 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-14-1922 to 2-14-1922
that I last saw him alive on 2-14-1922
and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:
accidental from being caught in drive belt of engine
(Duration) 4 hrs. yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) Geo. Jennings M. D.
2-15-22 (Address) Adair, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Hortons Idaho DATE OF BURIAL 1922

20. UNDERTAKER Howell & Huggs ADDRESS Adair, Ida.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Twin Falls*City of *Buhl*Registration District No. *39*Primary Registration District No. *2087*

(No. St.)

File No. *37036*Registered No. *37036*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Claus Gundersen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED*Male* *White* *Married*
(Write the word.)

6. DATE OF BIRTH

Feb. *20* *1855*
(Month) (Day) (Year)

7. AGE

67 Yrs. — Mos. *3* ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).*Retired*

9. BIRTHPLACE

(State or Country)

Denmark

10. NAME OF FATHER

Don't know

11. BIRTHPLACE OF FATHER

(State or Country)

Denmark

12. MAIDEN NAME OF MOTHER

Don't know

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs C. Gundersen

(Address)

Buhl Ida

15.

Filed *Feb. 18* *1922**J. H. Murphy*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

✓ *17* *✓✓*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 12 *1921* to *2-17-* *1922*that I last saw him alive on *2-17* *1922*and that death occurred on the date stated above, at *10* A. M.

The CAUSE OF DEATH* was as follows:

myocardial heart dis(Duration) Yrs. *3* mos. ds.Contributory
(Secondary)*Rheumatism*(Duration) *✓* yrs. mos. ds.(Signed) *Geo Jennings* M. D.*2-17-1922* (Address) *Buhl Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Buhl Ida

DATE OF BURIAL

Feb. 19, 1922

20. UNDERTAKER

J. H. Murphy

ADDRESS

Buhl

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 37037

Registered No. 6

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

I. PLACE OF DEATH

County of Washington
City of WeirRegistration District No. 86
Primary Registration District No. 1010
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William R Springle

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married

(Write the word.)

6. DATE OF BIRTH

Aug. 25 1862
(Month) (Day) (Year)

7. AGE

60 Yrs. 5 Mos. 1 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Laborer

9. BIRTHPLACE

(State or Country)

Texas

10. NAME OF FATHER

Wm Springle

11. BIRTHPLACE OF FATHER

(State or Country)

Texas

12. MAIDEN NAME OF MOTHER

Springle

13. BIRTHPLACE OF MOTHER

(State or Country)

Texas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wm Springle
(Address) Weir, Ida

15.

Filed 2/8 1922

W. P. Hamilton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 26 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 10 1921 to Nov 10 1921

that I last saw him alive on Nov 10 1921

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Epilepsy from trauma

(Duration) 34 Yrs. — mos. — ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. H. Marshall M. D.

Jan 22 (Address) Weir, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Hillcrest Cemetery

DATE OF BURIAL

1/28 1922

20. UNDERTAKER

Northam M. Cane

ADDRESS

Weir, Ida

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. *86*
County of *Washington* Primary Registration District No. *1010*
City of *St. Paul* (No. *1010*) St. *St. Paul*File No. *31050*Registered No. *5*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Margaret Lavine Stover

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female *White**Single*
(Write the word.)

6. DATE OF BIRTH

Apr *9* *1922*
(Month) (Day) (Year)

7. AGE

10 Yrs. *8* Mos. *14* ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

School Girl

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Wm Stover

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Emma Brown

13. BIRTHPLACE OF MOTHER

(State or Country)

Mont.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

William Stover

(Address)

Weiser Idaho

15.

Filed *2/8* *1922**W. P. Hamilton*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan *25* *1922*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 13 *1922* to *Jan 25* *1922*
that I last saw her alive on *Jan 24* *1922*
and that death occurred on the date stated above, at *12* M.

The CAUSE OF DEATH* was as follows:

Meningitis - cerebral.
Probably tubercular.
State Lab. unable to demonstrate.
(Duration) Yrs. mos. *15* ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

G. M. Waterhouse M. D.*Jan 14, 1922* (Address) *Weiser Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hillcrest Cemetery *Jan 26, 1922*

20. UNDERTAKER

ADDRESS

Northrup M. Baum *Weiser, Ida*

FORM V. S. No. 5-25 M. 1-19.

RECEIVED CERTIFICATE OF DEATH

37039

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Washington
City of WenatcheeRegistration District No. 86Primary Registration District No. 1010(No. 2)

St.)

File No. 4Registered No. 4

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Anna C. Everett

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

Wbr

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

Feb121860

(Month)

(Day)

(Year)

7. AGE

61

Yrs.

11

Mos.

3

ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Mo.

10. NAME OF FATHER

Abraham Groves

11. BIRTHPLACE OF FATHER

(State or Country)

Mo.

12. MAIDEN NAME OF MOTHER

Jennie Williams

13. BIRTHPLACE OF MOTHER

(State or Country)

Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Anna C. Everett

(Address)

15.

Filed 21819 22

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan

(Month)

15

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 19 20 to Jan 15th 19 22that I last saw him alive on Jan 14th 19 22and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Coronary Arteriosclerosis(Duration) 3 Yrs. mos. ds.Contributory
(Secondary)(Duration) yrs. mos. ds.

(Signed)

W. R. Hamilton M. D.15 19 22 (Address) Wenatchee, Wa.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL (or REMOVAL)

DATE OF BURIAL

Hillcrest Cemetery Jan 19 19 22

20. UNDERTAKER

ADDRESS

Northrup M. Cann Wenatchee

CERTIFICATE OF DEATH

37040 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Washington
City of WenatcheeRegistration District No. 86Primary Registration District No. 1010

File No. _____

Registered No. 3

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ida May Lemon

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.) married

6. DATE OF BIRTH

Oct 29 1872
(Month) (Day) (Year)

7. AGE

49 Yrs. 15 Mos. 15 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

House work

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Ida.

10. NAME OF FATHER

James Adams

11. BIRTHPLACE OF FATHER

(State or Country)

Ida.

12. MAIDEN NAME OF MOTHER

Olivia Clark

13. BIRTHPLACE OF MOTHER

(State or Country)

Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Jack Lemon

15.

Filed

2/8 1922H. R. Hamilton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 14 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 14 1921 to Jan 14 1922
that I last saw him alive on Jan 14 1922
and that death occurred on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:

Apothecary

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

H. R. Hamilton M. D.

(Address)

Wenatchee, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Willow Creek Cemetery Jan 16 1922

20. UNDERTAKER

ADDRESS

Northway FM Carey Wenatchee Ida.

RECEIVED
FEB 24 1922

CERTIFICATE OF DEATH

37045

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

Washington

Registration District No.

86

City of

Weiser

Primary Registration District No.

2112

(No.)

St.)

File No.

Registered No. 8

If death occurs away from usual residence, give facts called for under special information.

FULL NAME

Jerome Jesse Benson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Male

4. COLOR OR RACE

Wbr

5. SINGLE, MARRIED, WID-

OWED OR DIVORCED

married
(Write the word.)

6. DATE OF BIRTH

April 4

(Month)

(Day)

(Year)

7. AGE

37 Yrs. 10 Mos. 2 ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

P.R. Fireman

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

John D. Benson

11. BIRTHPLACE OF FATHER

(State or Country)

VT.

12. MAIDEN NAME OF MOTHER

Ann E. Lauch

13. BIRTHPLACE OF MOTHER

(State or Country)

Pa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. W. Benson

(Address)

Weiser Idaho

15.

Filed

2/10

1922

W. J. Hamilton
Local Registrar

16. DATE OF DEATH

Feb

(Month)

6th

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19

to

19

that I last saw him alive on 19

and that death occurred on the date stated above, at 7:30 AM.

The CAUSE OF DEATH* was as follows:

Accidental, The engine he was working on turned over crushing him,
No blame established by coroners jury

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

James J. McCann

Coroner

2/7 1922

(Address)

Weiser Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

Yrs.

mos.

days

In the

State

Yrs.

mos.

days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Hillcrest Cemetery

DATE OF BURIAL

2-9-1922

20. UNDERTAKER

Northern McCann

ADDRESS

Weiser Idaho

CERTIFICATE OF DEATH

37046

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

Registration District No.

Primary Registration District No.

(No.)

St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William Hamilton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

Wbr

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

Sept

27

1842
(Month) (Day) (Year)

7. AGE

79

Yrs. 4 Mos. 6 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Retired Contractor

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

John Hamilton

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. H. Hamilton
Meriden, Idaho

15.

Filed

2/10

1922

J. H. Hamilton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb

2nd

1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct-7-1921 to Feb 2nd 1922

that I last saw him alive on Feb 2nd 1922

and that death occurred on the date stated above, at 4 A. M.

The CAUSE OF DEATH* was as follows:

Apoplexy - 3rd attack

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

As above

(Duration) Yrs. mos. ds.

(Signed)

W. R. Hamilton

M. D.

2/4/1922

(Address)

Meriden, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Helleret Cemetery

2/5 1922

20. UNDERTAKER

ADDRESS

Wartham M. P. Cam

Weiser, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

RECEIVED CERTIFICATE OF DEATH

37047

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Washington

City of Cambridge

Registration District No. _____

Primary Registration District No. _____

(State) _____ St.)

File No. _____

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Bryan Hanson Tuttle

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Dec

24

1894

(Month)

(Day)

(Year)

7. AGE

27 yrs. 1 mos. 1 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Vona Colorado

10. NAME OF FATHER

Chas W Tuttle

11. BIRTHPLACE OF FATHER

(State or Country)

Nova Scotia

12. MAIDEN NAME OF MOTHER

Henry Hanson

13. BIRTHPLACE OF MOTHER

(State or Country)

Nova Scotia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Earl E Tuttle

(Address)

15.

Filed

2/26/22

191

W M Tuttle
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan

24

1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan. 22 1912, to Jan. 24 1922

that I last saw him alive on Jan. 24 1922

and that death occurred on the date stated above, 6:00 PM

The CAUSE OF DEATH* was as follows:

Botulism

(Duration) _____ yrs. _____ mos. 2 ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

W M Tuttle M. D.

19 (Address) Cambridge, Id.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cambridge Id

Jan 25 1922

20. UNDERTAKER

ADDRESS

J H Hilderson

Cambridge

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
CITIZENS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact
ment of OCCUPATION is very important. See instructions on back of certificate.

No. 5 2011 1612

PLACE OF DEATH

County of Windsor

City of Cambridge

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No.

Primary Registration District No.

(No.)

(St.)

Registered No.

If death occurred in a hospital, institution or camp, give the NAME instead of street and number.

CERTIFICATE OF DEATH

37048

State of MASS.
BOARD OF HEALTH
Bureau of Vital Statistics
File No.

RECEIVED
MAR 6 1922

VITAL

Charles William Tuttle

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male

White

widower
(Write the word.)

6. DATE OF BIRTH

Apr
(Month)

25
(Day)

1855
(Year)

7. AGE

66 yrs. 9 mos. 1 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) Character of industry, business, or establishment in which engaged (or employer)

Carpenter

9. BIRTHPLACE

(State or Country)

Massachusetts

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Earl E Tuttle

(Address)

15.

Filed 1-26-22 191

R. Whiteman
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan

26

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

1-22-22 191., to 1-26-22

that I last saw him alive on 1-26-22

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

Botulism

(Duration)

yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

R. Whiteman

19

(Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death.....yrs.....mos.....days.

In the

State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cambridge

Jan 28 1922

20. UNDERTAKER

ADDRESS

W. H. Bidder

Cambridge

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH Washington Bureau of Vital Statistics No. 37049
County of Washington Primary Registration District No. 1
City of Cambridge (No. 1 St.)

File No. _____
Registered No. _____
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Jane Ellis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH Aug 2 1874
(Month) (Day) (Year)

7. AGE 54 yrs. 5 mos. 4 ds. IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE Ohio
(State or Country)

10. NAME OF FATHER Thomas Smith

11. BIRTHPLACE OF FATHER Ohio
(State or Country)

12. MAIDEN NAME OF MOTHER Charley Midcott

13. BIRTHPLACE OF MOTHER Ohio
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Sam Ellis

(Address) _____

15. 1-26-22 191 1922
Filed 1-26-22 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 6 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 5 1922 to Jan 5 1922
that I last saw her alive on Jan 5 1922
and that death occurred on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Old age

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) E. A. W. W. W. W. W. M. D.

1/7 1922 (Address) Cambridge, Ohio

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Cambridge, Ohio Jan 7 1922

20. UNDERTAKER ADDRESS

Cambridge, Ohio

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

37051

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Washington
County of Washington Primary Registration District No. 1
City of Cambridge (No. 1 St.)

File No. _____

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ronald Charles Tuttle

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Jan 20 1901
(Month) (Day) (Year)

7. AGE 21 yrs. 9 mos. 9 ds.
IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION Labour
(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE Flagler Colorado
(State or Country)

10. NAME OF FATHER Charles W Tuttle

11. BIRTHPLACE OF FATHER Nova Scotia
(State or Country)

12. MAIDEN NAME OF MOTHER Henriette Hanson

13. BIRTHPLACE OF MOTHER Nova Scotia
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Earl E Tuttle
(Address) _____

15. Filed 2-16-22 191 1922
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Jan 21 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-23-22 191, to 1-25-22 191, that I last saw him alive on 1-25-22 191, and that death occurred on the date stated above, 4:45 P. M.

The CAUSE OF DEATH* was as follows:

Botulism
(Duration) yrs. mos. 2 ds.

Contributory (Secondary) _____

(Signed) W. H. Tuttleman M. D.

19. (Address) Cambridge, Me.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death? _____

Former or usual residence. _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Cambridge Me Jan 28 1922

20. UNDERTAKER ADDRESS

Jefferson Cambridge

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

37052

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. _____
County of Washington Primary Registration District No. _____
City of Cambria (No. _____ St.)

File No. _____

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hazel Marguerite Tullth
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH June 30 1897
(Month) (Day) (Year)

7. AGE 24 yrs. _____ mos. _____ ds.
IF LESS than 1 day how many _____ hrs. or _____ mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work School Teacher
(b) General nature of industry business, or establishment in which employed (or employer) _____

9. BIRTHPLACE Fort Raton Colorado
(State or Country)

10. NAME OF FATHER Alfred W Tullth

11. BIRTHPLACE OF FATHER Nova Scotia
(State or Country)

12. MAIDEN NAME OF MOTHER Hattie Harrison

13. BIRTHPLACE OF MOTHER Nova Scotia
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Earl E Tuttle
(Address) _____

15. Filed 2-16-22 1912 W. H. Harrison
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 23 1912
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-23-22 1912, to 1-23-22 1912, that I last saw her alive on 1-23-22 1912, and that death occurred on the date stated above, at 6 P M.
The CAUSE OF DEATH* was as follows:
Potulism
(Duration) _____ yrs. _____ mos. _____ ds.
Contributory (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) W. H. Harrison M. D.
19. (Address) Cambria, Id.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Cambria Id. Jan 22 1912

20. UNDERTAKER ADDRESS

W. H. Harrison Cambria

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

RECEIVED

CERTIFICATE OF DEATH

37053

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of

Primary Registration District No.

City of

(No.

St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William N. Lorton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

male white

Widowed
(Write the word.)

6. DATE OF BIRTH

Feb.

20

1927

(Month)

(Day)

(Year)

7. AGE

94 yrs. 10 mos. 18 ds.

IF LESS than 1 day
how many hrs. or
mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Kentucky

10. NAME OF FATHER

J. J. Lorton

11. BIRTHPLACE OF FATHER

(State or Country)

Kentucky

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. J. Lorton

Cambridge

15.

Filed

2/16/27

191

W. W. Putnam

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan 8 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 17-1-21 191, to 1-8-22 191,

that I last saw him alive on 191,

and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Senility.

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. W. Putnam M. D.

19. (Address) Cambridge

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cambridge

Jan 10 1922

20. UNDERTAKER

ADDRESS

J. A. Hudson

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

37054

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of Washington

Primary Registration District No.

City of Cambridge

(State) Idaho

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edmund William Tuttle

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male

White

(Write the word.) Single

6. DATE OF BIRTH

Jan
(Month)

21
(Day)

1894
(Year)

7. AGE

37 yrs. 11 mos. 29 ds.

IF LESS than 1 day
how many hrs. or
..... mins?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Maine

10. NAME OF FATHER

Charles W. Tuttle

11. BIRTHPLACE OF FATHER

(State or Country)

Maine

12. MAIDEN NAME OF MOTHER

Hannah Hanson

13. BIRTHPLACE OF MOTHER

(State or Country)

Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Earl E. Tuttle

(Address)

15.

Filed

2-26-22

191

W. H. Tuttle

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan
(Month)

29
(Day)

1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-23-22 191, to 1-25-22 191,

that I last saw him alive on 1-25-22 191

and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Botulism

(Duration)

..... yrs. mos. 2 ds.

Contributory (Secondary)

(Duration)

..... yrs. mos. ds.

(Signed)

W. H. Tuttle M. D.

19

(Address)

Cambridge, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death..... yrs. mos. days.

In the

State..... yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cambridge

Jan 28 1922

20. UNDERTAKER

ADDRESS

W. H. Tuttle

Cambridge

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.

37055

County of

Primary Registration District No.

File No.

City of

(No.)

St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2.

FULL NAME

Elsie Mae Under

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female

White

Single
(Write the word.)

6. DATE OF BIRTH

Feb 1 1922
(Month) (Day) (Year)

7. AGE

yrs. mos. ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Nt

9. BIRTHPLACE

(State or Country)

Adams Co Ida

10. NAME OF FATHER

Philip J. Under

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Elsabeth Miller

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Philip J. Under

(Address)

15.

Filed

2-26-22 191

V. Stewart
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb 2 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

2-2-22 191., to 2-2-22 191.,

that I last saw him alive on 2/1/22. 191.,

and that death occurred on the date stated above, P.M.

The CAUSE OF DEATH* was as follows:

Congenital Stenosis

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

M. D.

19. (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cambridge

Feb 9 1922

20. UNDERTAKER

ADDRESS

J. A. Henderson

Cambridge

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

37056

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Franklin Registration District No. 6
City of Cambridge Primary Registration District No. 1 (No. 1 St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hermie Hanna Tuttle

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Jan 21 1908
(Month) (Day) (Year)

7. AGE 14 yrs. 3 mos. 3 ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) (Sec. profession or part-time work) school girl
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Cambridge Idaho

10. NAME OF FATHER John W Tuttle

11. BIRTHPLACE OF FATHER
(State or Country) Nova Scotia

12. MAIDEN NAME OF MOTHER Hermie Hanna

13. BIRTHPLACE OF MOTHER
(State or Country) Nova Scotia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Earl E Tuttle

(Address)

15. Filed 2/26/27 191 191 Local Registrar Earl E Tuttle

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 24 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1/24/22 191, to 1/24/22 191, that I last saw him alive on 1-24-22 191, and that death occurred on the date stated above, at C.P.H.

The CAUSE OF DEATH* was as follows:

Potential

(Duration) yrs. mos. 2 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Earl E Tuttle

19. (Address) Cambridge

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Cambridge Idaho Jan 28 1922

20. UNDERTAKER ADDRESS

Earl E Tuttle Cambridge

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

37057

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Ada
City of BoiseRegistration District No. 2
Primary Registration District No. 1004
(No. 1807 W Idaho St.)File No. 37057
Registered No. 60

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Fred B. Anson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widower
(Write the word.)

6. DATE OF BIRTH.

April 9 1878
(Month) (Day) (Year)

7. AGE

73 Yrs. 8 Mos. 26 ds.IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....Retired

9. BIRTHPLACE

(State or Country) Idel

10. NAME OF FATHER

Fred Anson

11. BIRTHPLACE OF FATHER

(State or Country) Idel

12. MAIDEN NAME OF MOTHER

Mary White

13. BIRTHPLACE OF MOTHER

(State or Country) Idel

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George B. Bradley(Address) 1807 W Idaho St Boise Id

15.

Filed 3-6 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 5 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Mar 1 1922 to Mar 5 1922, that I last saw him alive on Mar 5 1922 and that death occurred on the date stated above, at 1 P. M.
The CAUSE OF DEATH* was as follows:Influenza(Duration) Yrs. mos. 7.95 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Geo B. Humphreys M. D.3-6-249.22 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Mary a. Idaho Mar 7 1922

20. UNDERTAKER

ADDRESS

Humphreys & Truba Boise Id

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

37058

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 2

County of Ada

Primary Registration District No. 1004

City of Boise

(No. 707 No 19)

St.)

File No.

37058

Registered No.

65

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Oscar E. W. Hinckley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

M

White

Married (ord.)

6. DATE OF BIRTH.

Apr 22 1843
(Month) (Day) (Year)

7. AGE

78 Yrs. 10 Mos. 12 ds.

If LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

Railway Mail Clerk

9. BIRTHPLACE

(State or Country)

Maine

10. NAME OF FATHER

Ursacian Hinckley

11. BIRTHPLACE OF FATHER

(State or Country)

Maine

12. MAIDEN NAME OF MOTHER

Reeth Watdwell

13. BIRTHPLACE OF MOTHER

(State or Country)

Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

707 N. 19 St. Boise Id

15.

Filed

3-13

1922

R. H. Paul
Local Registrar

16. DATE OF DEATH

Mar 10 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 1917 to Mar 10 1922

that I last saw him alive on Mar 10 1922

and that death occurred on the date stated above, at 11 A. M.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(Duration) 5 Yrs. 2 mos. ds.

Contributory
(Secondary)

Chronic Myocarditis

(Duration) 1 Yrs. 2 mos. ds.

(Signed)

J. M. Brantau M. D.

Mar 11 1922 (Address) Empire B. Boise Idaho

*State the DISEASE CAUSING DEATH; or in death from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery

Mar 12 1922

20. UNDERTAKER

ADDRESS

Summers & Schell

Boise Id.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of AdaCity of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. 1120 North 19th St.)File No. 37059

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Harmon Cox

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

Dec 6 1837
(Month) (Day) (Year)

7. AGE

84 Yrs. 3 Mos. 19 ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Retired

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

Cyrus Cox

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Jane Higbee

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs J. M. Teaslee

(Address)

Woodland Calif

15.

Filed 19.....

Local Registrar

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 25 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 22 1922 to March 25 1922
that I last saw him alive on March 25 1922
and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Dehydration of heart
(Senility) —
(Duration)..... yrs..... mos..... ds.

Contributory
(Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed)

Wm. B. Cook M. D.

3-25-22 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Woods Hill Cemetery

DATE OF BURIAL

3/26/1922

20. UNDERTAKER

Schubert & Schupfman

ADDRESS

BoiseBoeck

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon District No. 3
City of Caldwell Primary Registration District No. 1005
(No. 1322 St.)File No. 37069Registered No. 37

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

David Reed Allen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED married

6. DATE OF BIRTH

Jan 19 1894
(Month) (Day) (Year)

7. AGE

48 Yrs. 1 Mos. 27 ds.
IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Rancher

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

M. S. Allen

11. BIRTHPLACE OF FATHER

(State or Country)

Indiana

12. MAIDEN NAME OF MOTHER

Adeline M. Reed

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

M. B. Allen
(Address) Caldwell, Ida

15.

Filed Mar. 19 1922 John S. Meyers
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 16 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar. 2 1922 to Mar. 16 1922
that I last saw him alive on Mar. 16 1922
and that death occurred on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia(Duration) Yrs. 17 ds.Contributory (Secondary) Pneumonia(Duration) Yrs. 12 ds.(Signed) J. M. Henry M. D.3-18-1922 (Address) Caldwell, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Canyon Hill 3-19-1922

20. UNDERTAKER

C. V. Beckham Caldwell

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

Brastan
CERTIFICATE OF DEATH.State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of

City of

if death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

6. DATE OF BIRTH.

7. AGE

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15.

Filed

191

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Mar 17 1922 to Mar 30 1922,
that I last saw her alive on Mar 29 1922,
and that death occurred on the date stated above, at 1 A. M.

The CAUSE OF DEATH* was as follows:

Influenza and
Cerebral Hemorrhage

(Duration)

Yrs.

mos. 15 ds.

Contributory
(Secondary)

Respiratory Paralysis

(Duration)

Yrs.

mos. 1 hour

(Signed)

J. M. Brastan M. D.

Mar 30 1922 (Address) Empire B. Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death.....yrs.....mos.....days

In the

State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cem.

Apr 2 1922

20. UNDERTAKER

ADDRESS

Summers & Stebbins

Boise Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

✓ CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **37063.**Registered No. **91**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. _____

County of Ada Primary Registration District No. _____City of Boise State _____ St.)

If death occurs away from usual residence, give facts called for under special information.

APR 5 1922
BUREAU OF VITAL STATISTICSStella Mineau

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDMarried
(Write the word.)

6. DATE OF BIRTH.

Sept. 13 1876
(Month) (Day) (Year)

7. AGE

45 Yrs. 6 Mos. 16 ds.IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...At Home

9. BIRTHPLACE

(State or Country)

Indiana

10. NAME OF FATHER

Charles B Robinson

11. BIRTHPLACE OF FATHER

(State or Country)

N. H.

12. MAIDEN NAME OF MOTHER

Sarah M. Apperson

13. BIRTHPLACE OF MOTHER

(State or Country)

Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

C. B. Robinson
Boise Idaho

(Address)

15.

Filed _____ 191 _____

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

3 (Month) 29 (Day) 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

3/23 1922 to 3/29 1922that I last saw h. et alive on 3/29 1922and that death occurred on the date stated above, at 3 A M.

The CAUSE OF DEATH* was as follows:

Thrombosis mesenteric artery

(Duration) Yrs. mos. ds.

Contributory (Secondary) Carcinoma Sigmoid

(Duration) Yrs. mos. ds.

(Signed) Stella A. Peterson M. D.3/29 1922 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery Apr 1 1922

20. UNDERTAKER

ADDRESS

Thurman 9th & Boise Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

French
State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
37064

1. PLACE OF DEATH RECEIVED
County of Adams Registration District No. 11
City of Boise Primary Registration District No. 11
St. Tesquiere

File No. 92
Registered No. 92

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ruth Margaret Roberts

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX M. 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH.

July 12 1906
(Month) (Day) (Year)

7. AGE

15 Yrs. 8 Mos. 17 ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Student

9. BIRTHPLACE

(State or Country)

Boise Idaho

10. NAME OF FATHER

W. O. Roberts

11. BIRTHPLACE OF FATHER

(State or Country)

Kentucky

12. MAIDEN NAME OF MOTHER

Anna Peterson

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

W. O. Roberts

(Address)

15.

Filed

191

Local Registrar

16. DATE OF DEATH

March 29 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended, deceased from March 22 1922 to March 29 1922, that I last saw her alive on March 29 1922 and that death occurred on the date stated above, at 9:40 P.M.

The CAUSE OF DEATH* was as follows:

Endocarditis following Influenza

(Duration) Yrs. mos. 20 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) P. P. French M. D.19. (Address) 417 Overland Bldg Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery, Mar 31 1922

20. UNDERTAKER

ADDRESS

Summers & Krebs Boise Id

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada Registration District No. 1
City of Boise State Idaho

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

BUREAU OF VITAL STATISTICS

Anna JensenFile No. 37065
Registered No. 89

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female White Married
(Write the word.)

6. DATE OF BIRTH

Sept 7 1885
(Month) (Day) (Year)

7. AGE

36 Yrs. 6 Mos. 21 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Housewife

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

John Schwaab

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Caroline ? Schwaab

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. Jensen

(Address)

2613 Madison Boise

15.

Filed 5.30 1922R. H. Pratt

Local Registrar

16. DATE OF DEATH

March 25 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from March 5 1922 to March 25 1922that I last saw her alive on March 25 1922
and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Endocarditis, streptococcus pyogenes infection(Duration) Yrs. 2 mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

M. H. Gallman M. D.3/29/22 (Address) Boise, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery3/30 1922

20. UNDERTAKER

ADDRESS

Schneider & Hidenfaden Boise IdaGallman

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH

County of Ada Registration District No. 1
City of Boise BUREAU OF STATISTICS St. Luke's Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fred W. McMillan

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
37066

File No. 88
Registered No. 88

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE White. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single

6. DATE OF BIRTH — 1863
(Month) (Day) (Year)

7. AGE 59 Yrs. — Mos. — ds.
IF LESS than 1 day how many.....hrs. or.....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Paper Hanger
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Scotland.

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER
(State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER
(State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry Schbs.
(Address) Boise Idaho.

15. Filed 3-29-1922 R. A. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar 26 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 26 1922 to Mar 26 1922, that I last saw him alive on Mar 26 1922 and that death occurred on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:
Pneumonia
(Duration) — Yrs. 7 mos. — ds.

Contributory (Secondary) —
(Duration) — yrs. — mos. — ds.
(Signed) R. A. Pratt M. D.
3/29 1922 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Morris Hill Cemetery DATE OF BURIAL Mar 30 1922

20. UNDERTAKER Summers & Schbs. ADDRESS Boise Idaho.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada Registration District No. _____
City of Boise Primary Registration District No. _____
Broadway & Woodbine

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Davidson SpragueFile No. _____
Registered No. 87

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married

6. DATE OF BIRTH

April 21 1848
(Month) (Day) (Year)

7. AGE

75 Yrs. 11 Mos. 4 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Retired

9. BIRTHPLACE

(State or Country)

Maine

10. NAME OF FATHER

Capt. Eliza Sprague

11. BIRTHPLACE OF FATHER

(State or Country)

Maine

12. MAIDEN NAME OF MOTHER

Eliza A. Davidson

13. BIRTHPLACE OF MOTHER

(State or Country)

Nova Scotia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Frank R. Trade
Boise, Idaho

15.

Filed 3-25 1922P. H. Ratt
Local Registrar

16. DATE OF DEATH

March 26 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Jan 1920 to March 25 1922
that I last saw him alive on March 25 1922
and that death occurred on the date stated above, at 3:00 A.

The CAUSE OF DEATH* was as follows:

Cancer of stomach.(Duration) 2 Yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

M. H. Allen M. D.
Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Morris Hill Cemetery DATE OF BURIAL 3/26/1922

20. UNDERTAKER

ADDRESS

Schreber & Hidenfaden BoiseH. Tallman

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **37068**
Registered No. **86**

1. PLACE OF DEATH

County of *Ada* Registration District No. _____
City of *Boise* Primary Registration District No. _____
State *Idaho*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Laura E. Loucks

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Widow*
(Write the word.)

6. DATE OF BIRTH

March 7 1836
(Month) (Day) (Year)

7. AGE

86 Yrs. *17* Mos. *17* ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Retired Housewife

9. BIRTHPLACE

(State or Country)

New York

10. NAME OF FATHER

Henry Frey

11. BIRTHPLACE OF FATHER

(State or Country)

Am.

12. MAIDEN NAME OF MOTHER

Mary O'Boyle

13. BIRTHPLACE OF MOTHER

(State or Country)

Am.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs A. H. Oster
Boise Ida

(Address)

15.

Filed _____ 19 _____

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 24 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 15 1922 to *March 24 1922*

that I last saw him alive on *March 19 1922*

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

apoplexy

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Dr. Callister M. D.

19. (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery *3/26 1922*

20. UNDERTAKER

ADDRESS

Schubert & Hidenfaden *Boise*

Dr. Callister

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No: 37069

Registered No. 85

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Ada Registration District No. 1922
City of near Boise (No. Boise Idaho St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

BUREAU OF
STATISTICS

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.M WhiteSingle
(Write the word.)

6. DATE OF BIRTH.

(Month)

(Day)

(Year)

7. AGE

77

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).Miner

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

E. A. Drake

11. BIRTHPLACE OF FATHER

(State or Country)

Tenn

12. MAIDEN NAME OF MOTHER

Nancy Miller

13. BIRTHPLACE OF MOTHER

(State or Country)

Tenn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

W. K. Drake
Cameron Mo

15.

Filed 191

Local Registrar

16. DATE OF DEATH

(Month)

(Day)

1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 1 1922, to 3/18 1922
that I last saw him alive on 3/19 1922
and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Calcium Stomach

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) W. K. Drake M. D.3/23 1922 (Address) Boise

*State the DISEASE CAUSING DEATH; or in death from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill CemeteryMar 21 1922

20. UNDERTAKER

ADDRESS

Summers & KirkBoise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

Pittenger
CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Ada* Registration District No. _____
City of *Boise* Primary Registration District No. _____
Soldiers Home Hospital

File No. **37070**Registered No. **84**

If death occurs away from
usual residence, give fac-
called for under special
information.

RECEIVED
APR 5 1922
BUREAU OF VITAL
STATISTICS

2. FULL NAME

Don C. Henderson

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.*M.**White**Widow*

6. DATE OF BIRTH

October 18 18*54*
(Month) (Day) (Year)

7. AGE

77 Yrs. *5* Mos. *5* ds.

IF LESS than 1 day
how many hrs. or
..... min.

8. OCCUPATION

(a) Trade, profession or
particular kind of work...
(b) General nature of in-
dustry, business, or estab-
lishment in which employ-
ed (or employer).....

Retired.

9. BIRTHPLACE

(State or Country)

*Oregon*10. NAME OF
FATHER*Stephen C. Henderson*11. BIRTHPLACE
OF FATHER

(State or Country)

*Illinois*12. MAIDEN NAME
OF MOTHER*Catherine Mace*13. BIRTHPLACE
OF MOTHER

(State or Country)

Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Wm. H. Lemaster

(Address)

1909 Washington

15.

Filed *3-23* 1922

R. H. Pratt
Local Registrar

16. DATE OF DEATH

March 23 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Jan 15 1922 to *Mar 23* 1922
that I last saw him alive on *Mar 22* 1922
and that death occurred on the date stated above, at *5 A* M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) *Steed A. Pittenger* D.19. (Address) *Boise, Idaho*

*State the DISEASE CAUSING DEATH; or in death from VIOLENT CAUSE, state (1)
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted
if not at place of death?.....Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery *Mar 25* 1922

20. UNDERTAKER

ADDRESS

Summers & Co. *Boise, Idaho*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Smith.
State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Ada Registration District No. _____
City of Boise Primary Registration District No. _____
St. Idaho No. 1206 N 23

File No. 37071Registered No. 83

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Virginia Claire Hunter

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH.

Oct. 12 1 1920
(Month) (Day) (Year)

7. AGE

1 Yrs. 5 Mos. 11 ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

None

9. BIRTHPLACE

(State or Country)

Boise Idaho

10. NAME OF FATHER

Clare S. Hunter

11. BIRTHPLACE OF FATHER

(State or Country)

Michigan

12. MAIDEN NAME OF MOTHER

Kenneth Wetter

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

C. Hunter

(Address)

1706 N 23 st

15.

Filed

3-2-22 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 23 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 23 1922 to Mar 23 1922, that I last saw him alive on Mar 23 1922, and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

3/23/22, (Address) Boise, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill CemeteryMar 24 1922

20. UNDERTAKER

ADDRESS

Summers & Krebs Boise Ida

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

1. PLACE OF DEATH **RECEIVED**
County of *Ada* Registration District No. *1922*
City of *Boise* BUREAU OF VITAL STATISTICS *403 Franklin* St.)

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. **37072**
Registered No. *82*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Henry N. Coffin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *M.* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WID-OWED OR DIVORCED. *Married*

6. DATE OF BIRTH.

March 13 1849
(Month) (Day) (Year)

7. AGE

73 Yrs. *0* Mos. *9* ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

Retired.

9. BIRTHPLACE

(State or Country)

Indiana

10. NAME OF FATHER

William F. Coffin

11. BIRTHPLACE OF FATHER

(State or Country)

North Carolina

12. MAIDEN NAME OF MOTHER

Lemira Hunt

13. BIRTHPLACE OF MOTHER

(State or Country)

North Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Clyde E. Summers
Boise Idaho

(Address)

15.

Filed *3-23* 1922

R. V. Pratt
Local Registrar

16. DATE OF DEATH

Mar 22 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Mar 22 1922* to *Mar 22 1922*.
that I last saw him alive on *Mar 21 1922*,
and that death occurred on the date stated above, at *7:45 A.M.*

The CAUSE OF DEATH* was as follows:

Diabetes

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) *R. V. Pratt* M. D.3/23/1922 (Address) *Boise, Ida*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Morris Hill Cemetery

DATE OF BURIAL

Mar 24 1922

20. UNDERTAKER

Summers Bros.

ADDRESS

Boise Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. **37073**Registered No. **41**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of **Boise** Registration District No. **110 E. Barnock**
City of **Boise** Primary Registration District No. **110 E. Barnock** (No. **110 E. Barnock** St.)
If death occurs away from usual residence, give name called for under special information.

2. FULL NAME **Julia Pickrell**

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX **F** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Married**
(Write the word.)

16. DATE OF DEATH

6. DATE OF BIRTH.

7. AGE

66 Yrs. **8** Mos. **15** ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

At Home

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

Harmon

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) **Roy Pickrell**(Address) **Box 175, Boise, Idaho**

15.

Filed **3-22** 1922

Local Registrar

17. I HEREBY CERTIFY, That I attended deceased from **March 20** 1922 to **March 21** 1922, that I last saw him alive on **March 21** 1922, and that death occurred on the date stated above, at **11 A.M.**

The CAUSE OF DEATH* was as follows:

General Peritonitis(Duration) Yrs. mos. **2** ds.Contributory **Chronic Appendicitis**
(Secondary)(Duration) Yrs. mos. **4** ds.(Signed) **M. Allen Cressway** M. D.19 (Address) **Boise, Idaho**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery, MAR 25 1922

20. UNDERTAKER

ADDRESS

Hummer & Krebs, Boise, Idaho

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

APR 5 1922

BUREAU OF VITAL STATISTICS

Registration District No.

Primary Registration District No.

(No.)

Name St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

3-20

1922

R. H. Pratt

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

mch. 19-1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 1 1922 to Mar 19 1922
that I last saw him alive on Mar 18 1922

and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Ed. A. Tuttle M. D.

3/20/22

(Address) Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery

3/26/22

20. UNDERTAKER

ADDRESS

W. McBratney

Boise Idaho

1. PLACE OF DEATH

County of.....

City of.....

If death occurs away from usual residence, give facts called for under special information.

RECEIVED

CERTIFICATE OF DEATH

APR 5 1922

Registration District No.

Primary Registration District No.

BUREAU OF VITAL STATISTICS

2. FULL NAME

Alonzo Conklin

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

37075

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

M.

W.

Married.
(Write the word.)

6. DATE OF BIRTH

Feb 18 - 1844
(Month) (Day) (Year)

7. AGE

78 Yrs. 1 Mos. 1 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)Veteran Civil War.
Last 15 yrs. Watchman Bldg.
Federal Bldg.

9. BIRTHPLACE

(State or Country)

Indiana

10. NAME OF
FATHER

Cornelius Conklin

11. BIRTHPLACE
OF FATHER

(State or Country)

New York

12. MAIDEN NAME
OF MOTHER

Mary Austin

13. BIRTHPLACE
OF MOTHER

(State or Country)

Conn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Wm. Bratney
Boise Idaho

15.

Filed 3-20 1922

R. G. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mch - 19 - 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 1st 1921, to Mch 19th 1922
that I last saw him alive on Mch 19 1922
and that death occurred on the date stated above, at 7:45 AM.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver

(Duration) 1 Yrs. 6 mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. R. Newberry M. D.
3/21/22 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery

3/21 1922

20. UNDERTAKER

ADDRESS

Wm. Bratney Boise Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH **RECEIVED**
 APR 5 1922
 County of **Ada** Registration District No. **104**
 City of **Bonanza** (St.)

File No. **37076**
 Registered No. **77**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ernest Waldo Rummel

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Single**
 (Write the word.)

6. DATE OF BIRTH

March 12 1922
 (Month) (Day) (Year)

7. AGE

Yrs. **8** Mos. **8** ds.

IF LESS than 1 day
 how many..... hrs.
 or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

none

9. BIRTHPLACE

(State or Country)

Bonne Ida

10. NAME OF FATHER

Ernest Clyde Rummel

11. BIRTHPLACE OF FATHER

(State or Country)

Wyo.

12. MAIDEN NAME OF MOTHER

Nellie Richards

13. BIRTHPLACE OF MOTHER

(State or Country)

Cal.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

E. W. Rummel
168 N. 6th St.

15.

Filed **3-21** 19**22**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 20 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **March 12 1922** to **March 20 1922**

that I last saw her alive on **3-20-1922** and that death occurred on the date stated above, at **6 A.M.**

The CAUSE OF DEATH* was as follows:

Colitis ilei -

(Duration) Yrs. mos. ds.

Contributory
 (Secondary)

(Duration) yrs. mos. ds.

(Signed)

R. J. Blue M. D.
3-20 1922 (Address) **Bonne Idaho.**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery **3/21 1922**

20. UNDERTAKER

ADDRESS

Schmidt & Sons **Bonne**

Dr. Blue

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25, M. 1-16-

RECEIVED

CERTIFICATE OF DEATH.

1. PLACE OF DEATH.

County of Ada Registration District No. 1022
City of Boise Registration District No. 1022 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Emily C. Blair

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

37077

Registered No.

76

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word)

6. DATE OF BIRTH.

Feb 28 1861
(Month) (Day) (Year)

7. AGE

61 Yrs. 0 Mos. 20 ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

At Home

9. BIRTHPLACE

(State or Country)

Id.

10. NAME OF FATHER

Charles Van Vleet

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Rachael Black

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. David Summers(Address) 2201 N. 4th City

15.

Filed

3-26 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 18 1922
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from March 12 1922 to March 18 1922.
that I last saw her alive on March 16 1922.
and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Heart lesions of long standing, signs of degeneration of heart
(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed)

Boise Id.
3-18-1922 (Address) Boise Id.

*State the DISEASE CAUSING DEATH; or in death from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery Mar 20 1922

20. UNDERTAKER

ADDRESS

Summers & Krebs Boise Id.

WRITE PLAINLY, WITH UNFAADING INK.—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V-S. No. 1-35 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **37078**Registered No. **75**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Ada Registration District No. 211
City of Boise Primary Registration District No. East Bannock St. Idaho

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Rudolf Schaufelberger

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

M.White.Widowed

6. DATE OF BIRTH

Dec 11 1841
(Month) (Day) (Year)

7. AGE

80 Yrs. 3 Mos. 5 ds.

IF LESS than 1 day
how many hrs. or
..... min.

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

Miner

9. BIRTHPLACE

(State or Country)

Switzerland

10. NAME OF FATHER

Rudolf Schaufelberger

11. BIRTHPLACE OF FATHER

(State or Country)

Switzerland

12. MAIDEN NAME OF MOTHER

Rachel

13. BIRTHPLACE OF MOTHER

(State or Country)

Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. S. P. Nelson

(Address)

1211 E. Bannock

15.

Filed 3-18 1922

R. H. Pratt
Local Registrar

16. DATE OF DEATH

Mar 16 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 10 1922 to March 16 1922, that I last saw him alive on March 14 1922, and that death occurred on the date stated above, at 7:30 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) R. H. Pratt M. D.Boise (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill CemeteryMar 18 1922

20. UNDERTAKER

ADDRESS

Summers & Co.Boise

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **37079**Registered No. **74**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Ada Registration District No. 1
City of Boise Primary Registration District No. Home St. St.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED
APR 5 1922
BUREAU OF VITAL STATISTICS
Henry H. Roberts.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widower
(Write the word.)6. DATE OF BIRTH 1846
(Month) (Day) (Year)7. AGE 76 Yrs. — Mos. — ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Veteran of Civil War.

9. BIRTHPLACE

(State or Country)

South Trow

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed 3/18 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 17 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 15 1922 to March 17 1922
that I last saw him alive on March 17 1922
and that death occurred on the date stated above, at 1:45 M.
The CAUSE OF DEATH* was as follows:Pneumonia
(Duration) 2 yrs. 1 mos. 1 ds.
Contributory (Secondary) Senility
(Duration) 2 yrs. 1 mos. 1 ds.
(Signed) Fred A. Furey M. D.
3/18/22 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 2 yrs. 1 mos. 1 ds. In the State 2 yrs. 1 mos. 1 ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery 3/19/22

20. UNDERTAKER

ADDRESS

W. McBratney Boise Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada Registration District No. 1104
City of Boise Primary Registration District No. Lincoln
BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Sarah Gertrude LeflangFile No. 37080
Registered No. 73

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH

June 22 1887
(Month) (Day) (Year)

7. AGE

34 Yrs. 8 Mos. 23 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Housewife

9. BIRTHPLACE

(State or Country)

Baltimore Md.

10. NAME OF FATHER

John Wesley Elliot

11. BIRTHPLACE OF FATHER

(State or Country)

Vir.

12. MAIDEN NAME OF MOTHER

Marcell Woodend

13. BIRTHPLACE OF MOTHER

(State or Country)

Vir.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wallis S. Leflang

(Address)

Boise

15.

Filed 5 19 22

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 16 1922
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from Mar 9 1922 to Mar 16 1922
that I last saw him alive on 3/15 1922
and that death occurred on the date stated above, at 4 A.M.
The CAUSE OF DEATH* was as follows:Lobular Pneumonia

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Fred W. Taylor M. D.3/17 1922 (Address) Boise, Idaho

State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Washington, D.C.

DATE OF BURIAL

3/18 1922

20. UNDERTAKER

Schreiber & Hidenfaden

ADDRESS

Boise, IdahoPittinger

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH **RECEIVED**
 County of *Ada* Registration District No. *1922*
 City of *Bureau of Vital Statistics* State *Idaho*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William Eugene Burgett

CERTIFICATE OF DEATH

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. *37081*
 Registered No. *72*

If death occurred in a hospital, institution or camp, give its NAME instead of address and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*
 (Write the word.)

6. DATE OF BIRTH

1854
 (Month) (Day) (Year)

7. AGE

63 Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

Miner

9. BIRTHPLACE

(State or Country)

Micho.

10. NAME OF FATHER

Not obtainable

11. BIRTHPLACE OF FATHER

(State or Country)

" "

12. MAIDEN NAME OF MOTHER

" "

13. BIRTHPLACE OF MOTHER

(State or Country)

" "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

P. F. Peterson

(Address)

Household Bend Ida

15.

Filed *3* 19 *22*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 16 19 *22*
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Mar 11* 19 *22*, to *Mar 16* 19 *22*

that I last saw him alive on *Mar 11* 19 *22* and that death occurred on the date stated above, at *4 A.M.*

The CAUSE OF DEATH* was as follows:

Paralytic ileus following operation for adhesions

(Duration) Yrs. mos. ds. Contributory *Abdominal section* (Secondary)

(Duration) yrs. mos. ds.

(Signed) *Ed. H. H. H.* M. D.

3-16-1922 (Address) *Bear Lake, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

Nassau Shae Bend Ida

19. PLACE OF DIAL OR REMOVAL *Moore Will County*

DATE OF BURIAL *3/18/1922*

20. UNDERTAKER

ADDRESS

Schubert Hidenfaden Bear Lake

✓ CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
370891. PLACE OF DEATH Adm APR 5 1922
County of Ada Registration District No.
City of Boise Primary Registration District No.
St. ()

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John James KadingFile No.
Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-OWED OR DIVORCED married

6. DATE OF BIRTH

September 28 1899
(Month) (Day) (Year)

7. AGE

62 Yrs. 5 Mos. 13 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Engineer
Water Company

9. BIRTHPLACE

(State or Country)

Wisconsin

10. NAME OF FATHER

Carl Kading

11. BIRTHPLACE OF FATHER

(State or Country)

Mecklenburg, Germany

12. MAIDEN NAME OF MOTHER

Mary Tiedeman

13. BIRTHPLACE OF MOTHER

(State or Country)

Mecklenburg, Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

R. B. Kading

(Address)

1514 W. Wendover Ave
Boise

15.

Filed

19

Local Registrar

16. DATE OF DEATH

March 13 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar. 9 1921 to Mar. 13 1922
that I last saw him alive on Mar. 13 1922
and that death occurred on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Myocarditis(Duration) 1 Yrs. 6 mos. ds.Contributory Cardiac Dehydration
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. Carl Kier M. D.3/4 1922 (Address) Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery 3/15 1922

20. UNDERTAKER

ADDRESS

Schubert & Widensheim Boise

FORM V. S. No. 5-25 M. 1-16-13

1. PLACE OF DEATH **RECEIVED**

CERTIFICATE OF DEATH.

County of Ada Registration District No. 152
 City of Boise Primary Registration District No. South Boise
 STATISTICAL

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Polina A. Augier

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. **37083**Registered No. 07

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F. 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED. Married (w/child)

6. DATE OF BIRTH.

Feb 8 1892
 (Month) (Day) (Year)

7. AGE

20 Yrs. 1 Mos. 5 ds.

IF LESS than 1 day
 how many hrs. or
 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....
 (b) General nature of industry, business, or establishment in which employed (or employer).....

At Home

9. BIRTHPLACE

(State or Country)

Illinois

10. NAME OF FATHER

Isiah Killion

11. BIRTHPLACE OF FATHER

(State or Country)

Illinois

12. MAIDEN NAME OF MOTHER

Rose Montgomery

13. BIRTHPLACE OF MOTHER

(State or Country)

Louisiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Chas. E. Summers

(Address)

Boise Idaho

15.

Filed 7 1915 191

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 13 1915
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from February 23, 1915 to March 13, 1915, that I last saw her alive on March 13, 1915, and that death occurred on the date stated above, at 7:15 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia(Duration) Yrs. 3 mos. 3 ds.Contributory Myocarditis - Chronic (Secondary)Duration 10 yrs. 10 mos. 10 ds.(Signed) D. W. D. M. D.19 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Morris Hill Cem

DATE OF BURIAL

Mar 15 1915

20. UNDERTAKER

Summers & Co.

ADDRESS

Boise Idaho

CERTIFICATE OF DEATH

1. PLACE OF DEATH **RECEIVED**Registration District No. _____
County of Ada **APR 5 1922**
City of Boise **BUREAU OF VITAL STATISTICS** (No. 410 State _____) St.)
Primary Registration District No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Eusebio ArriagaState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **37084**

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH

1885
(Month) (Day) (Year)

7. AGE

about
36 Yrs. Mos. ____ ds.IF LESS than 1 day
how many ____ hrs.
or ____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Shepherd

9. BIRTHPLACE

(State or Country)

Spain

10. NAME OF FATHER

Don't Know

11. BIRTHPLACE OF FATHER

(State or Country)

Spain

12. MAIDEN NAME OF MOTHER

Don't Know

13. BIRTHPLACE OF MOTHER

(State or Country)

Spain

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Sam Urquiza
(Address) 8 Hailey, Idaho,

15.

Filed _____ 19 ____

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 14 19 22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 ____ to Mar 14 19 22
that I last saw him alive on Mar 13 19 22
and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Post Operative Lobar Pneumonia(Duration) ____ Yrs. ____ mos. 2 ds.
Contributory (Secondary) Postoperative Pneumonia(Duration) 8 yrs. ____ mos. ____ ds.(Signed) James H. Stewart M. D.3/13 19 22 (Address) Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death St. Alphonsus Hospital
____ yrs. ____ mos. ____ days. State ____ yrs. ____ mos. ____ days

Where was disease contracted if not at place of death?

Former or usual residence

Hailey, Idaho

19. PLACE OF BURIAL OR REMOVAL

Hailey, Idaho

DATE OF BURIAL

3/14 19 22

20. UNDERTAKER

Schreiber & Sidenfaden Boise, Ida

ADDRESS

Dr. Stewart

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **37085**Registered No. **7**1. PLACE OF DEATH **RECEIVED**
County of **Ada** Registration District No. **1302 North 11th**
City of **Bureau of Vital Statistics**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Warren Clyde Bloomer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Single**
(Write the word.)

6. DATE OF BIRTH

March 29 1921
(Month) (Day) (Year)

7. AGE

11 Yrs. **7** Mos. **7** ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)**None**

9. BIRTHPLACE

(State or Country)

Boise

10. NAME OF FATHER

W. C. Bloomer

11. BIRTHPLACE OF FATHER

(State or Country)

Id.

12. MAIDEN NAME OF MOTHER

Gertrude Bradshaw

13. BIRTHPLACE OF MOTHER

(State or Country)

Id.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

H. Schmidt

(Address)

Boise

15.

Filed **3-15** 19**22**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 7 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 6 1922 to **March 6 1922**
that I last saw him alive on **March 6 1922**
and that death occurred on the date stated above, at **9 P. M.**
The CAUSE OF DEATH* was as follows:**Pneumonia**

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

H. Schmidt

19. (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Monis Hill Cemetery

DATE OF BURIAL

3/13/22

20. UNDERTAKER

ADDRESS

Schmidt & Schmidt, Boise, Id.

CERTIFICATE OF DEATH

3708

BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. *Adm*
County of *Adm*
City of *Boston* Registration District No. *710* St. *Fort*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Patrick Henry Quirk Sr.

File No. *6*
Registered No. *66*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*
(Write the word.)

6. DATE OF BIRTH

March 12 18*36*
(Month) (Day) (Year)

7. AGE

85 Yrs. *11* Mos. *26* ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Retired

9. BIRTHPLACE

(State or Country)

County Wicklow - Ireland

10. NAME OF FATHER

Patrick H. Quirk

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Mary O'Connell

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Patrick H. Quirk Jr
710 Fort St. Bosc. Bosc.

(Address)

15.

Filed *3-10* 19*22**P. H. Quirk*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 8 19*22*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from:

19....., to 19.....
that I last saw him alive on 19.....
and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Died Suddenly. Senility was cause of death. Was not ill.

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

L. R. McCall M. D.*710* 19*22* (Address) *1200 St. Bosc.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death: yrs. mos. days. In the State: yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. John's Cemetery *3/11/1922*

20. UNDERTAKER

ADDRESS

Schneiber & Widensford *Bosc.*

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

Tracy
State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
37088
File No. *67*
Registered No. *104*

1. PLACE OF DEATH **RECEIVED**
Registration District No. _____
County of *Ada* APR 5 1922 Primary Registration District No. _____
City of *Bosse* BUREAU OF VITAL STATISTICS *22 D. 13 st.* St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Joseph J. Blodgett*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *M* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. *Married*
(Write the word.)

6. DATE OF BIRTH. *Mar. 7* 1852
(Month) (Day) (Year)

7. AGE *70* Yrs. *0* Mos. *2* ds.
IF LESS than 1 day how many hrs. or min. *2*

8. OCCUPATION *Engineer.*
(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE *Mass.*
(State or Country)

10. NAME OF FATHER *Ezra J. Blodgett*

11. BIRTHPLACE OF FATHER *Mass.*
(State or Country)

12. MAIDEN NAME OF MOTHER *Hannah A. Taylor*

13. BIRTHPLACE OF MOTHER *Mass.*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) *E. J. Blodgett*
(Address) *Mountain Home Ida.*

15. Filed *3-11* 1922 *E. J. Blodgett*
Local Registrar

16. DATE OF DEATH *Mar 9* 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *2-8-1922* to *2-9-1922*,
that I last saw him alive on *2-8-1922*,
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:
Chronic Pneumonia

(Duration) _____ Yrs. _____ mos. _____ ds.
Contributory (Secondary) _____

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) *W. A. Tracy* M. D.
Mar. 9 1922 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Morris Hill Cemetery* DATE OF BURIAL *Mar 10 1922*
20. UNDERTAKER *Summers Krebs* ADDRESS *Bosse Ida*

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **37089**

1. PLACE OF DEATH

County of *Ada*City of *Boise*

If death occurs away from usual residence, give facts called for under special information.

RECEIVED

Registration District No.

APR 5 1922

Primary Registration District No.

STAI

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Kenneth Bacon

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Feb. 25, 1922

(Month)

(Day)

(Year)

7. AGE

9 Yrs. Mos. ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

None.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Boise Idaho

10. NAME OF FATHER

H. R. Bacon

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Doris Pecora

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. McBratney

(Address)

Boise Idaho

15.

Filed

3 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 5 - 1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

*Feb. 25 - 22 1922, to March 5 1922*that I last saw him alive on *March 5 1922* and that death occurred on the date stated above, at *midnight* M.

The CAUSE OF DEATH* was as follows:

Low vitality - Bronchial Trouble

(Duration) Yrs. mos. ds.

Contributory (Secondary)

Prematurely born

(Duration) yrs. mos. ds.

(Signed)

*Maureen Robinson, M. D.**3/6/22* 19(Address) *Boise, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Morris Hill Cemetery**3/7 1922*

20. UNDERTAKER

ADDRESS

*W. McBratney**Boise Idaho*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-10-11

RECEIVED

CERTIFICATE OF DEATH.

1. PLACE OF DEATH. **APR 5 1922**
Registration District No. _____
County of Ada BUREAU OF VITAL STATISTICS
City of Boise Primary Registration District No. _____
(No. 7715, N. 2) St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **37090**
Registered No. 22

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Abraham Beep Cline

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male White Widower
(Write the word.)

6. DATE OF BIRTH.

June 7 1836
(Month) (Day) (Year)

7. AGE

85 Yrs. 8 Mos. 27 ds.

IF LESS than 1 day
how many hrs. or
min. 2

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Retired

9. BIRTHPLACE

(State or Country)

Canada

10. NAME OF FATHER

Jacob Cline

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Frances Bell

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

E. E. Cline

(Address)

Virgin, Utah

15.

Filed

3-6

1922

Local Registrar

16. DATE OF DEATH

3 4 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

3/3 1922 to 3/4 1922
that I last saw him alive on 3/3 1922

and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Fred A. Hingler M. D.

1922 (Address)

Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Burlington, Ontario, Canada

Mar 18 1922

20. UNDERTAKER

ADDRESS

Summers & Krebs Boise Idaho

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25

RECEIVED

CERTIFICATE OF DEATH.

1. PLACE OF DEATH Boise APR 5 1922
 County of BOURNE Registration District No. 2
 City of Boise Primary Registration District No. 1004
 (No. 1904 East Pennock St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Leureton B. Moreton

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 37091
Registered No. 61

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married

6. DATE OF BIRTH

Mar 16 1859
(Month) (Day) (Year)

7. AGE

62 Yrs. 11 Mos. 16 ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Guard
Penitentiary

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Jonathan Moreton

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Emma Boys

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Nathan B. Moreton

(Address)

St Anthony's Hotel

15.

Filed

3192

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 14 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar 2 1912 to March 4 1912
that I last saw him alive on March 3 1912
and that death occurred on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Geo. C. Calkins M. D.3/6 1922 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery Mar 6 1922

20. UNDERTAKER

ADDRESS

Summer & Sons Boise Idaho

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **37092**Registered No. **51**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH **RECEIVED**
Registration District No. **Ada**
County of **Ada** APR 5 1922
City of **Boise** Primary Registration District No. **007** State **Idaho** St.)
BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **George G. Eagleson**

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX **M.** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Widowed**6. DATE OF BIRTH **Apr 27 1839**
(Month) (Day) (Year)7. AGE **82** Yrs. **10** Mos. **4** ds.IF LESS than 1 day
how many hrs. or
min.?8. OCCUPATION **Retired.**(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....9. BIRTHPLACE **Ohio.**
(State or Country)10. NAME OF FATHER **William Eagleson.**11. BIRTHPLACE OF FATHER **Ohio.**
(State or Country)12. MAIDEN NAME OF MOTHER **Margaret Lowrey.**13. BIRTHPLACE OF MOTHER **Ohio.**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) **Harry Stebb.**(Address) **906 Banuock.**

15.

Filed **3-6** 1922

191

Local Registrar

16. DATE OF DEATH **March 3 1922**
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from **Feb 21st 1922** to **Mar 4th 1922**,
that I last saw him alive on **Mar 2 1922**
and that death occurred on the date stated above, at **2:30** P. M.

The CAUSE OF DEATH* was as follows:

outbreak to be epidemic in influenza

(Duration) Yrs. mos. ds.

Contributory **Age and auto-toxemia**
(Secondary) **influenza**

(Duration) yrs. mos. ds.

(Signed) **J. M. Taylor** M. D.**3/4 1922** (Address) **Boise, Ida**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **Morris Hill Cemetery**DATE OF BURIAL **Mar 5 1922**20. UNDERTAKER **Summers & Co.**ADDRESS **Boise, Ida**

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

APR 5 1922

Registration District No.

County of *Ada*

BUREAU OF VITAL STATISTICS

Primary Registration District No.

City of *Boise*

No. *208* *Owyhee Blvd.* St.)

File No. *37093*

Registered No. *58*

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME *Herschel Horatio Clay*

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

M.

W.

Married
(Write the word.)

6. DATE OF BIRTH

Sept, 8, 1854

(Month) (Day) (Year)

7. AGE

67 Yrs. *5* Mos. *25* ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Garage Business

9. BIRTHPLACE

(State or Country)

Ohio.

10. NAME OF FATHER

Don't know

11. BIRTHPLACE OF FATHER

(State or Country)

?

12. MAIDEN NAME OF MOTHER

Mary Richardson

13. BIRTHPLACE OF MOTHER

(State or Country)

Don't know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. McBratney

(Address)

Boise Idaho.

15.

Filed *3-4* 19 *22*

R. L. Rath
Local Registrar

16. DATE OF DEATH

Mar. 3-1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar. 2nd 1922 to *Mar. 3rd 1922*
that I last saw him alive on *Mar. 2nd 1922*
and that death occurred on the date stated above, at *3 A.M.*

The CAUSE OF DEATH* was as follows:

Fracture of base of skull - accidental - Fall from truck
(Duration) Yrs. mos. *8 hrs.*

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

B. Blatter M. D.

3/3 19 *22* (Address) *Boise, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Payette, Idaho

DATE OF BURIAL

3/5 19 *22*

20. UNDERTAKER

W. McBratney

ADDRESS

Boise Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **37094**
Registered No. **57**

1. PLACE OF DEATH

County of Ada Registration District No. 1129 1/2
City of Boise (Write the word.) River St.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Latt

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single

(Write the word.)

6. DATE OF BIRTH

March 2 - 1922
(Month) (Day) (Year)

7. AGE

Premature
Yrs. Mos. ds.

IF LESS than 1 day
how many 6 hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Boise Idaho

10. NAME OF FATHER

Frank Latt

11. BIRTHPLACE OF FATHER

(State or Country)

Iowa

12. MAIDEN NAME OF MOTHER

Amy Barnett

13. BIRTHPLACE OF MOTHER

(State or Country)

Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wm. Bratney

(Address)

Boise, Idaho

15.

Filed 3-2 1922

J. H. R.

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 2 - 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

3/2 - 22 1922 to 3/2 - 22 1922
that I last saw him alive on 3/2 1922
and that death occurred on the date stated above, at 2:15 PM.

The CAUSE OF DEATH* was as follows:

Prematurity

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

Mother had influenza

(Duration) yrs. mos. ds.

(Signed)

B. W. Mather

M. D.

3/2 1922 (Address) Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

County Cemetery

DATE OF BURIAL

3/2/22 1922

20. UNDERTAKER

Wm. Bratney

ADDRESS

Boise Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

1. PLACE OF DEATH.

RECEIVED

Registration District No.

County of *Ada*

APR 5 1922

Primary Registration District No.

City of *Marion*

BUREAU

No. *6th & Garden* St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Robert Hoeden

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. *37096*Registered No. *31*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

*M**White**Married*
(Write the word.)

6. DATE OF BIRTH.

Sept 10 1881
(Month) (Day) (Year)

7. AGE

70 Yrs. *6* Mos. *7* ds.

If LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

Farmer

9. BIRTHPLACE

(State or Country)

Scotland

10. NAME OF FATHER

Alexander Hoeden

11. BIRTHPLACE OF FATHER

(State or Country)

Scotland

12. MAIDEN NAME OF MOTHER

Janet Franfield

13. BIRTHPLACE OF MOTHER

(State or Country)

Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

A. Hoeden(Address) *Boise Ida. Box 938*

15.

Filed *3-20* 1922

Local Registrar

16. DATE OF DEATH

Mich 7 1922 to *Mich 17 1922*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Mich 7 1922 to *Mich 17 1922*
that I last saw him alive on *Mich 17 1922*
and that death occurred on the date stated above, at *5 P. M.*

The CAUSE OF DEATH* was as follows:

The Pneumonia following the flu

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *J. W. Cannon* M. D.*3/20* 1922 (Address) *Boise Idaho*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery *Mar 21 1922*

20. UNDERTAKER

ADDRESS

Drummers & Krebs *Boise Idaho*

McCalla

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. **37097**

Registered No. **30**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH **Ada** Registration District No. **192**
County of **Ada** Primary Registration District No. **192**
City of **Ada** St. **Idaho**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Ralph Hamming**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **M** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Married**

6. DATE OF BIRTH

Sept 9 1866
(Month) (Day) (Year)

7. AGE

55 Yrs. **6** Mos. **9** ds.

IF LESS than 1 day
how many.....hrs. or
.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

Janitor

9. BIRTHPLACE

(State or Country)

Holland

10. NAME OF FATHER

Herman Hamming

11. BIRTHPLACE OF FATHER

(State or Country)

Holland

12. MAIDEN NAME OF MOTHER

Rosette Rhytman

13. BIRTHPLACE OF MOTHER

(State or Country)

Holland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

R. Hamming
Meridian, Ida.

15.

Filed **3-22-1922**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 18 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Mar 16 1922** to **Mar 17 1922**, that I last saw him alive on **Mar 17 1922** and that death occurred on the date stated above, at **7: A. M.**

The CAUSE OF DEATH* was as follows:

Arteriosclerosis
Myocardial insufficiency

(Duration) **2** Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) **R. L. McCalla** M. D.

19. (Address) **Boise, Idaho**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery Mar 20 1922

20. UNDERTAKER

ADDRESS

Summers & Krebs Boise, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Dutton.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Adair Registration District No.
City of Near Bonanza Primary Registration District No.
2 miles West of Bonanza (St.)

File No. **37098**Registered No. 29

If death occurs away from usual residence, give facts called for under special information.

BUREAU OF VITAL
STATISTICS

2. FULL NAME Bertha May Wilson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH.

Sept 9 1885
(Month) (Day) (Year)

7. AGE

36 Yrs. 6 Mos. 2 ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

At Home

9. BIRTHPLACE

(State or Country) Penn.

10. NAME OF FATHER

H. E. Wray

11. BIRTHPLACE OF FATHER

(State or Country) Penn.

12. MAIDEN NAME OF MOTHER

Katie G. Bussick

13. BIRTHPLACE OF MOTHER

(State or Country) Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. H. Wilson

(Address) White Ranch

15.

Filed 3 13 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar. 11 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar. 8 1922 to Mar. 11 1922
that I last saw her alive on Mar. 10 1922
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Pneumonia
Flu

(Duration) Yrs. mos. 10 ds.

Contributory
(Secondary)

Apophxy

(Duration) Yrs. mos. ds.

(Signed)

C. L. Dutton M. D.

Mar. 19 22 (Address) Desland Bldg. - Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery Mar. 14 22

20. UNDERTAKER

ADDRESS

Summers & Co. Boise, Id.

Chen,

1. PLACE OF DEATH **RECEIVED**

CERTIFICATE OF DEATH.

County of Ada APR 5 1922
 City of Mar. Bona **BUREAU OF VITAL STATISTICS**
 Primary Registration District No. 1/2 miles West of Bona St.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Euretta Branic

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. **37099**Registered No. 27

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX F 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
 (Write the word.)

6. DATE OF BIRTH.

May 20 1865
 (Month) (Day) (Year)

7. AGE

56 Yrs. 9 Mos. 17 ds.

IF LESS than 1 day
 how many hrs. or
 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business, or establishment in which employed (or employer).

at Home

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

Charles Jappana

11. BIRTHPLACE OF FATHER

(State or Country)

Spain

12. MAIDEN NAME OF MOTHER

Mary Sigler

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

M. E. Branic
Boise R#9 Idaho

15.

Filed

5-81922

R. H. Galt
 Local Registrar

16. DATE OF DEATH

3 7 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
3-6-1922 to 3-7-1922

that I last saw her alive on 3-6-1922
 and that death occurred on the date stated above, at 12:15 M.

The CAUSE OF DEATH* was as follows:

Cerebral
Hemorrhage

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

R. J. B. Chen M. D.
Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Grassho Mo Mar 12 1922

20. UNDERTAKER

ADDRESS

Summer & Krebs Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **37100**Registered No. **26**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH **RECEIVED**
Registration District No. _____
County of **Ada** **APR 5 1922** Registration District No. _____
City of **Boise West of Boise St.**
BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Mary Ellen Webster**

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX **F** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Married**

6. DATE OF BIRTH.

June 7, 1886
(Month) (Day) (Year)

7. AGE

35 Yrs. **8** Mos. **29** ds.IF LESS than 1 day
how many.....hrs. or
.....min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)**at home**

9. BIRTHPLACE

(State or Country)

Nebraska

10. NAME OF FATHER

Thomas H. Wirtman

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Mary

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

W. E. Webster

(Address)

Boise, Idaho

15.

Filed

3-7**1922****R. A. Ratz**

Local Registrar

16. DATE OF DEATH

Mar 6, 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

3/4 1922 to **3/6 1922**that I last saw her alive on **3/5 1922**and that death occurred on the date stated above, at **5:20 A.M.**

The CAUSE OF DEATH* was as follows:

Acute Myocardial Degeneration(Duration) Yrs. **1** mos. **0** ds.Contributory
(Secondary)(Duration) Yrs. **0** mos. **0** ds.(Signed) **Harold W. Stone** M. D.**3/6 1922** (Address) **412 Overland Blvd**

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Joplin Cemetery**Mar 7 1922**

20. UNDERTAKER

ADDRESS

Summers & Sons**Boise, Idaho**

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. NO. 1-15 H. 1-15-11

PLACE OF DEATH		RECEIVED		CERTIFICATE OF DEATH		State of Idaho BOARD OF HEALTH Bureau of Vital Statistics	
1.	PLACE OF DEATH	APR 5 1922	Registration District No.	File No.	87101	Registered No.	22
County of	Ada	BUREAU OF VITAL STATISTICS	Primary Registration District No.				
City of	Near Boise		Miles South West of Boise				
If death occurs away from usual residence, give facts called for under special information.				If death occurred in a hospital, institution or camp, give its NAME instead of street and number.			
2. FULL NAME				William Bruch			
PERSONAL AND STATISTICAL PARTICULARS				MEDICAL CERTIFICATE OF DEATH			
3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.		16. DATE OF DEATH			
M	White	(Write the word.)		March 4 1922 (Month) (Day) (Year)			
6. DATE OF BIRTH				17. I HEREBY CERTIFY, That I attended deceased from			
March 26 1918 (Month) (Day) (Year)				December 21 1921, to March 4 1922,			
7. AGE				that I last saw him alive on March 4 1922			
3 Yrs. 11 Mos. 8 ds.				and that death occurred on the date stated above, at 2 P. M.			
8. OCCUPATION				The CAUSE OF DEATH* was as follows:			
(a) Trade, profession or particular kind of work... None				Enterocolitis Complicating Influenza			
(b) General nature of industry, business, or establishment in which employed (or employer).....							
9. BIRTHPLACE				(Duration) Yrs. mos. 5 ds.			
(State or Country) Idaho				Contributory (Secondary) Typhoid Fever			
10. NAME OF FATHER				(Duration) yrs. 2 mos. ds.			
W. M. Bruch				(Signed) M. Allen Callaway M. D.			
11. BIRTHPLACE OF FATHER				3-6-1922 (Address) Boise Idaho			
(State or Country) Missouri				*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.			
12. MAIDEN NAME OF MOTHER				18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)			
Ellen Young				At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days			
13. BIRTHPLACE OF MOTHER				Where was disease contracted if not at place of death?.....			
(State or Country) Nebraska				Former or usual residence			
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.				19. PLACE OF BURIAL OR REMOVAL			
(Informant) Wm. Bruch				Morris Hill Cemetery			
(Address) Boise Idaho R. 5				DATE OF BURIAL			
15.				March 6 1922			
Filed				20. UNDERTAKER			
1922				Summers & Sons			
Local Registrar				ADDRESS			
				Boise Idaho			

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. _____
Registered No. 26

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH **RECEIVED**

County of Ada APR 5 1922
City of _____
Registration District No. _____
Primary Registration District No. _____
(No. 26) Wales West of Boise (St.)
BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wale Russell Irish

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH Nov 22 1991
(Month) (Day) (Year)

7. AGE 2 Yrs. 3 Mos. 5 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country) Boise Idaho

10. NAME OF FATHER

W. B. Irish

11. BIRTHPLACE OF FATHER

(State or Country) New York

12. MAIDEN NAME OF MOTHER

Minnie Jones

13. BIRTHPLACE OF MOTHER

(State or Country) Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs W. B. Irish

(Address)

Rt 2 Boise Idaho

15.

Filed

19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb. 27 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 27 1922 to Feb. 27 1922 that I last saw him alive on Feb 27 1922 and that death occurred on the date stated above, at 1030 M.

The CAUSE OF DEATH* was as follows:

influenza, a

(Duration) Yrs. mos. ds.

Contributory (Secondary) Pneumonia & Intestinal Toxemia

(Duration) yrs. mos. ds.

(Signed)

J. Earl Kier M. D.2/3 1922 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Hamper Idaho

DATE OF BURIAL

Mar 3 1922

20. UNDERTAKER

Shummers & Krebs

ADDRESS

Boise Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of AdaRegistration District No. 124Primary Registration District No. 2202

City of _____

(No. _____ St.)

File No. 37195Registered No. 41

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ernest Chambers

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male white Single
(Write the word.)

6. DATE OF BIRTH

Jan 10 1900
(Month) (Day) (Year)

7. AGE

21 Yrs. 11 Mos. 29 ds.
IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Farmer
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Tenn

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country) Virginia

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country) Ind

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joe H. Chambers(Address) Kuna, IdaFiled 2-27 1922 W. C. Evans
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 9 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

12-30 1921 to 1-9 1922that I last saw him alive on 1-9 1922and that death occurred on the date stated above, at 12-30 PM

The CAUSE OF DEATH* was as follows;

Lobar Pneumonia(Duration) _____ Yrs. _____ mos. 12 ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) H. C. Robinson M. D.1/10 1922 (Address) Kuna, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Kuna Cemetery

DATE OF BURIAL

1-12 1922

20. UNDERTAKER

Paul K. Robinson

ADDRESS

Kuna, Ida

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Ada*

City of

Registration District No. *124*Primary Registration District No. *222*(No. *2 1/2 miles S.W. of Thoma*)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*John Butler*State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *37106*Registered No. *42*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M White

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

unknown
(Write the word.)

6. DATE OF BIRTH

unknown
(Month) (Day) (Year)

7. AGE

about 70
Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Switzerland

10. NAME OF FATHER

unknown

11. BIRTHPLACE OF FATHER

(State or Country)

unknown

12. MAIDEN NAME OF MOTHER

unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Chas. E. Summers

(Address)

Boise Idaho

15. Filed

*2-27-22**W. C. Stevens*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 1 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I *saw* attended deceased from*Feb 2 1922* to *1922*
that I last saw *alive* on *1922*and that death occurred on the date stated above, at *1922* M.

The CAUSE OF DEATH* was as follows

Apoplexy. Found dead and dead was due to natural causes.

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

Chas. E. Summers
2/4 1922 (Address) *Boise Idaho, Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Boise Idaho

DATE OF BURIAL

Feb 8 1922

20. UNDERTAKER

Summers & Feb Boise Ida

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 37107

Registered No. 12

1. PLACE OF DEATH

County of *Ada*
City of *Star*If death occurs away from
usual residence, give facts
called for under special in-
formation.Registration District No. *9-10*
BUREAU OF VITAL STATISTICS
Registration District No. *9-10*

2. FULL NAME

*Mary. Mauei Swearingen*If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *Female* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED *married*
(Write the word.)

6. DATE OF BIRTH

June 1 1897
(Month) (Day) (Year)

7. AGE

63 Yrs. *9* Mos. *12* ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)*Wife none*

9. BIRTHPLACE

*Genoa, County, Missouri*10. NAME OF
FATHER*Cogdill*11. BIRTHPLACE
OF FATHER

(State or Country)

*Unknown*12. MAIDEN NAME
OF MOTHER*Unknown*13. BIRTHPLACE
OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. M. S. Hughes
Star, Idaho

(Address)

15. Filed *Mar 13* 19*19**Gene J. Swan*
Local Registrar

16. DATE OF DEATH

March 12 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
Mar 12 1922 to *Mar 12 1922*
that I last saw him alive on *Mar 12 1922*
and that death occurred on the date stated above, at *1 P. M.*
The CAUSE OF DEATH* was as follows:
*Altogether Menstrual
dysregulation disease
& diabetes.*(Duration) yrs. mos. ds.
Contributory (Secondary) *Circulatory Weakness*(Duration) *Many* mos. ds.
(Signed) *Old Had* M. D.
19. (Address) *Star Idaho**State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Star

DATE OF BURIAL

Mar 14 1922

20. UNDERTAKER

Swearingen

ADDRESS

*Boise**9-10*
Eagle 2240

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH
in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

37108

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

RECEIVED

Registration District No.

9410

County of *Blaine*

MAR 31 1922

Primary Registration District No.

City of *Star*

BUREAU OF

STANDARD

St.)

File No. *12*

Registered No. *11*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Virgil - Jones

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single

6. DATE OF BIRTH

(Month)

(Day)

(Year)

7. AGE

13 yrs. *7* mos. *3* ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Long Valley

10. NAME OF FATHER

D. L. Jones

11. BIRTHPLACE OF FATHER

(State or Country)

Tenn

12. MAIDEN NAME OF MOTHER

Maggie Hall

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. May

(Address)

Engle St. Idaho

15.

Filed

Mar 12

191

Ernest Jones

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 11 1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar 6 to Mar 11 1922

that I last saw *him* alive on *Mar 11* 191

and that death occurred on the date stated above, at *3* M.

The CAUSE OF DEATH* was as follows:

Rheumatic Heart

(Duration) *None* yrs. *None* mos. *None* ds.
Contributory (Secondary) *Metastatic Rheumatism*

(Duration) *None* yrs. *None* mos. *None* ds.
(Signed) *Chas. H. Jones* M. D.
19 (Address) *Star Idaho*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Star

DATE OF BURIAL

Mar 12 1922

20. UNDERTAKER

Fry Summers

ADDRESS

Bone

1. PLACE OF DEATH

County of Ada
 City of Star

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED

MAR 31 1922

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 9+10Primary Registration District No. 9+10

St.)

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 12Registered No. 37109

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED

M. White Widower

6. DATE OF BIRTH

(Month)

(Day)

(Year)

7. AGE

68 Yrs. 10 Mos. 1 ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

Deputy Sheriff

9. BIRTHPLACE

(State or Country)

Wisconsin

10. NAME OF FATHER

Joseph Kendall

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. Haley

(Address)

Star Idaho

Orville Johnson

Local Registrar

Edgar Idaho

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 9 19 22
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19

that I last saw him alive on 19

and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(Duration) Yrs. mos. ds.

Contributory
 (Secondary)

(Duration) Yrs. mos. ds.

(Signed)

Teleph. E. Summers D.
Boise, Idaho

3/3 19 22 (Address) Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Star Cemetery

DATE OF BURIAL

Mar 4 19 22

20. UNDERTAKER

Summers & Co.

ADDRESS

Boise, Idaho

1. PLACE OF DEATH

County of Bannock Registration District No. 83
 City of Blainey Primary Registration District No. 3160
 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED CERTIFICATE OF DEATH

APR 8 1922
 BUREAU OF VITAL STATISTICS

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 37111

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED single
 (Write the word.)

6. DATE OF BIRTH

Aug 1 1906
 (Month) (Day) (Year)

7. AGE

15 Yrs. 6 Mos. 21 ds.

IF LESS than 1 day
 how many _____ hrs.
 or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

School Boy

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

James H. Hoey

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Minnie May Houston

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. J. J. Wootley
 (Address) Blainey Idaho

15.

Filed Mar 23 1922

J. J. Wootley
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 21 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 9 1922, to Mar 21 1922, that I last saw him alive on Mar 9 1922, and that death occurred on the date stated above, at 5:00 P.M.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Duration) 1 Yrs. _____ mos. _____ ds.

Contributory (Secondary)

none

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

J. J. Wootley

M. D.

3-23-1922 (Address) Blainey, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. 21 days. In the State 15 yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

Idaho Falls

19. PLACE OF BURIAL OR REMOVAL

Blainey Idaho

DATE OF BURIAL

3-24-1922

20. UNDERTAKER

C. E. Saylor

ADDRESS

Blainey

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **37112**
Registered No.

1. PLACE OF DEATH

County of Bannock Registration District No. 83
City of Swan Lake Registration District No. 3160
St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Frederick Edward Hennie

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

W5. SINGLE, MARRIED, WIDOWED OR DIVORCED
married
(Write the word.)

6. DATE OF BIRTH

Nov 8 1891
(Month) (Day) (Year)

7. AGE

30 Yrs. 4 Mos. 13 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)Farmer

9. BIRTHPLACE

(State or Country)

Bannock Co, Idaho

10. NAME OF FATHER

Henry Hennie

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Annie Moore

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Annie Hennie(Address) Swan Lake City

15.

Filed 3-21-1922 H. J. Hartwig
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March, 21, 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Mar., 16, 1922 to 19that I last saw him alive on Mar., 16, 1922,
and that death occurred on the date stated above, at 7:00 AM.

The CAUSE OF DEATH* was as follows:

Influenza Pneumonia(Duration) Yrs. mos. 6 ds.Contributory
(Secondary)none

(Duration) Yrs. mos. ds.

(Signed)

H. J. Hartwig M. D.3-21-1922 (Address) Shower, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Oxford, Idaho 3-23-1922

20. UNDERTAKER

C. E. Layton Shower

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock Registration District No. 53
City of Mayway Registration District No. 2160
If death occurs away from usual residence, give facts called for under special information.

File No. 37113

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Charles William Evans

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WID-

married

(Write the word.)

6. DATE OF BIRTH

Oct 9 1884
(Month) (Day) (Year)

7. AGE

38 Yrs. 4 Mos. 27 ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

Farmer

9. BIRTHPLACE

(State or Country)

Mayway, Idaho

10. NAME OF FATHER

C. B. Evans

11. BIRTHPLACE OF FATHER

(State or Country)

Brigham Utah

12. MAIDEN NAME OF MOTHER

Sarah Jane Sisk

13. BIRTHPLACE OF MOTHER

(State or Country)

Millsville Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

John A. Evans
Mayway Ida

15.

Filed

March, 5, 1923
J. H. Hastings
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 5 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb. 15, 1923, to March, 5, 1923,
that I last saw him alive on March, 5, 1923,
and that death occurred on the date stated above, at 10 A.M.
The CAUSE OF DEATH* was as follows:

Influenza Pneumonia

(Duration) _____ Yrs. _____ mos. 18 ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

J. H. Hastings, M. D.

3-5-1923 (Address) Mayway, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 38 yrs. 4 mos. 27 days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Malad Ida 3-7 1923

20. UNDERTAKER

ADDRESS

D. E. Johnson Malad

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **37114**

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Bannock Registration District No. 83
City of Armo Primary Registration District No. 3/60
St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

BUREAU
STLila Baldwin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female white Single
(Write the word.)

6. DATE OF BIRTH

July 24 1922
(Month) (Day) (Year)

7. AGE

6 20 ds.
Yrs. Mos. ds.
IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
-
- (b) General nature of industry, business or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country) Montana Idaho

10. NAME OF FATHER

George H. Baldwin

11. BIRTHPLACE OF FATHER

(State or Country) Utah

12. MAIDEN NAME OF MOTHER

Theodocia Hatch

13. BIRTHPLACE OF MOTHER

(State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) George H. Baldwin
(Address) Robin Idaho

15.

Filed Feb. 28, 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb. 14 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb. 13, 1922, to Feb. 14, 1922
that I last saw h. er alive on Feb. 13, 1922
and that death occurred on the date stated above, at 12:30 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia(Duration) - Yrs. 7 mos. - ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

P. A. Liddle M. D.2/17, 1922 (Address) M. S. Cannon Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Montana Idaho Feb. 16, 1922

20. UNDERTAKER - acting ADDRESS

Janette Curtis Robin Idaho

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock Registration District No. 83
City of Bowman Primary Registration District No. 2160
St.)File No. 37116

Registered No.

If death occurs away from usual residence, give facts called for under special information.

BUREAU OF VITAL
STATISTICS

2. FULL NAME

Mary Jane Owens

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

F White Married

6. DATE OF BIRTH

Aug 14 1886
(Month) (Day) (Year)

7. AGE

35 Yrs. 6 Mos. 7 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Housewife

9. BIRTHPLACE

(State or Country)

Malad, Ida

10. NAME OF FATHER

John S Owens

11. BIRTHPLACE OF FATHER

(State or Country)

Ogden, Ut

12. MAIDEN NAME OF MOTHER

Mary Jane Thomas

13. BIRTHPLACE OF MOTHER

(State or Country)

Bingham City, Ut

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mark S Owens

(Address)

Malad, Ida

15.

Filed Feb. 24 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb. 27 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Feb. 15, 1922 to Feb. 21, 1922
that I last saw her alive on Feb. 20, 1922,
and that death occurred on the date stated above, at 7:41 A.M.

The CAUSE OF DEATH* was as follows:

Influenza Pneumonia(Duration) — Yrs. — mos. 8 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

R. J. Hartigsen M. D.2-21-1922 (Address) Bowman, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Malad, Ida

DATE OF BURIAL

2-22 1922

20. UNDERTAKER

D. E. Johnson

ADDRESS

Malad

1. PLACE OF DEATH

County of Damrock
City of Swan Lake

If death occurs away from usual residence, give facts called for under special information.

RECEIVED

APR 5 1922

BUREAU OF VITAL

STATISTICS

CERTIFICATE OF DEATH

Registration District No. 83Primary Registration District No. 2160State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 37117

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Ellen E. Kofoed

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F.

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

July 16 1894
(Month) (Day) (Year)

7. AGE

67 Yrs. 7 Mos. 2 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Housewife

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Andrew Linsley

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Elizabeth E. Miller

13. BIRTHPLACE OF MOTHER

(State or Country)

U.S.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

D. J. Linsley(Address) Swan Lake Idaho

15.

Filed Feb. 24, 1922R. J. Linsley
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

2-18 22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

.....19....., to19.....,

that I last saw h..... alive on.....19.....,

and that death occurred on the date stated above, at.....M.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration)Yrs.....mos.....ds.

Contributory
(Secondary)

(Duration)yrs.....mos.....ds.

(Signed)

S. S. Ferguson
D.2-19-22(Address) Fortitude Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Wiston Idaho

DATE OF BURIAL

Feb. 21 1922

20. UNDERTAKER

W. A. Skidmore

ADDRESS

Preston Ida.

1. PLACE OF DEATH

County of Bannock
City of Armo

If death occurs away from usual residence, give facts called for under special information.

RECEIVED

CERTIFICATE OF DEATH

Registration District No. 53Primary Registration District No. 2160

BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 37119

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Marie Kohler Woske

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WID-

OWED OR DIVORCED

married

(Write the word.)

6. DATE OF BIRTH

September 4th 1890
(Month) (Day) (Year)

7. AGE

31 Yrs. 4 Mos. 5 ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

housewife

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Switzerland

10. NAME OF FATHER

Simon Kohler

11. BIRTHPLACE OF FATHER

(State or Country)

Switzerland

12. MAIDEN NAME OF MOTHER

marion Annen

13. BIRTHPLACE OF MOTHER

(State or Country)

Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

George Woske Jr

(Address)

15.

Filed Jan 11 1932L. J. Hartig
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 9 1932
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 6 1932 to Jan 9 1932that I last saw her alive on Jan 9 1932and that death occurred on the date stated above, at 2:00 AM.

The CAUSE OF DEATH* was as follows:

hemorrhage & shock

(Duration) Yrs. mos. ds.

Contributory
(Secondary)Placenta previa

(Duration) yrs. mos. ds.

(Signed)

L. J. Hartig M. D.

1-11-1932

(Address) Armo

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Armo

DATE OF BURIAL

1-12-1932

20. UNDERTAKER

none

ADDRESS

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH *Idaho* APR 3 1922
 County of *Camanche* Registration District No. *8.2*
 City of *Lama* Registration District No. *2158*
 If death occurs away from usual residence, give facts called for under special information.

File No. *37120*
 Registered No. *4*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Emerson V. Shurtliff

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*
 6. DATE OF BIRTH *June 19 1868*
 7. AGE *53* Yrs. *8* Mos. *3* ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

Merchant

9. BIRTHPLACE

(State or Country)

East Lake Utah

10. NAME OF FATHER

Emerson Shurtliff

11. BIRTHPLACE OF FATHER

(State or Country)

Massachusetts U.S.

12. MAIDEN NAME OF MOTHER

Mary Ann Tribe

13. BIRTHPLACE OF MOTHER

(State or Country)

London Eng

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. J. Peterson

(Address)

Roy Ida

15.

Filed *March 31 1922**Ellis Karsley*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 2nd 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Dec 3 1921* to *March 2 1922* that I last saw him alive on *March 1 1922* and that death occurred on the date stated above, at *11:20* M.

The CAUSE OF DEATH* was as follows:

Diph - acute hepatitis(Duration) Yrs. *3* mos. ds.

Contributory (Secondary)

none(Duration) yrs. *5-10* mos. ds.

(Signed)

*Ellis Karsley M.D.**March 1 1922* (Address) *Ellis Karsley*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Rock Springs Wyo *March 3 1922*

20. UNDERTAKER ADDRESS

W.D. Mackey *Idaho*

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **37121**

1. PLACE OF DEATH **BUREAU** Registration District No. **82**
County of **Sanborn** Primary Registration District No. **2459**
City of **Salt Spring** (No. _____ St.)

Registered No. **5**
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Samuel Wilson Myers**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **M** 4. COLOR OR RACE **W** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH **Aug 23 1882**
(Month) (Day) (Year)

7. AGE **39 yrs. 6 mos. 22 ds.**
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work **Rancher**
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) **Mo**

10. NAME OF FATHER

Geo. Myers

11. BIRTHPLACE OF FATHER

(State or Country) **Va**

12. MAIDEN NAME OF MOTHER

King

13. BIRTHPLACE OF MOTHER

(State or Country) **Mo ??**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Erge Myers**

(Address) **Bancroft, Salt**

15.

Filed **March 20 1912** **Edis Kaseley**
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March 17 1912
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **March 1 1912**, to **March 17 1912**, that I last saw him alive on **March 17 1912**, and that death occurred on the date stated above, at **1 A. M.** The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) yrs. mos. **3** ds.

Contributory **Influenza**
(Secondary)

(Duration) yrs. mos. **14** ds.

(Signed) **Edis Kaseley** M. D.

March 1912 (Address) **Salt Spring, Id**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Bancroft, Salt **March 20 1912**

20. UNDERTAKER

None

ADDRESS

CERTIFICATE OF DEATH

37122

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 47
Registered No. 3752

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of *Burns*City of *Portland*

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 28

Primary Registration District No. 2164

St. *Idaho*

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male*4. COLOR OR RACE *White*5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Unknown*

(Write the word.)

6. DATE OF BIRTH

Unknown
(Month) (Day) (Year)

7. AGE

About 70 years
Yrs. Mos. ds. IF LESS than 1 day
How many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work *Unknown*
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

7/3 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Unknown about Jan 15th
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19
that I last saw him alive on 19
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

*Frozen to death*Contributory
(Secondary)

(Signed)

2-13-22

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs mos days In the State yrs mos days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mountain View Cem Feb 12 1922

20. UNDERTAKER

ADDRESS

FORM V. S. No. 5A—23 M. 1-19.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH*

Registration District No.

Primary Registration District No.

No.

St.)

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from Jan 25 1922, to Feb 5 1922

that I last saw her alive on Feb 5 1922

and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

Feb 19 22 (Address) Peaslee, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bannock
 City of Blackfoot

Registration District No. _____

Primary Registration District No. _____

(No. 444 St.)

If death occurs away from
 usual residence, give facts
 called for under special in-
 formation.

2. FULL NAME

Emil Massier

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 47Registered No. 3755

If death occurred in a hos-
 pital, institution or camp,
 give its NAME instead of
 street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

Austrian5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDSingle
(Write the word.)

6. DATE OF BIRTH

Mar 29 1920
(Month) (Day) (Year)

7. AGE

1 Yrs. 10 Mos. 9 ds.

IF LESS than 1 day
 how many _____ hrs.
 or _____ min.?

8. OCCUPATION

(a) Trade, profession or
 particular kind of work
 (b) General nature of in-
 dustry, business or estab-
 lishment in which employ-
 ed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho10. NAME OF
FATHERJohn Massier11. BIRTHPLACE
OF FATHER

(State or Country)

Austria12. MAIDEN NAME
OF MOTHERKatherine Aiki13. BIRTHPLACE
OF MOTHER

(State or Country)

Austria

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John Massier

(Address)

1444 E Center

15.

Filed

7/6 1922

J. Young
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb. 6 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb. 1st 1922, to Feb. 6th 1922
 that I last saw him alive on Feb. 6th 1922
 and that death occurred on the date stated above, at 11 A. M.
 The CAUSE OF DEATH* was as follows:

Diphtheria

(Duration)

yrs. mos. 8 ds.Contributory
(Secondary)Cardiac Paralysis

(Duration)

yrs. mos. 1 ds.

(Signed)

Dr. J. W. Young M. D.
Blackfoot, Idaho

7-6 1922 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state
 (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted
 if not at place of death?

Former or
 usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mountain View Feb 7 1922

20. UNDERTAKER

ADDRESS

Chambers & Co

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Bannock*City of *Pocatello*

If death occurs away from usual residence, give facts called for under special information.

RECEIVED

Registration District No.

Primary Registration District No.

EUG (No.)

28 37126

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No. 3756

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME *Rachel A. Parks.*

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw her alive on

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Signed)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

No.

28, 37127

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE MARRIED, WID-
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

19 22

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Signed)

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

37128

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

Registration District No.

Primary Registration District No.

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

16. DATE OF DEATH

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

I HEREBY CERTIFY, That I attended deceased from

Feb 7 1922 to Feb 7 1922

that I last saw her alive on Feb 7 1922

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Premature birth.

(Duration)..... Yrs..... mos..... ds.

Contributory
(Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed)

A. M. Newton M. D.

Feb 8 1922 (Address) Pocatello, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No.

Primary Registration District No.

St.

28 37129 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on
and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Signed)

2-7-1922

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No.)

37130

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

1922
(Year)I HEREBY CERTIFY, That I attended deceased from
Feb 7 1922 to Feb 9 1922
that I last saw her alive on Feb 9 1922
and that death occurred on the date stated above, at 1032 P.M.

The CAUSE OF DEATH* was as follows:

Diphtheria

(Duration)

Yrs.

mos.

3 ds.

Contributory
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

M. D.

7/9

1922

(Address)

Pocatello, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

37131

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 28
County of Bannock Primary Registration District No. 2161
City of McCammon (No. _____ St.)File No. 48
Registered No. 3761

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Willard Green

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male white Single6. DATE OF BIRTH
April 24 1903
(Month) (Day) (Year)7. AGE
18 Yrs. 9 Mos. ds.
IF LESS than 1 day
how many _____ hrs.
or _____ min.?8. OCCUPATION
(a) Trade, profession or particular kind of work. Student
(b) General nature of industry, business or establishment in which employed (or employer).9. BIRTHPLACE
(State or Country) McCammon Ida10. NAME OF FATHER
Larid Green11. BIRTHPLACE OF FATHER
(State or Country) Cedar City, Utah12. MAIDEN NAME OF MOTHER
Dorretta Harris13. BIRTHPLACE OF MOTHER
(State or Country) Utah14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Dorretta Green
(Address) McCammon, Ida15. Filed 7/23 1922 J. Huang
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Feb 10 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
Jan. 5 1922 to Feb. 2 1922
that I last saw him alive on Feb 2 1922
and that death occurred on the date stated above, at 343 M.

The CAUSE OF DEATH* was as follows:

Splenic anaemia(Duration) _____ Yrs. _____ mos. _____ ds.
Contributory (Secondary) Splenic anaemia(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) H. C. Lavin M. D.
Feb 19 22 (Address) Pocostello, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days
Where was disease contracted if not at place of death? Idaho
Former or usual residence McCammon19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
McCammon, Ida Feb 12 19 2220. UNDERTAKER ADDRESS
H. L. McHon Pocostello
Idaho

✓ CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 2837132
County of Bannock Primary Registration District No. 2161
City of Pocatello (No. General Hosp. St.)File No. 48
Registered No. 3762

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Frank Mc Donald

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male white Not Known

6. DATE OF BIRTH

Not Known
(Month) (Day) (Year)

7. AGE

63 Yrs. He saysIF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)None

9. BIRTHPLACE

(State or Country)

Not Known

10. NAME OF FATHER

"

11. BIRTHPLACE OF FATHER

(State or Country)

"

12. MAIDEN NAME OF MOTHER

"

13. BIRTHPLACE OF MOTHER

(State or Country)

"

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address) Dr. Carl W. Clark
County Phy. Pocatello Ida

15.

Filed Feb 13 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 11 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 18 1922 to Feb 10 1922
that I last saw him alive on Feb 10 1922
and that death occurred on the date stated above, at 5 a. M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis, with
hemorrhage
Multiple carbuncles on back
post mortem lividity 8 ds.
(Duration) Yrs. mos. ds.Contributory (Secondary) Adenocarcinoma

(Duration) yrs. 6 mos. ds.

(Signed) Carl W. Clark M. D.2/13 1922 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death Not KnownFormer or usual residence Not Known

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Mt View Cem. Feb 13 1922

20. UNDERTAKER ADDRESS

H. L. Mc Han Pocatello Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bannock Registration District No. 218
 City of Pocatello Primary Registration District No. 2164
 (No. 413 - So - Fourth St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Alma Nell Blevins

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 48
 Registered No. 3763

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED Child
 (Write the word.)

6. DATE OF BIRTH March 16 1913
 (Month) (Day) (Year)

7. AGE 9 Yrs 11 Mos 1 ds. IF LESS than 1 day
 how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work At School.
 (b) General nature of industry, business or establishment in which employed (or employer) —

9. BIRTHPLACE Kentucky
 (State or Country)

10. NAME OF FATHER William A Blevins

11. BIRTHPLACE OF FATHER Kentucky
 (State or Country)

12. MAIDEN NAME OF MOTHER Lola E Ryan

13. BIRTHPLACE OF MOTHER Kentucky
 (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Beryl Blevins
 (Address) 413 - So - 4th

15. Filed 7/11 1922 J. P. Young
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

February 11 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 17 1922, to Feb 10 1922.
 that I last saw him alive on Feb 10 1922,
 and that death occurred on the date stated above, at 12:20 A.M.

The CAUSE OF DEATH* was as follows:

Myocarditis.

(Duration) Yrs. mos. 14 ds.
 Contributory (Secondary) Diphtheria Jan 15 - Jan 30

(Duration) yrs. mos. 15 ds.
 (Signed) Carl W Clark M. D.
Feb 11 1922 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Mountain View Cem DATE OF BURIAL Feb 12 1922

20. UNDERTAKER Schumacher & Hall ADDRESS Pocatello

CERTIFICATE OF DEATH

37131 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Power* Registration District No. *28*City of *Pauline* Primary Registration District No. *2161*(No. *4 miles from Pauline*)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Frank Kulock*File No. *48*
Registered No. *3764*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *German* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*6. DATE OF BIRTH *March 29 1864*
(Month) (Day) (Year)7. AGE *57* Yrs. *10* Mos. *14* ds. IF LESS than 1 day how many yrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work *Farmer*
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) *Germany*

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country) *Germany*

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country) *Germany*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address) *Pauline Idaho*15. Filed *Feb 15 1922*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 11 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19. to 19. that I last saw him alive on 19. and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Chosen in Blizzard 4 miles above Pauline in Power Valley

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) *Arvid A. Coonan**2/15 1922* (Address) *Pauline Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence *Pauline Ida.*

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Pocatello, Idaho 2/16 1922

20. UNDERTAKER

ADDRESS

A. L. McMan Pocatello Idaho

1. PLACE OF DEATH

County of *Bannock*
City of *Pocatello*

Registration District No. _____

Primary Registration District No. _____

(No. *St Anthony's Hosp.*)

File No. *48*

Registered No. *3765*

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Lulu Berg

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female white

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married

6. DATE OF BIRTH

Dec 24 1886
(Month) (Day) (Year)

7. AGE

35 Yrs. *1* Mos. *19* ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

House wife

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Birk

11. BIRTHPLACE OF FATHER

(State or Country)

Sueden

12. MAIDEN NAME OF MOTHER

not known

13. BIRTHPLACE OF MOTHER

(State or Country)

Sueden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Swan Berg

(Address)

Blackfoot, Ida

15.

Filed *Feb 13 1922*

J. Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 12 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 11 1922 to Feb 12 1922

that I last saw *her* alive on *Feb 12 1922*

and that death occurred on the date stated above, at *6 P. M.*

The CAUSE OF DEATH* was as follows:

General peritonitis following localized felix peritonitis

(Duration) Yrs. mos. *6* ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) *Ann Newton M. D.*

2/13 1922 (Address) *Pocatello, Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. *1* days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence *Blackfoot, Idaho.*

19. PLACE OF BURIAL OR REMOVAL

Blackfoot, Idaho

DATE OF BURIAL

Feb 14 1922

20. UNDERTAKER

H. L. McHown

ADDRESS

Pocatello

CERTIFICATE OF DEATH

37136 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 38
County of Bannock Primary Registration District No. 2161
City of Pocatello (No. 549 W. Centre St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Helen Adelaide SmithFile No. 48
Registered No. 3764

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female white widow

6. DATE OF BIRTH

April 17 1894
(Month) (Day) (Year)

7. AGE

78 Yrs. 9 Mos. 25 ds.
IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work.
-
- (b) General nature of industry, business or establishment in which employed (or employer).

House Keeper

9. BIRTHPLACE

(State or Country)

Maine

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

Robert Campbell
Maine

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Catherine Rogers
Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Mrs. Beatrice Steady
Pocatello, Idaho

15.

Filed

Feb 13 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb. 12 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
2 - 1 1922 to 2 - 12 1922that I last saw her alive on 2 - 12 1922
and that death occurred on the date stated above, at 9:30 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage(Duration) Yrs. mos. ds.
Contributory (Secondary) Senility(Duration) Yrs. mos. ds.
(Signed) Dr. Rued M. D.2/13 1922 (Address) Pocatello, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 1 yrs. mos. days. In the State 1 yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence Boise Idaho

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Pocatello, Idaho Feb 15 1922

20. UNDERTAKER

ADDRESS

B. L. McHew Pocatello
Ida

CERTIFICATE OF DEATH

37139 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

Bannock
Pocatello

Registration District No. 28

Primary Registration District No. 216

File No. 48

Registered No. 3769

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Jackson Hackworth

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male white widower

6. DATE OF BIRTH

Mar 28 1897
(Month) (Day) (Year)

7. AGE

84 Yrs. 10 Mos. 23 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

Farmer & Lumberman

9. BIRTHPLACE

(State or Country)

Kentucky

10. NAME OF FATHER

J. J. Hackworth

11. BIRTHPLACE OF FATHER

(State or Country)

Ky.

12. MAIDEN NAME OF MOTHER

Allen

13. BIRTHPLACE OF MOTHER

(State or Country)

Ky.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Geo. H. Hackworth

(Address)

406 W. Corson

15.

Filed

Feb 22 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 21 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 21 1922 to Feb 21 1922

that I last saw him alive on Feb 21 1922

and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Flu pneumonia

(Duration) Yrs. mos. 7 ds.

Contributory (Secondary) old age

(Duration) yrs. mos. ds.

(Signed) Geo. H. Hackworth M. D.

3/22/22 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. 3 mos. days. In the State yrs. 3 mos. days

Where was disease contracted if not at place of death?

Former or usual residence Missouri

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Mt View Am Pocatello Feb 22 1922

20. UNDERTAKER

ADDRESS

H. L. McHann Pocatello

CERTIFICATE OF DEATH

State of Idaho
37140 BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Blain Registration District No. 28
City of Pocatello (Registration District No. 2161)
1106 N. Harrison St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Doris Muna DuttonFile No. 48
Registered No. 3770

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH

Sept 17 1915
(Month) (Day) (Year)

7. AGE

6 Yrs. 5 Mos. 5 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Schoolgirl
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Blain Co

10. NAME OF FATHER

J. C. Dutton

11. BIRTHPLACE OF FATHER

(State or Country) Pocatello

12. MAIDEN NAME OF MOTHER

Florence Bailey

13. BIRTHPLACE OF MOTHER

(State or Country) Ogden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. C. Dutton(Address) 1106 N. Harrison

15. Filed

7/22 1922 J. Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 22 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Feb 11 1922 to Feb 22 1922 that I last saw him alive on Feb 21 1922 and that death occurred on the date stated above, at 7:15 A.M.

The CAUSE OF DEATH* was as follows:

myocarditis(Duration) Yrs. mos. 10 ds.Contributory (Secondary) Deplethuria(Duration) yrs. mos. 1 ds.(Signed) Asm. Newton M. D.7/22 1922 (Address) 1106 N. Harrison

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Blain Co DATE OF BURIAL 7/23 192220. UNDERTAKER J. C. Dutton ADDRESS Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A-25 M. 1-19.

CERTIFICATE OF DEATH

37141

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Power.*City of *Pauline.*Registration District No. *28*Primary Registration District No. *2101*

(No. St.)

File No. *48*Registered No. *3771*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Emma Lusk.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED
(Write the word.)*Female. white.**married*

6. DATE OF BIRTH

Jan 29 1902
(Month) (Day) (Year)

7. AGE

*20 Yrs. 0 Mos. 26 ds.*IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Housewife.

10. NAME OF FATHER

J. R. Bailey

11. BIRTHPLACE OF FATHER

(State or Country)

Not Known

12. MAIDEN NAME OF MOTHER

Anna Kerr.

13. BIRTHPLACE OF MOTHER

(State or Country)

Wellsville Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

B. A. Burge.

(Address)

15.

Filed

7-25-1922

Local Registrar

16. DATE OF DEATH

Feb. 24 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *Feb 20 1922* to *Feb 24 1922*that I last saw her alive on *Feb 20 1922*and that death occurred on the date stated above, at *3:38* M.

The CAUSE OF DEATH* was as follows:

Influenza pneumonia(Duration) Yrs. mos. *7* ds.
Contributory (Secondary) *Influenza*(Duration) yrs. mos. *10* ds.
(Signed) *D. L. Hay* M. D.*7-25-1922* (Address) *Pocatello, Idaho.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Pauline Ida**Feb 24 1922*

20. UNDERTAKER

ADDRESS

*W. F. McHaw.**Pocatello Ida.*

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Bannock*
City of *Pocatello*Registration District No. *2837142*
Primary Registration District No. *2161*
(No. (St.)File No. *48*
Registered No. *3772*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Carlyle Hovey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*
(Write the word.)6. DATE OF BIRTH *Dec 28 1891*
(Month) (Day) (Year)7. AGE *30* Yrs. *1* Mos. *28* ds. IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).*Printer.*

9. BIRTHPLACE

(State or Country)

Barron Wis

10. NAME OF FATHER

Thomas Hovey

11. BIRTHPLACE OF FATHER

(State or Country)

Norway

12. MAIDEN NAME OF MOTHER

Eliza A Babcock

13. BIRTHPLACE OF MOTHER

(State or Country)

Baldwin Wis

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Thomas Hovey
Eugene Oregon

15.

Filed

2/25 - 22

19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb. 24 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 26 1922 to *Feb 24 1922*
that I last saw him alive on *Feb 24 1922*
and that death occurred on the date stated above, at *8:30 P.M.*

The CAUSE OF DEATH* was as follows:

Septic Pneumonia
Erysipelas(Duration) Yrs. mos. *29* ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *E. J. Hovey* M. D.19..... (Address) *Pocatello, Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

19.....

20. UNDERTAKER

ADDRESS

W. F. M. Han *Pocatello, Ida.*

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

37143

1. PLACE OF DEATH

County of

City of

Registration District No.

Primary Registration District No.

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1922

Local Registrar

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

Contributory (Secondary)

(Signed)

M. D.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

37144

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Bannock*City of *Pocatello*Registration District No. *26-*Primary Registration District No. *2191*

(No.)

File No. *46*Registered No. *3774*If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

*Katherine Roach*If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OF RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

6. DATE OF BIRTH

May 15 1833

(Month)

(Day)

(Year)

7. AGE

88 9 10

Yrs.

Mos.

ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)*Retired*

9. BIRTHPLACE

(State or Country)

*New York*10. NAME OF
FATHER*Gatrick J. Fagen*11. BIRTHPLACE
OF FATHER

(State or Country)

*New York*12. MAIDEN NAME
OF MOTHER*Mary Hughes*13. BIRTHPLACE
OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

K. J. Roach

(Address)

155 N. 9th

15.

Filed

7-27 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 25 1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 10 1922 to *Feb 25 1922*that I last saw her alive on *Feb 20 1922*

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Pyonephrosis(Duration) *7 Yrs 4 mos 10* ds.Contributory *Uterine inversion*

(Secondary)

(Duration) *1 yrs 10 mos 16* ds.

(Signed)

H. C. Castle M. D.(Address) *Pocatello Idaho**State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs mos days In the State yrs mos days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

Mountain View *Feb 27 1922*
Chuncker Hall *Pocatello*

CERTIFICATE OF DEATH

37145

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock
City of Pocatello

Registration District No. _____

Primary Registration District No. _____

(No. 340 - 10 Fifth St.)

File No. _____

Registered No. 3775

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Julia Charlotte Cannon

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDSingle
(Write the word.)

6. DATE OF BIRTH

March 13 1907
(Month) (Day) (Year)

7. AGE

14 Yrs. 11 Mos. 13 da.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)at school

9. BIRTHPLACE

(State or Country) Pocatello Idaho

10. NAME OF FATHER

Carl J. Cannon

11. BIRTHPLACE OF FATHER

(State or Country) Sweden

12. MAIDEN NAME OF MOTHER

May Williams

13. BIRTHPLACE OF MOTHER

(State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) May Cannon(Address) 340 10 Fifth

15.

Filed 7/28 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb. 26 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Jan. 20 1922 to Feb. 26 1922
that I last saw her alive on Feb. 25 1922
and that death occurred on the date stated above, at 3 A.M.

The CAUSE OF DEATH* was as follows:

Valvular (mitral) insufficiencyContributory
(Secondary)(Duration) _____ yrs. _____ mos. _____ ds.
Pulmonary edema
(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

W. J. Howard M. D.
7/28 1922 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (FOR Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Mountain View Bur.

DATE OF BURIAL

20. UNDERTAKER

Schumacher & Hall

ADDRESS

Pocatello

V CERTIFICATE OF DEATH

37146

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock
City of PocatelloRegistration District No. 28Primary Registration District No. 2161(No. 858- No Tenth St.)File No. 48Registered No. 3776

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Eliza M Bingham

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white5. SINGLE, MARRIED, WIDOWED OR DIVORCED
married
(Write the word.)

6. DATE OF BIRTH

June 24 1868
(Month) (Day) (Year)

7. AGE

53 Yrs. 8 Mos. 4 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Hooper Utah

10. NAME OF FATHER

Nelson Arns

11. BIRTHPLACE OF FATHER

(State or Country)

Canada

12. MAIDEN NAME OF MOTHER

Mary Ann Williams

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mar Bingham

(Address)

858- No Tenth

15.

Filed

7/28 22

19

Eliza M Bingham
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

February 28 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 26 1922 to Feb 26 1922
that I last saw her alive on Feb 26 1922
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Cerebro spinal syphilis(Duration) 1 Yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

W W Crothers M. D.Feb 28 1922 (Address) Pocatello, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Pocatello Idaho

19

20. UNDERTAKER

ADDRESS

Schumacher & Hall Pocatello

✓ CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of BannockCity of BancroftRegistration District No. 84Primary Registration District No. 2161

(No. _____ St.)

File No. 37147

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Thomas Ed Whitworth

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

MW

(Write the word.)

6. DATE OF BIRTH

Feb 4

(Month)

1922

(Day)

(Year)

7. AGE

Yrs.

Mos.

ds.

IF LESS than 1 day
how many 8 hrs.
or min. 7

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Bancroft Ida

10. NAME OF FATHER

John Whitworth

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Jennie Bennett

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed 3-1 1922W. F. Baeh
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 4

(Month)

1922

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 41922

to

19that I last saw h. 1M alive on Feb 4 1922.and that death occurred on the date stated above, at 8:30M.

The CAUSE OF DEATH* was as follows:

Blue baby (failure of closure foramen ovalae)

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Walter F. Baeh

M. D.

19 (Address) Bancroft

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Chesterfield

DATE OF BURIAL

2-6 1922

20. UNDERTAKER

ADDRESS

✓ CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

37148

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

Registration District No.

County of

Primary Registration District No.

City of

(No.)

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

male

white

single
(Write the word.)

6. DATE OF BIRTH

December 30 1905
(Month) (Day) (Year)

7. AGE

16 Yrs. 1 Mos. 14 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

At School

9. BIRTHPLACE

(State or Country)

Arino

10. NAME OF FATHER

D. H. Evans

11. BIRTHPLACE OF FATHER

(State or Country)

Arino

12. MAIDEN NAME OF MOTHER

Mary Coffin
Eckhoff Bushnell

13. BIRTHPLACE OF MOTHER

(State or Country)

Dunsmuir, Idaho
Butterfield City, Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

D. H. Evans
Lava Hot Springs

15.

Filed

3-1 1922 W. L. Beck

Local Registrar

16. DATE OF DEATH

February 13 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 31 1922 to Feb 13 1922
that I last saw him alive on Feb 13 1922

and that death occurred on the date stated above, at 3:50 P.M.

The CAUSE OF DEATH* was as follows:

Diphtheria

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Wilson J. McDell M. D.

Feb 13 1922

(Address) Lava Hot Springs

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lava Hot Springs Arino Feb 14 1922

20. UNDERTAKER

ADDRESS

Schumacher Hall Pocatello

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

✓ CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of Bannock

Primary Registration District No.

City of Town of Lund

(No., St.)

File No. 37149

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Erastus Snow Hansen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

maleWhitemarried
(Write the word.)

6. DATE OF BIRTH

Nov. 31 1865
(Month) (Day) (Year)

7. AGE

56 yrs. 2 mos. 26 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Hans Hansen

11. BIRTHPLACE OF FATHER

(State or Country)

Denmark

12. MAIDEN NAME OF MOTHER

Annie Hallen Morsager

13. BIRTHPLACE OF MOTHER

(State or Country)

Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. Geo. Kutter

(Address)

Lund Idaho

15.

Filed 3-11972W. B. Bach

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb. 26 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb. 18 1922 to 191

that I last saw h..... alive on..... 191

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Rheumatic Suburitis(Duration) 5 yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) W. B. Bach M. D.19..... (Address) Bannock

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

191

20. UNDERTAKER

ADDRESS

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **37150**

Registered No.

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

1. PLACE OF DEATH

Registration District No. **84**County of **Bannock**Primary Registration District No. **2161**City of **Bancroft**

(No. St.)

If death occurs away from
usual residence, give facts
called for under special in-
formation.2. FULL NAME **Jennie Bennett Whitworth**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W5. SINGLE, MARRIED, WID-
OWED OR DIVORCED**Married**

(Write the word.)

6. DATE OF BIRTH

Feb 21

(Month)

(Day)

1884

(Year)

7. AGE

38

Yrs.

Mos.

ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work**housewife**(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country) **Ogden Utah**10. NAME OF
FATHER**F.T. Bennett**11. BIRTHPLACE
OF FATHER(State or Country) **Utah**12. MAIDEN NAME
OF MOTHER**Elizebeth Williams**13. BIRTHPLACE
OF MOTHER(State or Country) **Utah**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed **3-1-** **19 22****Local Registrar**

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 4 1922

(Month)

(Day)

19

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 2**19 22****to Feb 4****19 22**that I last saw h. er alive on **Feb 4** **19 22**

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Acute interstitial Nephritis(Duration) Yrs. **3** mos. ds.Contributory **Childbirth**

(Secondary)

(Duration) yrs. mos. ds.

(Signed) **Walter S. Paul** M. D.**2-4 19 22** (Address) **Bancroft***State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Chesterfield

DATE OF BURIAL

Feb 6 19 22

20. UNDERTAKER

ADDRESS

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
 County of Bear Lake Registration District No.
 City of St Charles Primary Registration District No. 55
 (No. St.)

If death occurs away from
 usual residence, give facts
 called for under special in-
 formation.

2. FULL NAME

Anna Olsen

File No. 37152
 Registered No.

If death occurred in a hos-
 pital, institution or camp,
 give its NAME instead of
 street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED married
 (Write the word.)

6. DATE OF BIRTH Dec 13 1898
 (Month) (Day) (Year)

7. AGE 13 Yrs. Mos. ds.
 IF LESS than 1 day
 how many hrs.
 or min. ?

8. OCCUPATION

(a) Trade, profession or
 particular kind of work
 (b) General nature of in-
 dustry, business or estab-
 lishment in which employ-
 ed (or employer)

House Wife

9. BIRTHPLACE

(State or Country)

St Charles Id

10. NAME OF FATHER

Ola Mattson

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME OF MOTHER

Josephine Anderson

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John Mattson

(Address)

St Charles

15.

Filed March 9 1922John Mattson
Local Registrar

16. DATE OF DEATH

Feb 17 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
 19....., to 19.....
 that I last saw him alive on 19.....
 and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Myocardial Regurgitation

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

R. D. Dutton

M. D.

19..... (Address) Paris Id

*State the Disease Causing Death; or in deaths from Violent Causes, state
 (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted
 if not at place of death?

Former or
 usual residence

19. PLACE OF BURIAL OR REMOVAL St Charles Id DATE OF BURIAL Feb 20 1922

20. UNDERTAKER

ADDRESS

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

APR 3 1922

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **37153**

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Bear Lake District No.
City of St. Charles Primary Registration District No. 53-
(No., St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ambrose Hibbert Boosh

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widowed
(Write the word.)

6. DATE OF BIRTH

March 21 1922
(Month) (Day) (Year)

7. AGE

65 Yrs. 11 Mos. 11 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Housewife.

9. BIRTHPLACE

(State or Country)

Cheshire, England

10. NAME OF FATHER

Thomas Hibbert

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Anne Rowland

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Sam Wilkes

(Address)

St. Charles, Ida.

15.

Filed March 28 1922John Mattson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 11 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
..... 19....., to 19.....

that I last saw him..... alive on..... 19.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) Yrs..... mos..... ds.

Contributory
(Secondary)Rheumatism

(Duration) Yrs..... mos..... ds.

(Signed)

J. P. Dutton

M. D.

19.....

(Address)

Paris, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Charles Id. March 14 1922

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

✓ CERTIFICATE OF DEATH.

1. PLACE OF DEATH **PECH** Registration District No. 46
County of Beneva Primary Registration District No. 2173
City of Plum (No. _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. **37154**Registered No. 3

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Irwin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH.

7 14 1864
(Month) (Day) (Year)

7. AGE

57 Yrs. 6 Mos. 13 ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

Farmer

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

William Irwin

11. BIRTHPLACE OF FATHER

(State or Country)

Ill.

12. MAIDEN NAME OF MOTHER

Sarah Jane Scott

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Geo. Irwin
Tekoa Wash.

15.

Filed

2/7

191

H. J. J. J.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb. 4 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to 191

that I last saw him alive on 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Heart failure

(Duration) Yrs. mos. ds.

Contributory Valvular leakage
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) John B. Gley M. D.

19. (Address) Tekoa Wash.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Golden R.d.2-7 1922

20. UNDERTAKER

ADDRESS

C. L. SchulerudTekoa Wash.

✓ CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **37155**
Registered No. **35**

1. PLACE OF DEATH

County of **Bingham**
City of **Blackfoot**Registration District No. **191**
Primary Registration District No. **2194**
No. _____ St. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Johannus Cornelis Van Seters

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED**Male** **White** **Single**
(Write the words.)

6. DATE OF BIRTH

Apr 16 1908
(Month) (Day) (Year)

7. AGE

13 Yrs. **9** Mos. **16** ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).**At school**

9. BIRTHPLACE

(State or Country)

Rotterdam Holland

10. NAME OF FATHER

Marinus Van Seters

11. BIRTHPLACE OF FATHER

(State or Country)

Holland

12. MAIDEN NAME OF MOTHER

Eva Adelaar

13. BIRTHPLACE OF MOTHER

(State or Country)

Holland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Marinus Van Seters**
(Address) **R D # 1 Blackfoot**15. **Feb 3 1922**
Filed **Mr. Walter E. Feltner**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 20 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 30 1922 to Feb 2 1922
that I last saw him alive on **Feb 2 1922**and that death occurred on the date stated above, at **11:15** M.

The CAUSE OF DEATH* was as follows:

Peritonitis(Duration) Yrs. _____ mos. **4** ds.Contributory
(Secondary)

(Duration) yrs. _____ mos. _____ ds.

(Signed)

F. W. Mitchell M. D.**4/3 1922** (Address) **Blackfoot Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL **Croveland Cem** DATE OF BURIAL **2-4 1922**20. UNDERTAKER **E. L. Eagle** ADDRESS **Blackfoot**

✓ CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bingham
City of Shelley, IdahoRegistration District No. 121
Primary Registration District No. 2194
(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Wm BowlerFile No. 37156
Registered No. 36

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH

Oct 1 1859
(Month) (Day) (Year)

7. AGE

62 Yrs. 4 Mos. 10 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Garitor

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

Benj. Bowler

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Martha Belton

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Joseph Bowler
Shelley, Ida

15.

Filed Feb. 11 1922Mrs. Mabel C. Palmer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 10 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from 2/6 - 1922 to 2/10 1922that I last saw him alive on 2-10- 1922
and that death occurred on the date stated above, at 6 A M.

The CAUSE OF DEATH* was as follows:

Respiratory obstruction
without specific
diagnosis(Duration) _____ Yrs. _____ mos. 4 ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Edwin Luther M. D.2/11/1922 (Address) Shelley, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Shelley Idaho

DATE OF BURIAL

2-11 1922

20. UNDERTAKER

B. B. Llewellyn

ADDRESS

Idaho Falls, Id.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Bingham*
City of *Blackfoot*Registration District No. *121*Primary Registration District No. *2194*(No. *Idaho* *Susane* *Asylum*)File No. *37157*Registered No. *37157*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Andrew Oyler

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

*Caucasian*5. SINGLE, MARRIED, WIDOWED OR DIVORCED
widower
(Write the word.)

6. DATE OF BIRTH

about 1831

(Month)

(Day)

1

(Year)

7. AGE

70-odd

Yrs.

Mos.

ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Newville, Pa.

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

taken from Asylum records
(Informant) *Martha E. High*(Address) *Blackfoot, Idaho*

15.

*Feb. 16 1922**Ms. Thelma E. Pater*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

2
(Month)*15*
(Day)*1922*
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

*Feb. 9, 1922 to Feb. 15, 1922*that I last saw him alive on *Feb. 15, 1922*and that death occurred on the date stated above, at *1:15 P.M.*

The CAUSE OF DEATH* was as follows:

Senile decay

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

F. W. Mitchell

M. D.

Feb. 15 1922

(Address)

Blackfoot, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... Yrs. *4* mos. *24* days. In the State *25* Yrs. mos. daysWhere was disease contracted if not at place of death? *Not Known*Former or usual residence *Challis, Idaho*

19. PLACE OF BURIAL OR REMOVAL

Green City cemetery

DATE OF BURIAL

2.17.1922

20. UNDERTAKER

E. J. Park

ADDRESS

*Blackfoot**Idaho*

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of BinghamCity of BlackfootRegistration District No. 127Primary Registration District No. 1007

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Agatha CarsonState of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

37138

File No. _____

Registered No. 38

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widow (the word.)

6. DATE OF BIRTH

March 30th 1848
(Month) (Day) (Year)

7. AGE

73 Yrs. 10 Mos. 18 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country) England

10. NAME OF FATHER

David Morgan

11. BIRTHPLACE OF FATHER

(State or Country) England

12. MAIDEN NAME OF MOTHER

Hannah Tanner

13. BIRTHPLACE OF MOTHER

(State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James E. Carson(Address) Blackfoot, Ida.

15.

Filed Feb. 20 1922 Mrs. Hattie E. Carson

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

February 18th 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 1st 1921, to Feb 18 1922
that I last saw him alive on Feb 18 1922
and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of pelvic organs.(Duration) Yrs. 5 mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) W. C. Hamplinger D.2/20/1922 (Address) Blackfoot, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Iona, IdahoFeb 21 1922

20. UNDERTAKER

E. L. Eagle

ADDRESS

Blackfoot.

✓ CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **37159**Registered No. **37**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

Registration District No. **121**County of **Bingham**Primary Registration District No. **1007**City of **Blackfoot**(No. **704 North Shilling** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Ada Opal Latham**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

(Write the word.)

6. DATE OF BIRTH

January

(Month)

27th

(Day)

1922

(Year)

7. AGE

30

Yrs.

Mos.

ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Nane

(b) General nature of industry, business or establishment in which employed (or employer)

Blackfoot

9. BIRTHPLACE

(State or Country)

Blackfoot, Idaho

10. NAME OF FATHER

Archibald W. Latham

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Lydia S. Johnson

13. BIRTHPLACE OF MOTHER

(State or Country)

South Dakota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A W Latham

(Address)

Blackfoot, Idaho

15.

Filed **Feb. 25** 1922 **Mrs Helen E. Latham**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

February

(Month)

25

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 24**1922**to **Feb 25****1922**that I last saw her alive on **Feb. 24** 1922and that death occurred on the date stated above, at **9:15** M.

The CAUSE OF DEATH* was as follows:

Pneumo - Pneumonia(Duration) Yrs. mos. **2** ds.Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

W. E. Parie

M. D.

1922

(Address)

Blackfoot Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Grove City Cemetery

DATE OF BURIAL

2/26 1922

ADDRESS

Blackfoot.

FORM V. S. No. 5-25 M. 1-19.

✓ CERTIFICATE OF DEATH

37161

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Bingham*
City of *Abodeen*Registration District No. *116*Primary Registration District No. *2195*(No. *1*)

St.)

File No. *4*Registered No. *68*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Sara Turner

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED*Female white widowed*
(Write the word.)

6. DATE OF BIRTH

May 3 1838
(Month) (Day) (Year)

7. AGE

83 Yrs. *9* Mos. *8* ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).*Housewife*

9. BIRTHPLACE

(State or Country)

Tennessee

10. NAME OF FATHER

Jay

11. BIRTHPLACE OF FATHER

(State or Country)

Tennessee

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John Burkner
Abodeen Ida

(Address)

15.

Filed

Feb 13 22
McMurtre

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 11 22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 1 22 to *Feb 11 22*
that I last saw him alive on *Feb 4 19 22*
and that death occurred on the date stated above, at *7:15 P.*

The CAUSE OF DEATH* was as follows:

old age

(Duration) Yrs. mos. ds.

Contributory
(Secondary)*Pneumonia*

(Duration) Yrs. mos. ds.

(Signed)

W. H. McMurtre M. D.*13 22* (Address) *Abodeen Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

9.0.27
*Abodeen**Feb 13 19 22*

20. UNDERTAKER

ADDRESS

R. W. Lenthwaite
Abodeen Ida

CERTIFICATE OF DEATH

37162

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bingham
City of StirlingRegistration District No. 116Primary Registration District No. 2155

(No. _____ St.)

File No. 4Registered No. 67If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Barbara Cleone GoughIf death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDFemale white Single
(Write the word.)

6. DATE OF BIRTH

Jan 19 1922
(Month) (Day) (Year)

7. AGE

21 ds.
Yrs. Mos. ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho10. NAME OF
FATHERJohn C Gough11. BIRTHPLACE
OF FATHER

(State or Country)

Utah12. MAIDEN NAME
OF MOTHERMelinda Robinson13. BIRTHPLACE
OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. C. Gough
Stirling, Ida15. Feb 9 1922 Mcmenamin
Filed 19 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 9 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
Feb 6 1922 to Feb 9 1922
that I last saw h. he alive on Feb 9 1922
and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Myocardial infarction(Duration) Yrs. mos. 2 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Mcmenamin M. D.Feb 9 1922 (Address) Stirling, Ida*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Yuma, Ida

DATE OF BURIAL

Feb 11 1922

20. UNDERTAKER

Friends

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH
in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Blaine*Registration District No. *57*
Primary Registration District No. *2022*File No. *37163*City of *Harley*

(No.)

St.)

Registered No. *5*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Betty Jane Salisbury

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

wht.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

Jan. 81 1922
(Month) (Day) (Year)

7. AGE

Yrs. Mos. *26 hrs.*IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Harley

10. NAME OF FATHER

Harry Salisbury

11. BIRTHPLACE OF FATHER

(State or Country)

Michigan

12. MAIDEN NAME OF MOTHER

Anabel Thudyard

13. BIRTHPLACE OF MOTHER

(State or Country)

Michigan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Harry Salisbury(Address) *Harley, Ida.*

15.

Filed *2-1 1922**R. H. Wright*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb. 1 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 31 1922 to Feb 1 1922
that I last saw her alive on *Feb 1 1922*
and that death occurred on the date stated above, at *3 P.M.*

The CAUSE OF DEATH* was as follows:

Chniation

(Duration) Yrs. mos. ds.

Contributory
(Secondary)*Cough & Pneumonia*

(Duration) yrs. mos. ds.

(Signed)

2/1 1922 (Address) *Harley, Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Harley, Ida.

DATE OF BURIAL

2/2 1922

20. UNDERTAKER

Ralph Harris

ADDRESS

Harley, Ida.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **37164**
Registered No. **6**

1. PLACE OF DEATH

County of **Blaine**City of **Hailey**Registration District No. **57**Primary Registration District No. **2022**(No. **1522**)

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary Ann Walker

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

in house
(Write the word.)

6. DATE OF BIRTH

July

(Month)

11

(Day)

1844

(Year)

7. AGE

77 Yrs. **6** Mos. **28** ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

Housewife

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

Thomas Gavin

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Sarah Gavin

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. T. E. Kittsmiller
(Address) **Hailey, Idaho**

15.

Filed **2-15****1922****1922****R. H. Wright**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Plummer
Feb **9** **1922**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 10, 1922, to **Feb 9, 1922**,
that I last saw h. **OK** alive on **2** **7** **1922**,
and that death occurred on the date stated above, at **7:30** M.
The CAUSE OF DEATH* was as follows:
Arteriosclerosis

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Hailey, Idaho

DATE OF BURIAL

Feb. 12, 1922

20. UNDERTAKER

R. H. Harris

ADDRESS

Hailey

1. PLACE OF DEATH

County of Blaine Registration District No. 57
 City of Hailey Primary Registration District No. 2022
 (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John H. Mizer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

Jan 19 1. 88
 (Month) (Day) (Year)

7. AGE

41 Yrs. 18 ds. IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

Sawmill Operator

9. BIRTHPLACE

(State or Country)

Kansas

10. NAME OF FATHER

Thos. Mizer

11. BIRTHPLACE OF FATHER

(State or Country)

Indiana

12. MAIDEN NAME OF MOTHER

Ann Caldwell

13. BIRTHPLACE OF MOTHER

(State or Country)

Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. John Mizer
Hailey, Idaho

(Address)

15.

2-8 19 22 R. H. Wright

Local Registrar

✓ CERTIFICATE OF DEATH

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 37165

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

Wright,

16. DATE OF DEATH

Feb 6 19 22
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug. 15 19 21, to Feb-6 19 22
 that I last saw him alive on Feb 6 19 22
 and that death occurred on the date stated above, at 99 M.

The CAUSE OF DEATH* was as follows:

Bright's Disease

(Duration) Yrs. mos. ds.

Contributory
 (Secondary)

(Duration) yrs. mos. ds.

(Signed) Robert H. Wright M. D.
2/7 19 22 (Address) Hailey, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Hailey, Ida 2-8 19 22

20. UNDERTAKER

R. D. Harris Hailey

✓ CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

37166

1. PLACE OF DEATH *Blaine*
 County of *Blaine* Registration District No. *57*
 City of *Hailey* Primary Registration District No. *2022*
 (No. St.)

File No. *37166*
 Registered No. *8*

If death occurs away from
 usual residence, give facts
 called for under special in-
 formation.

If death occurred in a hos-
 pital, institution or camp,
 give its NAME instead of
 street and number.

2. FULL NAME *Charles Samuel Goldesberry*

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED
 (Write the word.)

6. DATE OF BIRTH *Feb. 24 1922*
 (Month) (Day) (Year)

7. AGE *✓* Yrs. *✓* Mos. *2* ds. IF LESS than 1 day
 how many hrs. or min.?

8. OCCUPATION
 (a) Trade, profession or
 particular kind of work. *✓*
 (b) General nature of in-
 dustry, business or estab-
 lishment in which employ-
 ed (or employer).

9. BIRTHPLACE *Hailey, Idaho*
 (State or Country)

10. NAME OF FATHER *Charles S. Goldesberry*

11. BIRTHPLACE OF FATHER *Colorado*
 (State or Country)

12. MAIDEN NAME OF MOTHER *Emily Dougherty*

13. BIRTHPLACE OF MOTHER *Missouri*
 (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *E. M. L. Dougherty*
 (Address) *Hailey, Idaho*

15. Filed *3-10 1922* *R. H. Wright*
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Brook.
Feb. 26 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Feb. 24 1922, to *Feb. 26 1922*,
 that I last saw ~~hear~~ alive on *Feb. 26 1922*,
 and that death occurred on the date stated above, at *4:30 AM*.

The CAUSE OF DEATH* was as follows:

Atelectasis Pulmonum
congenital

(Duration) Yrs. mos. *7* ds.

Contributory (Secondary)

(Duration) yrs. mos. *2* ds.

(Signed) *L. J. Brock* M. D.

3/10 1922 (Address) *Hailey, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state
 (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
 Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
 if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Hailey, Idaho *Feb 27 1922*

20. UNDERTAKER ADDRESS

J. J. Davis *Hailey*

✓ CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bonner Registration District No. 78
City of Sandpoint Primary Registration District No. 2155
(No. 310 S. St. Clair St.)If death occurs away from
usual residence, give facts
called for under special in-
formation.File No. 37167

Registered No. _____

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

2. FULL NAME

Cordelia Hansen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F.

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDWidowed

(Write the word.)

6. DATE OF BIRTH

Feb.21844

(Month)

(Day)

(Year)

7. AGE

78

Yrs.

Mos.

18

ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of workAt. Home(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country)

Wis10. NAME OF
FATHERArnold Burgas11. BIRTHPLACE
OF FATHER

(State or Country)

Unknown12. MAIDEN NAME
OF MOTHERJane Porter13. BIRTHPLACE
OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Minnie McKay,
Lee, Mont.

(Address)

15.

Filed March 6 1922Floyd Wendle
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb.2019 22

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb. 12 1922 to Feb. 20 1922that I last saw her alive on Feb. 18 1922and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Valerian heart disease(Duration) ? Yrs. mos. ds.Contributory
(Secondary)gastro-intestinal hemorrhage

(Duration) yrs. mos. ds.

(Signed)

M. S. Wallentin M. D.2-22-1922 (Address) Sandpoint, Ida.*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Sandpoint, Ida.

DATE OF BURIAL

2/22 1922

20. UNDERTAKER

B. H. Pugh, Sandpoint, Ida.

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH
in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **37168**

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH *Not stated*
 County of *Boyer* Registration District No. *78*
 City of *Kootenai* Primary Registration District No. *2155*
 (No. *Kootenai* - *Idaho* - *Idaho* St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Eva Smith*

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *F* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED *Single*
 (Write the word.)

6. DATE OF BIRTH

March 3rd 1899
 (Month) (Day) (Year)

7. AGE

23 Yrs. Mos. ds. IF LESS than 1 day
 how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

At Home

9. BIRTHPLACE

(State or Country)

Washington

10. NAME OF FATHER

Morton Smith

11. BIRTHPLACE OF FATHER

(State or Country)

Ind.

12. MAIDEN NAME OF MOTHER

Melinda Colyar

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Morton Smith
Kootenai Ida.

15.

Filed

March 6 1922
Floyd Weadell
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb. 10 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Dec-15 1922* to *Feb. 10 1922*, that I last saw her alive on *Feb 5 1922* and that death occurred on the date stated above, at *5 P.M.*

The CAUSE OF DEATH* was as follows:

pulmonary tuberculosis(Duration) *1 Yrs. 6 mos.* ds.Contributory
(Secondary)(Duration) *yrs.* mos. ds.

(Signed)

H. R. W. Allen, M.D.
Sanapoint, Ida.

*State the Disease Causing Death; or in Deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death *yrs.* *mos.* *days.* In the State *yrs.* *mos.* *days*

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Sprague, Wash.**19*

20. UNDERTAKER

ADDRESS

B. H. Pugh, Sanapoint, Ida.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

✓ CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Banner*
City of *Sandpoint*Registration District No. *78*Primary Registration District No. *2155*(No. *507 S. Marion* St.)File No. *37170*

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Yvonne Thompson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F.

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

(Write the word.)

6. DATE OF BIRTH

July *4* *1921*
(Month) (Day) (Year)

7. AGE

7 Yrs. *13* Mos. *13* ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) *Idaho.*

10. NAME OF FATHER

Lester Thompson

11. BIRTHPLACE OF FATHER

(State or Country) *Mont.*

12. MAIDEN NAME OF MOTHER

Pearl Finley

13. BIRTHPLACE OF MOTHER

(State or Country) *Mont.*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mrs. Lester Thompson*(Address) *Sandpoint, Ida.*

15.

Filed *March 6* *1922* *Floyd Wendle*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb. *17* *1922*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

2-15 *1922* to *2-17* *1922*that I last saw her alive on *2-16* *1922*and that death occurred on the date stated above, at *6 A.* M.

The CAUSE OF DEATH* was as follows:

broncho-pneumonia(Duration) _____ Yrs. _____ mos. *5* ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) *L. P. Macmillan* M. D.*2-22* *1922* (Address) *Sandpoint, Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Sandpoint, Ida.

DATE OF BURIAL

2/18 *1922*

20. UNDERTAKER

B. H. Pugh, Sandpoint, Ida.

ADDRESS

1. PLACE OF DEATH

Registration District No. 85

County of Bonner

Primary Registration District No. 2185

City of Priest River,

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Douglas Ray Woodley

File No.

Registered No. 36

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

(Write the word.)

6. DATE OF BIRTH

Feb. 15 1922
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day

how many 17 hrs.

or min.?

Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work.

None

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Idaho.

10. NAME OF FATHER

William Woodley

11. BIRTHPLACE OF FATHER

(State or Country) Canada

12. MAIDEN NAME OF MOTHER

Ethel Haggard

13. BIRTHPLACE OF MOTHER

(State or Country) Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Priest River, Ida,

15.

Filed

Mar 11 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb. 15 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb. 14 1922 to Feb. 15 1922

that I last saw him alive on Feb. 15 1922

and that death occurred on the date stated above, at 12:30 P.M.

The CAUSE OF DEATH* was as follows:

Blue Baby.

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

Feb. 15 1922 (Address) Priest River, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Buried

DATE OF BURIAL

Feb. 17 1922

20. UNDERTAKER

F. W. Woodley

ADDRESS

F. W. Woodley

1. PLACE OF DEATH

County of BonnerRegistration District No. 85City of Priest River, IdahoPrimary Registration District No. 2185File No. 2Registered No. 53

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary H. Overacker

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widowed

(Write the word.)

6. DATE OF BIRTH

Aug 27 1848
(Month) (Day) (Year)

7. AGE

73 Yrs. 5 Mos. 23 ds.

IF LESS than 1 day

how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Housekeeper

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Mich.

10. NAME OF FATHER

Ransom French

11. BIRTHPLACE OF FATHER

(State or Country)

Mich.

12. MAIDEN NAME OF MOTHER

Rebecca -----

13. BIRTHPLACE OF MOTHER

(State or Country)

not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address) Priest River, Ida.

15.

Filed March 1 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb. 22 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb. 1 1922 to Feb. 22 1922that I last saw her alive on Feb. 18 1922and that death occurred on the date stated above, at P.M.

The CAUSE OF DEATH* was as follows:

Chronic Valvular heart Disease

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

M. D.

Feb 23 1922 (Address) Priest River, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Priest River, Ida.

DATE OF BURIAL

Feb 24 1922

20. UNDERTAKER

Wm Davis

ADDRESS

Newport WN.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

MAR 20 1922 CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

37173

File No.

Registered No. 19

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Bonneville Registration District No. 73
City of Ucon (No. near Ucon, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Nanua, Peterson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female white

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Nov. 2 1921
(Month) (Day) (Year)

7. AGE

3 Yrs. 16 Mos. 16 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

no.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Ucon.

10. NAME OF FATHER

Joseph W. Peterson

11. BIRTHPLACE OF FATHER

(State or Country) Utah

12. MAIDEN NAME OF MOTHER

Ella Selcock

13. BIRTHPLACE OF MOTHER

(State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joseph W. Peterson(Address) Ucon.

15.

Filed Feb. 18 1922 Ucon
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb. 18 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

..... 19....., to 19.....
that I last saw him alive on 18th Feb 1922
and that death occurred on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:

gout feverExposure

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) W. E. Kettinger M.D.19..... (Address) globe fall

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Grant

DATE OF BURIAL

Feb. 20 1922

20. UNDERTAKER

Chas. H. Hume

ADDRESS

Idaho Falls

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 73
County of Bonneville Primary Registration District No. 214-0
City of Idaho Falls (No. People's Shop St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Earl, GillianFile No. _____
Registered No. 18

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH

July 4 1891
(Month) (Day) (Year)

7. AGE

31 Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)Rancher.

9. BIRTHPLACE

(State or Country)

Ohio.

10. NAME OF FATHER

Hugh Gillian

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio.

12. MAIDEN NAME OF MOTHER

Don't know.

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Maurell Gillian
(Address) Stockton, Id.

15.

Filed 2/1 19 22 W. J. J. J.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 27 22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 25 22 to Jan 27 22
that I last saw him alive on Jan 27 1922and that death occurred on the date stated above, at 1270 M.

The CAUSE OF DEATH* was as follows:

General Septicemia(Duration) Yrs. mos. 3 ds.Contributory (Secondary) Ruptured appendix
strangulated bowels.(Duration) Yrs. mos. 5 ds.(Signed) H. J. J. J. M. D.19 (Address) Idaho Falls, Id.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Idaho Falls, Id. 19 22

20. UNDERTAKER

Hayes ADDRESS Idaho Falls

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Bonneville*
City of *Idaho Falls*Registration District No. *13*
Primary Registration District No. *211-0*
(No. *Spencer* St.)File No. *37175*
Registered No. *17*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Heena. Kuen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*
(Write the word.)6. DATE OF BIRTH *March 22, 1894*
(Month) (Day) (Year)7. AGE *28* Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)*House wife*

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

August Jaeger

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Don't know

13. BIRTHPLACE OF MOTHER

(State or Country)

''

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. J. Kuen
*Idaho Falls*15. Filed *2/1* 19 *22* *W. Kuen*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 24, 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *1-17-1922* to *1-24-1922*that I last saw her alive on *1-24-1922* and that death occurred on the date stated above, at *5 P.M.*

The CAUSE OF DEATH* was as follows:

Perforated Peritonitis

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed)

J. J. Kuen, M. D.

19

(Address) *Idaho Falls*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL (DATE OF BURIAL)

Rose Hill Idaho Falls Jan 27, 1922

20. UNDERTAKER

ADDRESS

W. Kuen *Idaho Falls**160 Hollister*

✓ CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock
City of Idaho FallsRegistration District No. 73Primary Registration District No. 211-0

(No. _____ St.)

File No. 37176Registered No. 16

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Eliza M. Blatter

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female White

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widow
(Write the word.)

6. DATE OF BIRTH

March 15 1842
(Month) (Day) (Year)

7. AGE

79 Yrs. 10 Mos. 11 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

at Home

9. BIRTHPLACE

(State or Country)

Ill

10. NAME OF FATHER

John Weber

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Catherine Bowman

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Gottlieb Blatter

(Address)

R.D. 3 Idaho Falls

15.

Filed 2/219 22W. M. Mullan

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

January 26 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov. 13, 1921, to Jan. 26, 1922
that I last saw him Dec. 13, 1921 alive onand that death occurred on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:

Chronic nephritis(Duration) Indefinite yrs. mos. ds.Contributory (Secondary) Chronic endocarditis(Duration) Indefinite yrs. mos. ds.(Signed) John C. Mullan, M.D.1-28-22 (Address) Idaho Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Armon, Ida

DATE OF BURIAL

1-29-22

20. UNDERTAKER

Edmund Woodley

ADDRESS

Idaho FallsJ. C. Mullan

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Boiseville*
City of *Idaho Falls*Registration District No. *73*Primary Registration District No. *215-0*(No. *3* St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Gloria M. Silcox*State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *37177*Registered No. *10*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

May 20 1921
(Month) (Day) (Year)

7. AGE

7 19
Yrs. Mos. ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Mark Silcox

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Edith Maughan

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mark Silcox

(Address)

Idaho Falls

15.

Filed

2/1

19

*22**Clayton*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 9 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

*Jan 3 1922 to Jan 9 1922*that I last saw him alive on *Jan 7 1922*and that death occurred on the date stated above, at *12 A.M.*

The CAUSE OF DEATH* was as follows:

Cerebral-Spinal meningitis of the diplococcus type(Duration) Yrs. mos. *6* ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) *H. Ray Hutchins* D.19 (Address) *Idaho Falls*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Idaho Falls

DATE OF BURIAL

1-11 1922

20. UNDERTAKER

Edwin Woodley

ADDRESS

Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RE

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **37178**Registered No. **17**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Bannock
City of Idaho FallsRegistration District No. 73Primary Registration District No. 2100

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Sebastian Schmalzgruber

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

married
(Write the word.)

6. DATE OF BIRTH

Aug 28 1868
(Month) (Day) (Year)

7. AGE

53 Yrs. 5 Mos. 0 ds.

IF LESS than 1 day

how many..... hrs
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

Carpenter

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

?

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

?

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mike Schmalzgruber

(Address)

Idaho Falls

15.

Filed

2/3

19

22 W. J. Schmalzgruber
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 27 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY That I attended deceased from

Jan 26 1922 to Jan 27 1922that I last saw him alive on Jan 27 1922and that death occurred on the date stated above, at 50 M.

The CAUSE OF DEATH was as follows:

Ischemic and
myocardial

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) A. P. Schmalzgruber M. D.1-78 1922 (Address) Idaho Falls Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Idaho Falls

DATE OF BURIAL

1-30 1922

20. UNDERTAKER

B. B. Schmalzgruber

ADDRESS

Idaho Falls

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **37180**

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of BoundaryCity of Bonners Ferry

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No. 5156

(No. St.)

2. FULL NAME

Richard Clinton Erritt

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Infant
(Write the word.)

6. DATE OF BIRTH

Dec61920

(Month)

(Day)

(Year)

7. AGE

Yrs. 14Mos. 5

ds.

IF LESS than 1 day

how many hrs.

or min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

William R. Erritt

11. BIRTHPLACE OF FATHER

(State or Country)

Wisc.

12. MAIDEN NAME OF MOTHER

Sarah Alice Holston

13. BIRTHPLACE OF MOTHER

(State or Country)

Minn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wm R. Erritt

(Address)

15.

Filed

Feb. 11 1922ES Fry
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb

(Month)

11

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan. 29 1922 to Feb. 11 1922that I last saw him alive on Feb. 11 1922and that death occurred on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration)

Yrs.

mos. 14

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

R. B. Bowell

M. D.

4/11 1922 (Address) Bonners Ferry Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Bonners Ferry Ida

DATE OF BURIAL

2/13 1922

20. UNDERTAKER

Orl. L. L. L.

ADDRESS

Bonners Ferry

1. PLACE OF DEATH
County of *Boundary*
City of *Naples, Ida.*
If death occurs away from usual residence, give facts called for under special information.

CERTIFICATE OF DEATH

Registration District No. *29*
Primary Registration District No. *216*
(No. St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **37181**
Registered No.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

John William Mc Cellan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*
(Write the word.)

6. DATE OF BIRTH *Jan. 22nd 1850*
(Month) (Day) (Year)

7. AGE *72* Yrs. Mos. *18* ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

Joseph Mc Cellan

11. BIRTHPLACE OF FATHER

(State or Country)

Penn.

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. W. Mc Cellan
Naples Idaho

15.

Filed 191....

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *Feb. 11th 1922*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Feb. 1 1922* to *Feb. 11 1922* that I last saw him alive on *Feb. 2 1922* and that death occurred on the date stated above, at *4:15 P. M.*

The CAUSE OF DEATH* was as follows:

Cancer of stomach

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

R. B. Bowell

415 1922 (Address) *Boulevard Ferry Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days, State yrs. mos. days

Where was disease contracted

if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

St. Arthur, Ida.

DATE OF BURIAL

..... 191....

20. UNDERTAKER

D. O. O. F. Lodge

ADDRESS

St. Arthur, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

1. PLACE OF DEATH.

Registration District No. 79County of BoundaryPrimary Registration District No. 2186City of Bonners Ferry

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Richard C. RobinsonState of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37182

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Jan
(Month)26
(Day)1860
(Year)

7. AGE

102 yrs. 1 mos. 8 ds.IF LESS than 1 day
how many hrs. or
..... mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer.

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Oregon

10. NAME OF FATHER

Richard C. Robinson

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Sarah G. Petree

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

William A. Skell

(Address)

Bonners Ferry

15.

Filed

2/20/1932E. E. Fry
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb.
(Month)18th
(Day)1932
(Year)17. I HEREBY CERTIFY, That I attended deceased from Feb. 6th 1932, to Feb. 18th 1932.that I last saw him alive on Feb. 18th 1932.and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

fracture of the pelvis

(Duration) yrs. mos. ds.

Contributory
(Secondary)elephantiasis(Duration) yrs. mos. 5 ds.

(Signed)

E. E. Fry M. D.2/19/1932 (Address) Bonners Ferry, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death yrs. mos. days.

In the

State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Pilot Rock, Ore.1931

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **37183**
Registered No.

1. PLACE OF DEATH

County of Boundary
City of Boonville

Registration District No. 77
Primary Registration District No. 2156
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Isaac J. Smith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widowed
(Write the word.)

6. DATE OF BIRTH Oct 26 1850
(Month) (Day) (Year)

7. AGE 71 Yrs. 3 Mos. 23 ds. IF LESS than 1 day how many..... hrs. or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Farmer

9. BIRTHPLACE

(State or Country)

Canada

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Thompson Smith
Boonville

15.

Filed 2/20/ 1922

E. E. Sanyden
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 14 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

..... 19....., to 19.....
that I last saw h..... alive on..... 19.....
and that death occurred on the date stated above, at..... M.
The CAUSE OF DEATH* was as follows:

Cancer of the tongue.

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

E. E. Sanyden
Carone

19..... (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Glasgow Mont

DATE OF BURIAL

2/22 1922

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **37184**

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Butte
City of mooreRegistration District No. 59

Primary Registration District No. _____

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lydia Latham

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

widowed

6. DATE OF BIRTH.

-Mar.
(Month)23
(Day)1858
(Year)

7. AGE

-63 Yrs. 9 Mos. 29 ds.IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)Housewife

9. BIRTHPLACE

(State or Country) Glamorganshire

10. NAME OF FATHER

Shewellan Jones

11. BIRTHPLACE OF FATHER

(State or Country) Wales.

12. MAIDEN NAME OF MOTHER

Martha Griffiths

13. BIRTHPLACE OF MOTHER

(State or Country) Wales.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. H. E. Hansen(Address) M. Nampa

15.

Filed

2/16/22 F. M. Cannon

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb
(Month)13
(Day)1922
(Year)17. I HEREBY CERTIFY, That I attended deceased from Aug 6 1921, to Feb 9 1922that I last saw her alive on 2-9- 1922and that death occurred on the date stated above, at 1:30 A M.

The CAUSE OF DEATH* was as follows:

Cardiac Decompensation(Duration) 1 Yrs. 6 mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. Cannon M. D.2/16/22 (Address) Arco, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Moore Ida

DATE OF BURIAL

7/6/22

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED
MAY 5 1922

✓ CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 37185

Registered No.

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.1. PLACE OF DEATH *Blaine*
County of *Blaine* Registration District No. *58th*
Primary Registration District No. *2138*
City of *Blaine* (No. St.)If death occurs away from
usual residence, give facts
called for under special in-
formation.2. FULL NAME *Abellus Swingle*

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED *in arrears*
(Write the word.)6. DATE OF BIRTH *Feb 1 1850*
(Month) (Day) (Year)7. AGE *71* Yrs. *11* Mos. *1* ds.
IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work. *Farming.*
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country) *Pennsylvania*10. NAME OF
FATHER *Simon Swingle*11. BIRTHPLACE
OF FATHER *Pennsylvania*

(State or Country)

12. MAIDEN NAME
OF MOTHER *Unknown*13. BIRTHPLACE
OF MOTHER *Pennsylvania*

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *by C. Swingle*(Address) *Blaine*

15.

Filed *4-3 1922**L.W. Leuchter*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 29th 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

..... 19, to 19

that I last saw him alive on 19

and that death occurred on the date stated above, at *11 A.* M.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) Yrs. mos. ds.

Contributory
(Secondary)

..... (Duration) yrs. mos. ds.

(Signed) M. D.

..... 19, (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Shoshone, Idaho

DATE OF BURIAL

3.30.1922

20. UNDERTAKER

Brennan

ADDRESS

Shoshone, Idaho

✓ CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Camas*City of *Coral*

If death occurs away from usual residence, give facts called for under special formation.

Registration District No. *58th*Primary Registration District No. *2138*(No. *58th*)

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. *37186*

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Julia Lauretta Wilson

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

F

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Feb
(Month)*5th*
(Day)*1922*
(Year)

7. AGE

Yrs. Mos. *4* ds.IF LESS than 1 day
how many *17* hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Coral, Idaho

10. NAME OF FATHER

James Amos Wilson

11. BIRTHPLACE OF FATHER

(State or Country)

Missouri

12. MAIDEN NAME OF MOTHER

Luna Kunkel

13. BIRTHPLACE OF MOTHER

(State or Country)

Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. A. Wilson (by L.W.)

(Address)

Coral, Idaho

15.

Filed

*Mar 3 1922**L. W. Blenck*

Local Registrar

16. DATE OF DEATH

Feb
(Month)*10th*
(Day)*1922*
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19....., to

19.....

that I last saw him alive on 19.....

and that death occurred on the date stated above, at *1 A.* M.

The CAUSE OF DEATH* was as follows:

Unknown
(No physician in attendance)
(Duration) Yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

19..... (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Coral, Idaho

DATE OF BURIAL

Feb 11 1922

20. UNDERTAKER

ADDRESS

✓
CERTIFICATE OF DEATHState of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada Registration District No. 3
 City of Star Primary Registration District No. 2005
 (No. 1-1) St.

If death occurs away from
usual residence, give facts
called for under special in-
formation.

File No. 37187
 Registered No. 93

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

2. FULL NAME

Lloyd Wm Eisele

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH

June 14 1921
(Month) (Day) (Year)

7. AGE

8 Yrs. 26 Mos. 26 da. •
IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Wm H Eisele

11. BIRTHPLACE OF FATHER

(State or Country)

Kansas

12. MAIDEN NAME OF MOTHER

Lloyd L. Miller

13. BIRTHPLACE OF MOTHER

(State or Country)

Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

O. H. Eisele

(Address)

15.

Filed Mar. 11 - 1922 John L. Meyer
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 10 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 9 1922, to March 9 1922,
 that I last saw him alive on March 9 1922,
 and that death occurred on the date stated above, at 12 M.
 The CAUSE OF DEATH* was as follows:

Memoria

(Duration) Yrs. mos. 2 ds.

Contributory (Secondary) flu

(Duration) Yrs. mos. 2 ds.

(Signed) Dr. S. D. Dwyer M. D.

19 (Address) C

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL Canyon Hill DATE OF BURIAL 3-11-1922

20. UNDERTAKER Star Cemetery ADDRESS Paul L. Case Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
 N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH
 in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

March 9 -

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
37188

1. PLACE OF DEATH

County of CanyonRegistration District No. 3City of CalhounPrimary Registration District No. 2005(No. 100)

St.)

File No. 32Registered No. 32

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME May E. Reeper

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female Whitemarried
(Write the word.)

6. DATE OF BIRTH

Nov 5 1891
(Month) (Day) (Year)

7. AGE

30 Yrs. 4 Mos. 2 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Housewife

9. BIRTHPLACE

(State or Country)

Colorado

10. NAME OF FATHER

John Eckhart

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Hannah Boyer

13. BIRTHPLACE OF MOTHER

(State or Country)

Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Hannah M. Eckhart

(Address)

Calhoun Ida

15.

Filed Nov. 9 - 1922John H. Meyer
Local Registrar

16. DATE OF DEATH

Nov 7 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Mar 4 1922 to Mar 9 1922that I last saw her alive on Mar 7 1922

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Influenza Pneumonia(Duration) Yrs. mos. 3 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

38 1922

(Address)

Calhoun Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Canyon Hill 3-9 1922

20. UNDERTAKER

ADDRESS

Paul L. Case Calhoun

RECEIVED CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Canyon* City of *Houston*

If death occurs away from usual residence, give facts called for under special information.

Registration District No. *3* Primary Registration District No. *2005* St. *113* File No. *37189* Registered No. *37*

2. FULL NAME

 Terrell Pleasant McCubbin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

 male white

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

 married

6. DATE OF BIRTH

 April 21 1881
(Month) (Day) (Year)

7. AGE

 60 Yrs. 10 Mos. 16 ds. IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer). *Rancher*

9. BIRTHPLACE

(State or Country)

 Oregon

10. NAME OF FATHER

 Abraham McCubbin

11. BIRTHPLACE OF FATHER

(State or Country)

 Kentucky

12. MAIDEN NAME OF MOTHER

 Sarah Deen

13. BIRTHPLACE OF MOTHER

(State or Country)

 Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

 Charles McCubbin

(Address)

 Houston, Tex. #2

15. Filed

 May 8 1922 *J. H. Meyers*
Local Registrar

16. DATE OF DEATH

 March 7 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *March 2 1922* to *March 7 1922* that I last saw him alive on *March 7 1922* and that death occurred on the date stated above, at *22nd* M.

The CAUSE OF DEATH* was as follows:

 Chronic Interstitial Nephritis (Duration) *One* Yrs. mos. ds.

Contributory (Secondary)

 Influenza (Duration) *5* Yrs. mos. ds.

(Signed)

 B. R. Whittenburg, D.O. *March 8 1922* (Address) *Caldwell, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death *yrs. mos. days.* In the State *yrs. mos. days.*

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

 Lastine Oregon 3- 1922

20. UNDERTAKER

ADDRESS

 V. Pechham Caldwell

Cal.

RECEIVED

DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **37190**
Registered No. **30**

1. PLACE OF DEATH

County of *Canyon*City of *Caldwell*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Becky E. Calhoun

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

widow
(Write the word.)

6. DATE OF BIRTH

Feb. 18 1876
(Month) (Day) (Year)

7. AGE

*46 Yrs. 0 Mos. 18 ds.*IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)*Housewife.*

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

Henry Prowl

11. BIRTHPLACE OF FATHER

(State or Country)

Don't know.

12. MAIDEN NAME OF MOTHER

Eglie.

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

AJ Lyle
R.F.D # 2. Caldwell

15.

Filed

Mar. 5 - 1922 John H. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 6 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *Feb. 22 1922* to *March 6 1922*that I last saw him alive on *Feb. 22 1922*and that death occurred on the date stated above, at *3 P. M.*

The CAUSE OF DEATH* was as follows

Tuberculosis of lungs.(Duration) *3* Yrs..... mos..... ds.Contributory
(Secondary)

(Duration) yrs..... mos..... ds.

(Signed)

J. H. Lyle

M. D.

3/7 1922 (Address) *Caldwell, Idaho.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Pleasant Ridge

DATE OF BURIAL

3-8-1922

20. UNDERTAKER

C. W. Dickham

ADDRESS

Caldwell Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Permit sent Sept 20, 1951

DISINTERMENT PERMIT

STATE OF IDAHO
DEPARTMENT OF PUBLIC HEALTH
BOISE, IDAHO

APPLICATION HAVING BEEN MADE for the disinterment of the body of Becky G. Calhoun
now lying buried in Pleasant Ridge Cemetery, in the City or Town of Caldwell
County of Canyon State of Idaho, who died on the 6 day of March, 1922, Aged 46 years 0 months
18 days, the cause of death being Tuberculosis of Lungs and
not directly or indirectly by diphtheria; (membranous croup); scarlet fever; smallpox; leprosy; asiatic cholera; typhus fever;
or yellow fever as shown by the certificate of death of said deceased, given by
F. M. Cole, M.D. attending physician

THIS IS TO CERTIFY that permission is hereby given for such disinterment and removal by Private
to Canyon Hill Cemetery in the City or Town of Caldwell County of Canyon
State of Idaho to take effect upon the approval by the local board of health of the City, Town, or County of
Canyon

it being understood and provided that nothing herein shall be deemed as contravening or in
anywise modifying or releasing the Regulations of the Department of public health governing the Transportation of
Corpses or the requirements for a Transportation permit, and all Transportation Companies and Common Carriers will be
governed accordingly; and provided further, that where the disinterment is for the purpose of reinterment in another
part of the same cemetery, or in a contiguous cemetery, the removal shall not be made by any public conveyance. The
disinterment and removal must be done under the personal supervision of a licensed Embalmer in good standing. If the
remains are to be removed from the cemetery they (including the disinterred casket), must be enclosed in a new metallic
lined outer case before removal.

permit issued to:

Given under my hand and Seal of the Department of public health at Boise, Idaho,
this 20th day of September, A.D. 1951.

W. W. Benson

by Director, Division of Vital Statistics

The foregoing application for disinterment and removal is hereby approved by the local Board of Health of the City,
Town or County of _____ State of Idaho, this _____ day of _____ 19____.

Health officer

1. PLACE OF DEATH

County of CanyonCity of Greenleaf

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED
MAY 10 1922
CERTIFICATE OF DEATHRegistration District No. 3Primary Registration District No. 2005

(No. _____ St.)

Full Name Martha Evadine PetersState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 37191Registered No. 29

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDFemale white single
(Write the word.)

6. DATE OF BIRTH

Jan 5 1911
(Month) (Day) (Year)

7. AGE

11 Yrs. 1 Mos. 28 ds.
IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

at home

9. BIRTHPLACE

(State or Country)

California

10. NAME OF FATHER

Evan Isaac Peters

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Silvia Mendenhall

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank D. Roberts

(Address) Greenleaf, Idaho

15. Filed March 4 - 1922 John H. Meyer -
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 3 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
Nov. 25 1921, to March 3 1922
that I last saw her alive on March 3 1922
and that death occurred on the date stated above, at 9:20 P. M.
The CAUSE OF DEATH* was as follows:

Chronic heart failure sudden

(Duration) 11 Yrs. mos. ds.

Contributory Chronic heart failure
(Secondary)

+myocarditis (Duration) 11 Yrs. mos. ds.

(Signed) S. D. Caldwell M. D.

19 (Address) Caldwell, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Greenleaf, Ida 3-5-1922

20. UNDERTAKER ADDRESS

C. V. Pickham Caldwell, Ida

RECEIVED CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon Registration District No. 3
City of Baldwell Primary Registration District No. 2005
No. 37192 St.File No. 37192Registered No. 28If death occurs away from
usual residence, give facts
called for under special in-
formation.If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

2. FULL NAME

Al Morrison

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDSingle
(Write the word.)

6. DATE OF BIRTH

1 (Month) 5 (Day) 1855 (Year)

7. AGE

64 Yrs. 1 Mos. 17 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.Rancher(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country)

Texas10. NAME OF
FATHERR. Morrison11. BIRTHPLACE
OF FATHER

(State or Country)

Indiana12. MAIDEN NAME
OF MOTHER13. BIRTHPLACE
OF MOTHER

(State or Country)

New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. B. Gray

(Address)

R. L. Caldwell

15.

Filed

Mes. 4- 1922John H. Meyer

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March (Month) 2 (Day) 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

.....19....., to19.....

that I last saw h..... alive on.....19.....

and that death occurred on the date stated above, at.....M.

The CAUSE OF DEATH* was as follows:

Struck by O.S.L. train #5
accident

(Duration) Yrs. mos. ds.

Contributory Full crushed
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) Paul L. Case M.D.3-30-22 Address Canyon
Baldwell Idaho*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Canyon Hill

DATE OF BURIAL

3-4 1922

20. UNDERTAKER

Paul L. Case

ADDRESS

Baldwell

1. PLACE OF DEATH

County of CanyonCity of Caldwell

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED CERTIFICATE OF DEATH

Registered District No. 3Primary Registration District No. 1005No. 1005

St.

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 37193Registered No. 27

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDmarried

6. DATE OF BIRTH

May 22, 1865
(Month) (Day) (Year)

7. AGE

36 Yrs. 9 Mos. 5 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Laborer.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Tenn.

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Parker.

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Mrs. H. A. Russell
Caldwell, Ida.

15.

Filed Mar. 12 1922John V. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb. 27, 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Never 19....., Dead Feb. 27, 1922
that I last saw him alive on.....
and that death occurred on the date stated above, at 11:15 A.M.

The CAUSE OF DEATH* was as follows:

Heart failure
Sudden

(Duration) Yrs. mos. ds.

Contributory
(Secondary)Sent. Rheum - likely
old myocardial
(Duration) 10 yrs. mos. ds.

(Signed)

S. R. Redleg M. D.

19..... (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Canyon Hill 3-1 1922

20. UNDERTAKER

ADDRESS

E. V. Beckham Caldwell

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of CanyonCity of Caldwell

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 3Primary Registration District No. 2005(No.)

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37194Registered No. 26

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Earl J. Haworth

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male white

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

6. DATE OF BIRTH

Jan 7 1903
(Month) (Day) (Year)

7. AGE

19 Yrs. 1 Mos. 19 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).at home

9. BIRTHPLACE

(State or Country)

Washington

10. NAME OF FATHER

D. L. Haworth

11. BIRTHPLACE OF FATHER

(State or Country)

Iowa

12. MAIDEN NAME OF MOTHER

Clara Gillett

13. BIRTHPLACE OF MOTHER

(State or Country)

Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

D. L. Haworth

(Address)

Caldwell, Ida

15.

Filed

Feb. 27 - 1922 John V. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb. 26 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 10 1922 to Feb 26 1922
that I last saw him alive on Feb 26 1922
and that death occurred on the date stated above, at 6:45 M.

The CAUSE OF DEATH* was as follows:

Cerebral abscess(Duration) Yrs. 3 mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. W. Meyer M. D.(Address) Caldwell, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Greenleaf Cem 2-27-1922

20. UNDERTAKER

ADDRESS

E. V. Beckham Caldwell

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon
City of Caldwell

RECEIVED

Registration District No. 3Primary Registration District No. 2005

(No.)

St.)

File No. 37195Registered No. 25

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jeremiah T. Miller

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

MaleWhiteMarried
(Write the word.)

6. DATE OF BIRTH

November 29 1849
(Month) (Day) (Year)

7. AGE

77 Yrs. 2 Mos. 26 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Rancher

9. BIRTHPLACE

(State or Country)

Pennsylvania

10. NAME OF FATHER

Michael Miller

11. BIRTHPLACE OF FATHER

(State or Country)

Bedford Co. Penn.

12. MAIDEN NAME OF MOTHER

Irish

13. BIRTHPLACE OF MOTHER

(State or Country)

Bedford Co. Pa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. A. Miller

(Address)

Caldwell, Ida.

15.

Filed Feb. 28 - 1922John H. Meyer
Local Registrar

16. DATE OF DEATH

Feb 25 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 20 1922 to Feb 25 1922
that I last saw him alive on Feb 25 1922
and that death occurred on the date stated above, at 8:15 P.

The CAUSE OF DEATH* was as follows:

pneumonia

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

M. D.

W. E. Miller
Feb 26 1922 (Address) Caldwell, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Canyon Hill 2-28-1922

20. UNDERTAKER

ADDRESS

E. V. Beckham Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M-1-19-

1. PLACE OF DEATH

County of Canyon
City of Caldwell

If death occurs away from usual residence, give facts called for under special information.

RECEIVED

APR 6 1922

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 3
Registration District No. 200504
St. IdahoState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. _____
Registered No. 25

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jeremiah T. Miller

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED married
(Write the word.)6. DATE OF BIRTH Nov. 29 - 1849
(Month) (Day) (Year)7. AGE 72 Yrs. 2 Mos. 26 ds.
IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Rancher.

9. BIRTHPLACE

(State or Country)

Penn.

10. NAME OF FATHER

Michael Miller

11. BIRTHPLACE OF FATHER

(State or Country)

Bedford co-Penn.

12. MAIDEN NAME OF MOTHER

Irish.

13. BIRTHPLACE OF MOTHER

(State or Country)

Bedford co. Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. A. Miller
Caldwell, Idaho15. Filed Feb. 28 - 1922 John H. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb. 25 - 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Feb. 18 - 1922 to Feb. 25 - 1922
that I last saw him alive on Feb. 25 - 1922
and that death occurred on the date stated above, at _____ M.
The CAUSE OF DEATH* was as follows:
pneumonia influenza(Duration) Yrs. mos. 7 ds.
Contributory (Secondary) Asthma(Duration) Yrs. mos. ds.
(Signed) J. A. Miller M. D.
4/4 1922 (Address) Caldwell Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Canyon Hill.

DATE OF BURIAL

2-28 - 1922

20. UNDERTAKER

C. V. Beckham

ADDRESS

Caldwell, Idaho.

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 37196

Registered No. 24

1. PLACE OF DEATH

County of Canyon
City of CaldwellRegistration District No. 3
Primary Registration District No. 2003
(No.) (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Robert Henry McGuire

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED widower
(Write the word.)

6. DATE OF BIRTH

mch 27 1887
(Month) (Day) (Year)

7. AGE

64 Yrs. 10 Mos. 27 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

Rancher & Stockman

9. BIRTHPLACE

(State or Country)

New Brunswick Can.

10. NAME OF FATHER

R. McGuire

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Margaret Dole

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Robert E. McGuire
(Address) R-2 - Caldwell, Idaho

15.

Filed Feb. 25 - 1922

John H. Meyers
Local Registrar

16. DATE OF DEATH

Feb 24 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Feb 10 1922 to Feb 24 1922
that I last saw him alive on Feb 24 1922
and that death occurred on the date stated above, at 4:14 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) Yrs. mos. 14 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. H. Meyers

M. D.

19

(Address)

Caldwell - Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Canyon Hill

DATE OF BURIAL

2-26-1922

20. UNDERTAKER

Paul L. Base

ADDRESS

Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
37197
File No. _____
Registered No. 23
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Canyon
City of Caldwell
Registration District No. 3
Primary Registration District No. 2005
St. _____
If death occurs away from usual residence, give facts called for under special information.

RECEIVED
MAR 20 1922

BUREAU OF VITAL STATISTICS

2. FULL NAME Mary C. Cover

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
6. DATE OF BIRTH July 27 1856
7. AGE 65 Yrs. 6 Mos. 26 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION Housewife
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE Minn.
(State or Country)

10. NAME OF FATHER Sameul Kelsey

11. BIRTHPLACE OF FATHER Minn.
(State or Country)

12. MAIDEN NAME OF MOTHER Mary Hollis

13. BIRTHPLACE OF MOTHER Penn.
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. W. Hughes
Address Caldwell, Idaho

15. Filed Feb 25 - 1922 John V. Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 24th 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 21 1922 to Feb 23 1922
that I last saw him alive on Feb 23 1922
and that death occurred on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:
Cardiac renal disease

(Duration) 3 Yrs. mos. ds.
Contributory High blood pressure
(Secondary)

(Duration) 5 yrs. mos. ds.
(Signed) W. Montgomery M. D.
Feb 25 1922 (Address) Caldwell, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL 19

20. UNDERTAKER ADDRESS R. V. Beckham Caldwell

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH
in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **37198**
Registered No. **22**

1. PLACE OF DEATH

County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 2005-
(No. St.)

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Chas Ray Tague

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

male white single

6. DATE OF BIRTH

April 17 1884
(Month) (Day) (Year)

7. AGE

37 Yrs. 10 Mos. 6 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

Rancher

9. BIRTHPLACE

(State or Country)

Nebraska

10. NAME OF
FATHER

Joseph H. Tague

11. BIRTHPLACE
OF FATHER

(State or Country)

Indiana

12. MAIDEN NAME
OF MOTHER

Martha E. Wise

13. BIRTHPLACE
OF MOTHER

(State or Country)

Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. H. Tague
Progan, Cal.

15.

Filed

Feb. 23-1922 Joh. S. Meyer

Local Registrar

16. DATE OF DEATH

Feb 23 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 18 1922 to Feb. 23 1922
that I last saw him alive on Feb. 22 1922
and that death occurred on the date stated above, at 3.38 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) Yrs. mos. 5 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

(Address)

M. D. Tague
2-13-22 Caldwell

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Ontario Cem.

19.....

20. UNDERTAKER

ADDRESS

C. V. Beckman Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

Dec. 14 - 1922

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon
City of Greenleaf

Registration District No. 3
Primary Registration District No. 2005
(No. 7115 St.)

File No. 37199
Registered No. 21

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John C. Steele

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married

6. DATE OF BIRTH March 4 1860
(Month) (Day) (Year)

7. AGE 61 Yrs. 11 Mos. 17 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION (a) Trade, profession or particular kind of work Rancher
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Missouri

10. NAME OF FATHER Wm Steele

11. BIRTHPLACE OF FATHER (State or Country) Missouri

12. MAIDEN NAME OF MOTHER Martha Stone

13. BIRTHPLACE OF MOTHER (State or Country) Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Anna Steele
(Address) Greenleaf, Ida.

15. Filed Feb. 24 1922 John D. Meyer
Local Registrar

16. DATE OF DEATH Feb 21 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 14 1921 to Feb 18 1922
that I last saw him alive on Feb 18 1922
and that death occurred on the date stated above, at 4:25 P.M.
The CAUSE OF DEATH* was as follows:

Heart Failure
(Duration) Yrs. mos. ds.
Contributory (Secondary) Myofibrosis Chronic
(Duration) 1+ yrs. mos. ds.
(Signed) Geo. Dudley M. D.
19 (Address) Caldwell, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Star Ida DATE OF BURIAL 2-24 1922

20. UNDERTAKER C. V. Peckham ADDRESS Caldwell

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

37200

1. PLACE OF DEATH

County of Banyon District No. 3
City of Baldwell Primary Registration District No. 2005
(No. Canyon County Poor Farm St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

A. B. LewisFile No. _____
Registered No. 20

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED widower
(Write this word.)

6. DATE OF BIRTH

(Month) (Day) (Year) 1848

7. AGE

74 Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Farmer

9. BIRTHPLACE

(State or Country)

Indiana

10. NAME OF FATHER

Lewis

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Walter Rogers

(Address)

R. 1. Middleton Sta

15.

Filed

Feb. 22, 1922John V. Meyers
Local Registrar

16. DATE OF DEATH

Feb 20 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb. 6, 1922 to Feb. 20, 1922
that I last saw him alive on Feb. 18, 1922
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Myocarditis(Duration) Yrs. mos. ds.
Contributory (Secondary) Influenza

(Duration) Yrs. mos. ds.

(Signed) W. H. Rogers M. D.(Address) Baldwell

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Banyon Hill

DATE OF BURIAL

2-22-1922

20. UNDERTAKER

Paul L. Case

ADDRESS

Baldwell

FORM No. 5-A—25 M. 1-19.

1. OF DEATH

County of CanyonCity of Wilder

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

REG.

Primary Registration District No. 2005(No. 15 St.)State of Idaho
BOARD OF HEALTH
Bureau 37201File No. 19Registered No. 19

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed Feb. 15 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 14 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Summer 1919 to Feb 14 1922that I last saw him alive on Feb 14 1922and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

diabetes mellitus

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) W. H. B. de M. D.Feb. 1922 (Address) Wilder, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH

County of Canyon
City of Nampa

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Geo. Miller

CERTIFICATE OF DEATH

Registration District No. 7

Registration District No. 1066

(No. _____)

(St. _____)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 37202

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word)

6. DATE OF BIRTH

Jan 30 1922
(Month) (Day) (Year)

7. AGE

X
Yrs. Mos. ds.

IF LESS than 1 day
how many 16 hrs.
or — min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Ida

10. NAME OF FATHER

Lincoln Earl Miller

11. BIRTHPLACE OF FATHER

(State or Country) Mo.

12. MAIDEN NAME OF MOTHER

Hester F. Lair

13. BIRTHPLACE OF MOTHER

(State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. J. J. Miller

(Address) Nampa Ida

15.

Filed March 10 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 30 1922
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from Jan 31 1922, to Jan 31 1922, that I last saw him alive on Jan 31 1922, and that death occurred on the date stated above, at 6 A M.

The CAUSE OF DEATH* was as follows:

Prematurity

(Duration) Yrs. mos. 16 hrs ds.

Contributory (Secondary)

(Duration) Yrs. mos. 16 hrs ds.

(Signed) M. J. J. Miller

(Address) Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Nampa

DATE OF BURIAL

1/30 1922

20. UNDERTAKER

None

ADDRESS

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED

MAR 20 1922

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

37203

1. PLACE OF DEATH

County of

City of

Registration District No.

Primary Registration District No.

(No.

St.)

File No.

Registered No.

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF
FATHER11. BIRTHPLACE
OF FATHER

(State or Country)

12. MAIDEN NAME
OF MOTHER13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Mar. 10 1922

Local Registrar

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

19..... to 19.....

that I last saw h..... alive on 19.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Suicide - Gun
shot in foreheadContributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Paul L. Casper

2/6 1922 (Address) Bonanza

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rohlerstown

2-9 1922

20. UNDERTAKER

ADDRESS

Paul L. Casper

Bonanza

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

(No. *Nazrine Hospital* St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

19

17. I HEREBY CERTIFY, That I attended deceased from

Jan 27, 1922 to Feb 11, 1922

that I last saw her alive on Feb 11, 1922

and that death occurred on the date stated above, at 10⁰⁰ A.M.

The CAUSE OF DEATH* was as follows:

Operation for abscess in rt. right
Bliss abscess in abdomen
Aulderos - Ruptured Appendix
(Duration) Yrs. mos. 14 ds.

Contributory (Secondary)

Parotitis (Double)

(Duration)

Yrs.

mos.

3 ds.

(Signed)

Thos E. Mangum M. D.

Feb 11, 1922 (Address) Nampa, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Boise Ida

2-13-1922

20. UNDERTAKER

ADDRESS

Fred K Robinson Nampa

Ida

FORM V. S. No. 5-A—25 M. 1-19.

1. PLACE OF DEATH

County of BanyonCity of Harmon

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No.

Primary Registration District No.

(No. Harmon St.)

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 37205

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb. 23 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 22 1922 to Feb 23 1922that I last saw her alive on Feb 22, 1922,and that death occurred on the date stated above, at 4 A M.

The CAUSE OF DEATH* was as follows:

Meat poisoning - probably ptomaine(Duration) Yrs. mos. 1 ds.Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) Geo. W. Proctor M. D.19 (Address) Harmon, Mo.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Harmon2-25 1922

20. UNDERTAKER

ADDRESS

Geo. W. Proctor

(Proctor)

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County Canyon Registration District No. _____
 City of Hamper Primary Registration District No. _____
 (No. _____) (St. _____)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John M. Devos

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 37206
 Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
 (Write the word.)

6. DATE OF BIRTH Dec 8 1919
 (Month) (Day) (Year)

7. AGE 2 Yrs. 3 Mos. _____ ds.
 IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work None
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Ida

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country) Mo.

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country) Mich

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. M. Devos

(Address) Hamper, Ida 901. 8 ave

15.

Filed March 9 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 5 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 28 1922 to Mar 5 1922 that I last saw him alive on Mar 4 1922 and that death occurred on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:

Polar pneumonia

(Duration) _____ Yrs. _____ mos. 10 ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Geo. R. Proctor M. D.

March 9 1922 (Address) Hamper, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL 3-6 1922

20. UNDERTAKER

ADDRESS

Fred K. Robinson Hamper

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **37207**

Registered No.

1. PLACE OF DEATH

County of Campana Registration District No.
City of Nampa (No.) (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jimmie Oaki

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED
(Write the word.)

6. DATE OF BIRTH

June 23 1917
(Month) (Day) (Year)

7. AGE

4 Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country) Japan

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country) Japan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. Oaki(Address) Nampa Ida

15.

Filed March 10 1922Pearle Dadd
Local Registrar

16. DATE OF DEATH

Mar 6 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19....., to 19.....

that I last saw him alive on 19.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Struck by automobile
Accident Skull
crushed

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Paul L. Casper19..... (Address) Coroner
Baldwin Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Kahlerstown Cem 3-7-1922

20. UNDERTAKER

ADDRESS

Thos. R. Quinn Nampa Ida

✓ CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of CanyonCity of Nampa

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. 410-16th av N St.)State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 37208

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Donald W Riggs

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

Yrs. 5 Mos. 4 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

W D Riggs

11. BIRTHPLACE OF FATHER

(State or Country)

Missouri

12. MAIDEN NAME OF MOTHER

Grace Clouse

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W D Riggs

(Address)

Nampa Ida

15.

Filed March 9 1922 19..

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 7 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Mar 6 1922 to Mar 6 1922that I last saw him alive on Mar 6 1922and that death occurred on the date stated above, at 7 A M.

The CAUSE OF DEATH* was as follows:

Meningitis - as a complication of broncho-pneumonia
(Duration) not known mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Geo. R. Proctor M. D.March 9 1922 (Address) Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Kohler Law Cemetery 3-9-22

20. UNDERTAKER

ADDRESS

Geo. L. Robinson Nampa

ED

✓ CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **37209**

Registered No. _____

1. PLACE OF DEATH

County of CanyonCity of Nampa

Registration District No. _____

Primary Registration District No. _____

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Bertha M. Chambers

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female white married
(Write the word.)

6. DATE OF BIRTH

Feb 24 1900
(Month) (Day) (Year)

7. AGE

22 Yrs. - 11 Mos. - 11 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Housewife

9. BIRTHPLACE

(State or Country)

Wash.

10. NAME OF FATHER

D. D. Wilson

11. BIRTHPLACE OF FATHER

(State or Country)

Ill

12. MAIDEN NAME OF MOTHER

Gertrude Hopkinson

13. BIRTHPLACE OF MOTHER

(State or Country)

Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

D. D. Wilson(Address) Nampa Ida

15.

Filed March 19 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 8 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 28 1922 to March 8 1922that I last saw her alive on March 8 1922and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Bronchitis Pneumonia(Duration) Yrs. _____ mos. 3 ds.

Contributory (Secondary)

Influenza(Duration) Yrs. _____ mos. 5 ds.

(Signed)

M. J. Fink

M. D.

Mar 9 1922 (Address) Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cuna Ida19

20. UNDERTAKER

ADDRESS

Paul K RobinsonNampa Ida

FORM V. S. No. 5-A-25 M. 1-19.

1. PLACE OF DEATH

County of Canyon
City of Naupaka

If death occurs away from usual residence, give facts called for under special information.

CERTIFICATE OF DEATH

Registration District No. 7Primary Registration District No. 2006(No. St.)State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 37210Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Henry Therneau

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDM white Widowed
(Write the word.)

6. DATE OF BIRTH

845
(Month) (Day) (Year)

7. AGE

76 Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

Farmer

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

Henry Therneau

11. BIRTHPLACE OF FATHER

(State or Country)

France

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. R. Lamm

(Address)

Naupaka Ida

15.

Filed

March 1922Earle Dodd

Local Registrar

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 1 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 9 1921, to Dec 15 1921that I last saw him alive on Dec 15 1921and that death occurred on the date stated above, at 2 A.M.

The CAUSE OF DEATH* was as follows:

General paresis(Duration) Yrs. 6 mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

H. P. Ross

M. D.

(Address)

Naupaka Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sherman Tex.19

20. UNDERTAKER

ADDRESS

F. K. RobinsonNaupaka Ida

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Canyon

City of _____

If death occurs away from
usual residence, give facts
called for under special in-
formation.

Registration District No. _____

Primary Registration District No. _____

(No. _____)

(St. _____)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **37211**

Registered No. _____

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

2. FULL NAME

William Francis Lowe

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male white

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDMarried
(Write the word.)

6. DATE OF BIRTH

Apr 3 1884
(Month) (Day) (Year)

7. AGE

37 Yrs. 10 Mos. 18 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)Farmer

9. BIRTHPLACE

(State or Country)

Oalt Lake Utah10. NAME OF
FATHERWm. J. Lowe11. BIRTHPLACE
OF FATHER

(State or Country)

England12. MAIDEN NAME
OF MOTHERFrancis A. Wiggill13. BIRTHPLACE
OF MOTHER

(State or Country)

Iafuca

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) XJ. L. Fous

(Address) _____

15.

Filed Mar 15 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

2 15 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____ 19____, to _____ 19____

that I last saw him _____ alive on _____ 19____

and that death occurred on the date stated above, at 8:00 P.M.

The CAUSE OF DEATH* was as follows:

Had an Epileptic Seizure
while unloading a load of sand
and fell in such a manner that
his wind pipe rested on top of end
of ribs - (Duration) _____ Yrs. _____ Mos. _____ ds.
Contributors (Secondary) _____
Death (Found dead) _____
Epilepsy - (Duration) 23 yrs. _____ mos. _____ ds.

(Signed)

F. J. Coleman M. D.2-17-1922 (Address) Kuna Idaho*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)At place _____ In the _____
of death _____ yrs. _____ mos. _____ days. State _____ yrs. _____ mos. _____ daysWhere was disease contracted
if not at place of death?Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Kahului Cem

DATE OF BURIAL

2-18-22

20. UNDERTAKER

F. J. Coleman

ADDRESS

Kuna

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH

County of Canyon

City of _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No. _____

Primary Registration District No. _____

(No.) _____

St.) _____

Registered No. _____

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 37212

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

7. AGE

Yrs. _____ Mos. 20 ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed Mar 18 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 17 (?) 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

on 28 1922 to _____ 19____that I last saw him alive on Jan 31 1922and that death occurred on the date stated above, at 34 M.

The CAUSE OF DEATH* was as follows:

Natural causes - congenital in origin

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Geo. R. Proctor M. D.

March 9, 1922 (Address) Nampa, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Robb Lawns Cem 2/18 1922

20. UNDERTAKER

ADDRESS

Frank Roberson Nampa
Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Canyon
City of Nampa

Registration District No. 7

Primary Registration District No. 2000

(No. _____)

St. _____

File No. 37213

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lyndon Wheeler

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

Single

(Write the word.)

6. DATE OF BIRTH.

Unknown

(Month)

(Day)

(Year)

7. AGE

20

Yrs.

Mos.

ds.

IF LESS than 1 day
how many hrs. or
..... min. 2)

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

None

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Don Byrnes

(Address)

Nampa Idaho

15.

Filed

March 10 1922

Charles Smith

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July

27

1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 1

1920

to July 27

1922

that I last saw him alive on July 27

1922

and that death occurred on the date stated above, at 2:30 P.

The CAUSE OF DEATH* was as follows:

Tuber culosis (Pulmonary)

(Duration)

Unknown

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

Don Byrnes

M. D.

227 1922 (Address) Nampa Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death.

1 yrs. 11 mos. 27 days

In the

State

..... yrs. mos. days

Where was disease contracted

if not at place of death?.....

Unknown

Former or

usual residence

Boise Idaho

19. PLACE OF BURIAL OR REMOVAL

Nampa Ida

DATE OF BURIAL

2-28 1912

20. UNDERTAKER

Fred H. Robinson

ADDRESS

Nampa Ida

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **37214**

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Canyon
City of Nampa

Registration District No. _____

Primary Registration District No. _____

St. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Archie Livengood

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH.

(Month)

(Day)

(Year)

7. AGE

17 Yrs. _____ Mos. _____ ds.IF LESS than 1 day
how many _____ hrs. or
_____ min. 2]

8. OCCUPATION

(a) Trade, profession or particular kind of work. _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country)

Lewiston Idaho

10. NAME OF FATHER

A J Livengood

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Storrey Barnes
Nampa Idaho

15.

Filed

March 1912

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb
(Month)2
(Day)1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 9th 1918 to Feb 2 1922,that I last saw him alive on Feb 2 1922,and that death occurred on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

Chronic nephritis(Duration) 4 Yrs. _____ mos. _____ ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Attorney M. D.3/2 1922 (Address) Nampa Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. 3 yrs. 8 mos. _____ days In the State. _____ yrs. _____ mos. _____ daysWhere was disease contracted if not at place of death? Lewiston IdahoFormer or usual residence Lewiston Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Kohlman Bur3-4 1912

20. UNDERTAKER

ADDRESS

Paul K. RobinsonNampa

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

1. PLACE OF DEATH

County of Canyon
City of Pa.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED CERTIFICATE OF DEATH.

Registration District No. 3
Primary Registration District No. 1007
(No. 4113 St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 37215
Registered No. 6

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

widower

(Write the word.)

6. DATE OF BIRTH.

Jan 26 1894
(Month) (Day) (Year)

7. AGE

76 Yrs. 16 Mos. 16 ds.

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...

Retired

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

Joan Lauphear

11. BIRTHPLACE OF FATHER

(State or Country)

Do not know

12. MAIDEN NAME OF MOTHER

Do not know

13. BIRTHPLACE OF MOTHER

(State or Country)

Do not know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

C E Lauphear

(Address)

15.

Filed 2-1 1922 Lulu Maldrop
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb. 12 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1st 1922 to Feb. 12 1922.

that I last saw him alive on Feb. 12 1922

and that death occurred on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) 5 Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. H. Mendenhall M. D.

7-3 1922 (Address) Parma

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Batavia Iowa 191

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **37216**
Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. **3**County of **Canyon**
City of **Paige**Primary Registration District No. **2007**

(No. _____)

St. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William J. Evans

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

m

(Write the word.)

6. DATE OF BIRTH.

Nov

(Month)

3

(Day)

1854

(Year)

7. AGE

66

Yrs.

2

Mos.

18

ds.

IF LESS than 1 day
how many.....hrs. or
.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....**Farmer**

9. BIRTHPLACE

(State or Country)

North Carolina

10. NAME OF FATHER

Reuben Evans

11. BIRTHPLACE OF FATHER

(State or Country)

Do not know

12. MAIDEN NAME OF MOTHER

Do not know

13. BIRTHPLACE OF MOTHER

(State or Country)

Do not know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. Annie Coffey

(Address)

Emmett Idaho

15.

Filed

8 - 1**1922****Hubert Haldrop**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb

(Month)

21

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 19 1912 to **Feb 20 1922**that I last saw him alive on **Feb 20 1922**and that death occurred on the date stated above, at **9 A. M.**

The CAUSE OF DEATH* was as follows:

influenza.(Duration) Yrs. mos. **4** ds.Contributory
(Secondary)**Meningitis**(Duration) Yrs. mos. **2** ds.(Signed) **H. M. Hatcher** M. D.Address **Garma Idaho**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Quaker Church**Feb 23 1922**

20. UNDERTAKER

ADDRESS

Reuben Evans**Garma**

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH **RECEIVED**
Registration District No. **3**
County of **Canyon** **MAH**
City of **Parma** **MAH**
Primary Registration District No. **1007**
St. **INDO.**

File No. **37217**Registered No. **8**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Paul Goddard

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX **M** 4. COLOR OR RACE **W** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **S**

(Write the word.)

6. DATE OF BIRTH.

Dec 25 1921
(Month) (Day) (Year)

7. AGE

Yrs. **2** Mos. **17** ds.

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country)

Canyon Co

10. NAME OF FATHER

Frank Goddard

11. BIRTHPLACE OF FATHER

(State or Country)

Ill

12. MAIDEN NAME OF MOTHER

Louisa Parma

13. BIRTHPLACE OF MOTHER

(State or Country)

Indo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Frank Goddard

(Address)

Parma Ida

15.

Filed **8-1**

1922

Paul Goddard

Local Registrar

16. DATE OF DEATH

Feb 11 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Nov 25** 1921 to **Feb 11** 1922.

that I last saw him alive on **Feb 10** 1922.

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Pyloric Stenosis

(Duration) Yrs. **2** mos. **17** ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. Mitchell M. D.

(Address)

Parma

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR CREMATION

DATE OF BURIAL

Parma**Feb 12, 1922**

20. UNDERTAKER

ADDRESS

Parma Fur Co**Parma**

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Cassia Registration District No. 117
 City of Burley Primary Registration District No. 2-19-6
 (No. 720; N. York St.)
 If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Boatman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female White Single (Write the word.)

6. DATE OF BIRTH

Jan. 31 1922
 (Month) (Day) (Year)

7. AGE

IF LESS than 1 day
 how many 6 hrs. or
30 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business, or establishment in which employed (or employer)

at home

9. BIRTHPLACE

(State or Country)

Burley Ida.

10. NAME OF FATHER

Urban Boatman

11. BIRTHPLACE OF FATHER

(State or Country)

Tenn.

12. MAIDEN NAME OF MOTHER

Mable Fick

13. BIRTHPLACE OF MOTHER

(State or Country)

Oklahoma

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Urban Boatman

(Address)

Burley Ida.

15.

Filed

Feb. 2 1922

Hoyle Patterson

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb. 1 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb. 31 1922 to Feb. 1 1922
 that I last saw him alive on Feb. 1 1922

and that death occurred on the date stated above, at 6:30 A.M.

The CAUSE OF DEATH* was as follows:

Mal development

(Duration) Yrs. mos. ds.

Contributory
 (Secondary)

(Duration) Yrs. mos. ds.

(Signed)

2-1 1922 (Address) Burley, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
 of death yrs. mos. days, State yrs. mos. days

Where was disease contracted
 if not at place of death?

Former or
 usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Burley Ida. Feb. 2 1922

20. UNDERTAKER

ADDRESS

Ed. George Burley Ida.

Patterson.
 State of Idaho
 BOARD OF HEALTH

Bureau of Vital Statistics

File No. 37218

Registered No. 367

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. **37219**
 Registered No. **570**
 If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of *Cassia*Registration District No. *117*City of *Burley*Primary Registration District No. *2196*

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *J. Stella Turner*

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widow

(Write the word.)

6. DATE OF BIRTH.

May 16th 1869
(Month) (Day) (Year)

7. AGE

52 Yrs. *8* Mos. *29* ds.IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Proprietress of Stone Laundry

9. BIRTHPLACE

(State or Country)

Potomac N.Y.

10. NAME OF FATHER

A. D. Nash

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Kennett B. Stowe

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *R. W. Turner*(Address) *Burley, Ida.*15. *Feb. 16th 1922*
Filed*D. J. Patterson*
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

*Feb**13**1922*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

2-4-1922 to *2-13-1922*that I last saw *her* alive on *2-13-1922*and that death occurred on the date stated above, at *3* P.M.

The CAUSE OF DEATH* was as follows:

Erysipelas(Duration) *6* Yrs. *6* mos. *6* ds.

Contributory (Secondary)

Plague Poisoning

(Duration)

Yrs. mos. ds.

(Signed)

Joseph Tremsted

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days, State yrs. mos. daysWhere was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Denver, Colo.

DATE OF BURIAL

Feb. 18, 1922

20. UNDERTAKER

L. B. Gallagher

ADDRESS

Burley, Ida.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37324
Registered No. 37324
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of *Cassia*Registration District No. *117*City of *Burley*Primary Registration District No. *2196*

If death occurs away from usual residence, give facts called for under special information.

(No. St.)

2. FULL NAME *J. Thomas Smith*

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married (Write the word.)

6. DATE OF BIRTH.

April 10 1882
(Month) (Day) (Year)

7. AGE

69 Yrs. *10* Mos. *4* ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

John Smith

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Elizabeth Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *J. J. Smith*(Address) *Shelley Ida*

15.

Filed *2-16-22* 191....

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb. 14 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

*Feb. 9 1922 to Feb. 14 1922*that I last saw him alive on *Feb. 13 1922*and that death occurred on the date stated above, at *2 a* M.

The CAUSE OF DEATH* was as follows:

Pneumonia(Duration) Yrs. *4* mos. *10* ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) *J. W. Patterson* M. D.*2-16-1922* (Address) *Burley, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days, State yrs. mos. daysWhere was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Shelley Ida

DATE OF BURIAL

Feb. 18 1922

20. UNDERTAKER

L. B. Gallogly

ADDRESS

Burley Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. **3723172**
 Registered No. **3723172**
 If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of *Cassia*
 City of *Burley*
 If death occurs away from usual residence, give facts called for under special information.

Registration District No. *117*
 Primary Registration District No. *2.196*
 (No. *Burley Emergency Hospital* St.)

2. FULL NAME *Alfred Ellipse*

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. *Married*

6. DATE OF BIRTH

Unknown
 (Month) (Day) (Year)

7. AGE

35 Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work *Express Messenger*
 (b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) *Unknown*

10. NAME OF FATHER

"

11. BIRTHPLACE OF FATHER

(State or Country) "

12. MAIDEN NAME OF MOTHER

"

13. BIRTHPLACE OF MOTHER

(State or Country) "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *L.B. Galloway*
 (Address) *Burley Ida.*

15. *Feb. 6* 191*22* *L.J. Patterson*
 Filed Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb. *6* 191*22*
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191. to 191.

that I last saw h. alive on 191.

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Internal Injury of Intestines
Caused By Rail Road accident

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) *L.B. Galloway* (Coroner) M.B.
2/6/1922 (Address) *Burley Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
 of death yrs. mos. days, State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Salt Lake City Ut. *Feb. 8* 191*22*

20. UNDERTAKER

L.B. Galloway *Burley Ida.*

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

Registration District No. 117
County of Cassin Primary Registration District No. 2196
City of Burley (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Olin Montague Niebu

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 37222
Registered No. 573

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widower
(Write the word.)

6. DATE OF BIRTH

Dec 29 1850
(Month) (Day) (Year)

7. AGE

71 Yrs. 1 Mos. 18 ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

School Teacher

9. BIRTHPLACE

(State or Country)

New York

10. NAME OF FATHER

Don't Know

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

"

13. BIRTHPLACE OF MOTHER

(State or Country)

"

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Fred Wilber

(Address)

Burley Id

15.

Filed 2-18-22 1922

H. J. C. Pattison
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 17 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 2 1922, to Feb 17 1922,
that I last saw him alive on Feb 16 1922,
and that death occurred on the date stated above, at 2 A. M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) 3 yrs. 3 mos. 3 ds.

Contributory
(Secondary)

hypertension

(Duration) 3 yrs. 3 mos. 3 ds.

(Signed)

J. C. Pattison

M. D.

2-15 1922, (Address) Burley, Id

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Ottawa Kan

on arrival

20. UNDERTAKER

ADDRESS

R. H. Watt

Burley Id

FORM V. S. No. 5-12 M. 6-15-17.

1. PLACE OF DEATH

County of Cassia
 City of Albion, Ida.
 If death occurs away from
 usual residence, give facts
 called for under special
 information.

CERTIFICATE OF DEATH

Registration District No. 114
 Primary Registration District No. 2196
 (No. St.)

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 372374
 Registered No. 372374

If death occurred in a hos-
 pital, institution or camp,
 give its NAME instead of
 street and number.

2. FULL NAME

Hannah Harper

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.Widowed
(Write the word.)

6. DATE OF BIRTH.

November 7th 1836
 (Month) (Day) (Year)

7. AGE

86 Yrs. 3 Mos. 20 ds.

IF LESS than 1 day
 how many hrs. or
 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Glennoganshire Wales

10. NAME OF FATHER

William T. Jones

11. BIRTHPLACE OF FATHER

(State or Country)

Wales

12. MAIDEN NAME OF MOTHER

Lucy Lewis

13. BIRTHPLACE OF MOTHER

(State or Country)

Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thomas E. Harper(Address) Albion, Idaho

15.

Filed Feb. 28 1922Dr. C. Patterman

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 27 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191... to 191...

that I last saw h..... alive on 191...

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Old age

(Duration) Yrs. mos. ds.

Contributory
 (Secondary)

(Duration) Yrs. mos. ds.

(Signed) L. B. Gecoggy, Coroner, M. D.

2/28/22 (Address) Burley, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
 of death yrs. mos. days, State yrs. mos. days

Where was disease contracted
 if not at place of death?

Former or
 usual residence

19. PLACE OF BURIAL OR REMOVAL

Hamaville Utah

DATE OF BURIAL

Mar. 2, 1922

20. UNDERTAKER

L. B. Gecoggy

ADDRESS

Burley Ida

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of CassiaCity of Burley

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 117Primary Registration District No. 2196

(No. _____ St.)

File No. 37224Registered No. 375

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Nancy Moffett

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

February 2 1922
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many 12 hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

None

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Moses Franklin Moffett

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Mabel Agnes Bruce

13. BIRTHPLACE OF MOTHER

(State or Country)

Wyoming

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Horathy Rich MD

(Address)

Burley Idaho

15.

Filed

Feb. 28 1922 H. J. Patterson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

February 2 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 2 1922 to Feb 3 1922that I last saw h.e. alive on Feb 3 1922and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency(Duration) 12 hrs. Yrs. mos. ds.Contributory
(Secondary)Prematurity (7th mo. of gestation)

(Duration) yrs. mos. ds.

(Signed)

Horathy Rich M. D.

19

(Address)

Burley, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Burley, IdahoFeb 4 1922

20. UNDERTAKER

ADDRESS

None

CERTIFICATE OF DEATH

Butler.
State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37229.6
Registered No. 2196

1. PLACE OF DEATH

County of CassiaRegistration District No. 117Primary Registration District No. 2196

(No. St.)

City of Seele
If death occurs away from
usual residence, give facts
called for under special
information.

2. FULL NAME Elda Evelyn Louder

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.Single (Write the word.)

6. DATE OF BIRTH.

July 16 1922
(Month) (Day) (Year)

7. AGE

7 Yrs. 14 Mos. ds.

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of in-
dustry, business, or estab-
lishment in which em-
ployed (or employer)

At Home

9. BIRTHPLACE

(State or Country) Seele Ida.10. NAME OF
FATHERElmer F. Louder11. BIRTHPLACE
OF FATHER(State or Country) Bountiful Utah12. MAIDEN NAME
OF MOTHERFrances Lena Dunn13. BIRTHPLACE
OF MOTHER(State or Country) Oakley Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Elmer F. Louder(Address) Burley Ida. R.F.D. #2

15.

Filed

Feb. 31922L. J. C. Patterson

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb. 2 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Feb. 1 1922 to Feb. 2 1922
that I last saw her alive on Feb. 2 1922

and that death occurred on the date stated above, at 10:30 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia(Duration) Yrs. mos. 3 ds.Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) F. H. Butler M. D.Feb. 5 1922 (Address) Burley

*State the Disease Causing Death; or in deaths from Violent
Causes, state (1) Means of Injury; and (2) whether Accidental,
Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place In the
of death yrs. mos. days, State yrs. mos. days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Seele Ida.

DATE OF BURIAL

Feb. 4 - 1922

20. UNDERTAKER

L. B. Tolley

ADDRESS

Burley Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS
should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement
of OCCUPATION is very important. See instructions on back of certificate.

Patterson Cooper

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37226
Registered No. 577
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Caria
City of Burley
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 117
Primary Registration District No. 2196
(No. 2 St.)

2. FULL NAME Joseph M. Taylor

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widowed

6. DATE OF BIRTH. Feb. 14 1922
(Month) (Day) (Year)

7. AGE 83 Yrs. # Mos. 6 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Missouri

10. NAME OF FATHER John Taylor

11. BIRTHPLACE OF FATHER
(State or Country) Kentucky

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER
(State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Pearl Lodge
(Address) Burley, Ida.

15. Filed Mar. 3rd 1922 Dr. J. C. Patterson
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 20 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 20 1922 to Feb. 20 1922 that I last saw him alive on Feb. 20 1922 and that death occurred on the date stated above, at 6:30 P. M.

The CAUSE OF DEATH* was as follows:
Senile Debility
(Duration) several Yrs. mos. ds.
Contributory (Secondary)
(Duration) Yrs. mos. ds.
(Signed) J. C. Patterson M. D.
2-21-1922 (Address) Burley, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days, State yrs. mos. days
Where was disease contracted
if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Burley, Ida. DATE OF BURIAL 1922

20. UNDERTAKER L. B. Galloway ADDRESS Burley, Ida.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 372378
Registered No. 372378
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of CassiaRegistration District No. 117City of BurleyPrimary Registration District No. 2196

If death occurs away from usual residence, give facts called for under special information.

(No. St.)

2. FULL NAME Lenny C. Smith

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widowed

(Write the word.)

6. DATE OF BIRTH.

Unknown
(Month) (Day) (Year)

7. AGE

65 Yrs. Mos. ds.IF LESS than 1 day
how many hrs. or
..... min.?"

8. OCCUPATION

(a) Trade, profession or particular kind of work

Miner

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. E. Mary(Address) Ashland, Oregon

15.

Filed Mar 3rd 1922Doyle Patterson

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb. 12 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
Feb. 1 - 1922 to Feb. 12 - 1922that I last saw him alive on Feb. 12 - 1922
and that death occurred on the date stated above, at 7:34 P.M.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease(Duration) 2 Yrs. mos. ds.Contributory
(Secondary)(Duration) 4 Yrs. mos. ds.(Signed) W. H. Cooper M. D.19. (Address) Burley, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days, State yrs. mos. daysWhere was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Burley Ida

DATE OF BURIAL

Feb. 17. 1922

20. UNDERTAKER

L. B. Golligay

ADDRESS

Burley Ida

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. **37228**
 Registered No. **579**
 If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Cassia Registration District No. 117
 City of Burley Primary Registration District No. 2196
 If death occurs away from usual residence, give facts called for under special information. STANNO St.)

2. FULL NAME Myrtle Lathamer Cotton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED, Married

6. DATE OF BIRTH Mar. 30 1881
 (Month) (Day) (Year)

7. AGE 41 Yrs. 11 Mos. 20 ds.
 IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Housewife
 (b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Logan Co. Kentucky

10. NAME OF FATHER Clauden Lathamer

11. BIRTHPLACE OF FATHER

(State or Country) Kentucky

12. MAIDEN NAME OF MOTHER

Ellen Mitchell

13. BIRTHPLACE OF MOTHER

(State or Country) Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) K. C. Cotton
 (Address) Gale Ida.

15. Filed Mar 3 1922 D. J. C. Patterson
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 20 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 18 1922 to Feb 20 1922

that I last saw him alive on Feb 20 1922 and that death occurred on the date stated above, at 12 noon

The CAUSE OF DEATH* was as follows:

Subacute Obstruction
Glens
 (Duration) 3 Yrs. 3 mos. 3 ds.

Contributory (Secondary)

(Duration) 3 Yrs. 3 mos. 3 ds.
 (Signed) D. J. C. Cotton M. D.
Burley Ida.
 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 3 yrs. 3 mos. 3 days, State 8 yrs. 3 mos. 3 days

Where was disease contracted if not at place of death? Gale Ida.

Former or usual residence Gale Ida.

19. PLACE OF BURIAL OR REMOVAL

Burley Ida.

20. UNDERTAKER

L. B. Gentry

DATE OF BURIAL

Feb. 21 1922

ADDRESS

Burley Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Clark*
City of *Spencer*Registration District No. *125*Primary Registration District No. *2203*

(No. _____, _____ St.)

File No. *37229*

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William Owen Johnson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

male white Single
(Write the word.)

6. DATE OF BIRTH

Feb. 13 1921
(Month) (Day) (Year)

7. AGE

*1 Yrs. 11 mos. 11 ds.*IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Wyoming

10. NAME OF FATHER

Chas Johnson

11. BIRTHPLACE OF FATHER

(State or Country)

Kansas

12. MAIDEN NAME OF MOTHER

Angie Baker

13. BIRTHPLACE OF MOTHER

(State or Country)

Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Chas Johnson

(Address)

*American Falls Ida*15. Filed *Feb 25 1922*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb. 24 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

*Feb 19 1922 to Feb 24 1922*that I last saw him alive on *Feb 24 1922*and that death occurred on the date stated above, at *4:20 PM*

The CAUSE OF DEATH* was as follows:

Bronchopneumonia(Duration) _____ Yrs. _____ mos. *3* ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

*W E Jones M.D.**225 1922* (Address) *Subotz Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

*American Falls Ida*DATE OF BURIAL *Feb 26 1922*

20. UNDERTAKER

Chiffey

ADDRESS

Idaho Falls Ida

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Chautauque*City of *Orpio*

If death occurs away from usual residence, give facts called for under special information.

Registration District No. *90*Primary Registration District No. *2168*

(No. St.)

2. FULL NAME

*Emma Aptell*State of Idaho
BOARD OF HEALTH

Bureau of Vital Statistics

File No. *37230*Registered No. *3*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

Nov
(Month)*8*
(Day)*1857*
(Year)

7. AGE

70 Yrs.*7* Mos.*17* ds.IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

E. M. Aptell

11. BIRTHPLACE OF FATHER

(State or Country)

Iowa

12. MAIDEN NAME OF MOTHER

M. Lundy

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mrs. Vera Holden*(Address) *Orpio, Idaho*

15.

Filed *Feb 15 1922*

1922

J. J. Family
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan
(Month)*25*
(Day)*1922*
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

..... 191..... to 191.....

that I last saw h..... alive on 191.....

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Carcinoma of orbit(Duration) *7* Yrs. mos. ds.Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

Feb 15 1922 (Address)*M. J. Family, M. D.*
Orpio, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days, State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Local County, Idaho

DATE OF BURIAL

Jan 27 1922

20. UNDERTAKER

W. A. Shaw

ADDRESS

Orpio

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17

RECEIVED
MAR 20 1922

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Clearwater*

Registration District No. *90*

City of *Orono*

Primary Registration District No. *2168*

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Margie E. Merrill

State of Idaho
BOARD OF HEALTH

Bureau of Statistics

File No. *37231*

Registered No. *4*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH.

Aug 21 1860
(Month) (Day) (Year)

7. AGE

60 Yrs. *4* Mos. *17* ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Housekeeper

9. BIRTHPLACE

(State or Country)

Ida

10. NAME OF FATHER

Chaflin Merrill

11. BIRTHPLACE OF FATHER

(State or Country)

New York

12. MAIDEN NAME OF MOTHER

Julie K. McEwen

13. BIRTHPLACE OF MOTHER

(State or Country)

New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. W. McEwen
Orono Ida

15.

Filed

July 15 1922

E. M. Daily
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 8 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

about 1910 to *Jan 8 1922*

that I last saw her alive on *Jan 8 1922*

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Acute nephritis with uraemic poisoning

(Duration) Yrs. mos. *8* ds.

Contributory (Secondary)

Epilepsy

(Duration) Yrs. mos. ds.

(Signed)

Jan 8 1922 (Address) *M. D. Orono Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days, State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Orono Ida

DATE OF BURIAL

Jan 10 1922

20. UNDERTAKER

W. A. Shaw

ADDRESS

Orono

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

RECEIVED
MAR 20 1922

CERTIFICATE OF DEATH

1. PLACE OF DEATH Bureau of Vital Statistics Registration District No. 90
County of Elmore STATISTICAL Registration District No. 2168
City of Proffo (No. _____, _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37234
Registered No. 7

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Alexander L. Nicholson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH 7 3 1872
(Month) (Day) (Year)

7. AGE about 20 yrs. 0 mos. 0 ds. IF LESS than 1 day how many 0 hrs. or 0 min?

8. OCCUPATION

(a) Trade, profession or particular kind of work insurance agent
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Canada

10. NAME OF FATHER

?

11. BIRTHPLACE OF FATHER

(State or Country)

?

12. MAIDEN NAME OF MOTHER

?

13. BIRTHPLACE OF MOTHER

(State or Country)

?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. W. Hutton
Proffo, Idaho

15.

Filed

Feb 1 1922

J. M. Hutton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

February 13 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 30 1921, to February 13 1922
that I last saw him alive on Feb. 13 1922
and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Epileptoid Convulsions

(Duration) 0 yrs. 0 mos. 0 ds.

Contributory (Secondary)

Insanity

(Duration) 7 yrs. 2 mos. ? ds.

(Signed) John S. Stevens M. D.
214 1922 (Address) on fine Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place 5 yrs. 13 mos. 13 ds. In the ? yrs. 0 mos. 0 ds.

Where was disease contracted, ?

If not at place of death? ?

Former or usual residence Shoshone Co. Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wallace Ida Feb 1922

20. UNDERTAKER

ADDRESS

V. A. Shaw Proffo

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Statistics
File No. **37235**

Registered No. **8**
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of *Clearwater*City of *Gilbert*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Carl Frost

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH.

Feb
(Month)*14*
(Day)*1907*
(Year)

7. AGE

15 Yrs.*11* Mos.*11* ds.

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9. BIRTHPLACE

Idaho
(State or Country)

10. NAME OF FATHER

Edw. Waters

11. BIRTHPLACE OF FATHER

Unknown
(State or Country)

12. MOTHER NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

Unknown
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

*Mr. A. W. Groat
Gilbert, Ida*

15.

Filed

Feb 1, 1912

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb
(Month)*25*
(Day)*1912*
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191

to

191

that I last saw him alive on

and that death occurred on the date stated above, at *7:20* A.M.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(Duration)

3 Yrs.

mos.

ds.

Contributory
(Secondary)*Influenza*

(Duration)

8 Yrs.

mos.

ds.

(Signed)

J. M. Groat M. D.

State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death yrs. mos. days. State yrs. mos. days

Where was disease contracted

if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

Gilbert, Ida

DATE OF BURIAL

Feb. 27, 1912

20. UNDERTAKER

A. A. Shaw

ADDRESS

Croft

should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of ElmoreRegistration District No. 34Primary Registration District No. 2020

City of _____

(No. _____ St.)

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

John E. CoderFile No. 37236
Registered No. 4If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX, 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED
Male White Single
(Write the word.)

6. DATE OF BIRTH

Feb. 2 1895
(Month) (Day) (Year)

7. AGE

27 Yrs. 0 Mos. 5 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work. Farmer & Trapper.
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer) _____

9. BIRTHPLACE

(State or Country) Grangeville Idaho.10. NAME OF
FATHERE. H. Coder.11. BIRTHPLACE
OF FATHER(State or Country) Penn.12. MAIDEN NAME
OF MOTHERMary d. Straugh13. BIRTHPLACE
OF MOTHER(State or Country) Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harry H. Coder.
(Address) 602 2d mine Pocetello Id.

15.

Filed 2-13- 1922J. E. Evans
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb. 7th 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
_____ 19____, to _____ 19____
that I last saw h. _____ alive on _____ 19____
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Accidental - caught
in snow slide

_____. (Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary) _____

_____. (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. E. Evans M. D.Feb 12 22 (Address) W. T. Jones, Ida.*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted
if not at place of death? _____Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Mt. Home Ida

DATE OF BURIAL

2-14-1922

20. UNDERTAKER

L. S. Benson,

ADDRESS

Manpa, Ida

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Elmore
City of Montrose

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 34
Primary Registration District No. 2020
(No. _____, St. _____)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37237
Registered No. 5

2. FULL NAME

Clara Belle Hoffman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH

Nov. 29 1921
(Month) (Day) (Year)

7. AGE

0 Yrs. 2 Mos. 26 ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Orchard Ida.

10. NAME OF FATHER

Corda Hoffman

11. BIRTHPLACE OF FATHER

(State or Country)

Ida

12. MAIDEN NAME OF MOTHER

Katherine Daley

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Corda A. Hoffman
Orchard Ida.

(Address)

15.

Filed

2-27-1922

J. E. Evans
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Febr. 25 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Febr. 24 1922 to Febr 25-1922

that I last saw h. 21 alive on 2-24-1922
and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

..... (Duration) Yrs. mos. 4 ds.

Contributory
(Secondary)

..... (Duration) yrs. mos. ds.

(Signed)

J. E. Evans M. D.

2-27-1922 (Address) Montrose Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Mont. Home

DATE OF BURIAL

2-27-1922

20. UNDERTAKER

L. B. Benson Montrose Ida.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Elmore*City of *Mtn Home*Registration District No. *34*Primary Registration District No. *2020*

(No. _____ St.)

File No. *37238*Registered No. *6*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Sarah J. Lawson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widow
(Write the word.)

6. DATE OF BIRTH

Feb.

(Month)

12

(Day)

1887

(Year)

7. AGE

65

Yrs.

0

Mos.

13

ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

Henry Mater

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Catharin Wilkes

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

*Grace Lawson
Waterloo Iowa.*

15.

Filed

*2-26-1922**J. E. Evans*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb.

(Month)

25

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from *11-28* 19*21* to *Feb 25* 19*22*that I last saw her alive on *Feb 25* 19*22*and that death occurred on the date stated above, at *9 P.* M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(Duration) _____ Yrs. *10* mos. _____ ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

L. O. P. Hamilton M. D.*2-26-1922*

(Address)

Mt Home Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

After Iowa

DATE OF BURIAL

19

20. UNDERTAKER

L. S. Benson

ADDRESS

Hampton, Ida.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Franklin
City of PrestonRegistration District No. 27Primary Registration District No. 2119(No. 2119)

St.)

File No. 37239Registered No. 18

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Elizabeth Davis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

widowed
(Write the word.)

6. DATE OF BIRTH

Jul. 6 1842
(Month) (Day) (Year)

7. AGE

80 Yrs. 7 Mos. 1 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Wales

10. NAME OF FATHER

Thomas Lewis

11. BIRTHPLACE OF FATHER

(State or Country)

Wales

12. MAIDEN NAME OF MOTHER

Margaret Jones

13. BIRTHPLACE OF MOTHER

(State or Country)

Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Inscribed)

(Address)

Margaret A. Pershan

15.

Filed

3-419 22Mrs. M. L. Lippert
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 7 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec. 1 19 21, to Feb 7 19 22that I last saw h. alive on Feb 6 19 22and that death occurred on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart DiseaseParalysis(Duration) 5 Yrs. x mos. 7 ds.Contributory
(Secondary)Arteriosclerosis(Duration) 2 yrs. 7 mos. 1 ds.

(Signed)

J. C. Humphreys M. D.Feb 19 22 (Address) Preston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. 0 mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Preston

DATE OF BURIAL

Feb. 10 19 22

20. UNDERTAKER

W. A. Skidmore

ADDRESS

Preston Ida.

1. PLACE OF DEATH

County of Franklin Registration District No. 27
 City of Preston Primary Registration District No. 2119
 (No. 113) St.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Elvira Henderson Horstgen

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 37240Registered No. 9

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED married
 (Write the word.)

6. DATE OF BIRTH

April 15 1877
 (Month) (Day) (Year)

7. AGE

25 Yrs. 9 Mos. 16 ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Soda Springs, Idaho

10. NAME OF FATHER

Wm A. Henderson

11. BIRTHPLACE OF FATHER

(State or Country)

Kaysville Utah

12. MAIDEN NAME OF MOTHER

Elvira A. Stevenson

13. BIRTHPLACE OF MOTHER

(State or Country)

Millville Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Dora Henderson

(Address)

Preston Idaho

15.

Filed 3-4

1922

Mrs. Ida Lipsch
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Febr 1 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov. 22 1921, to Febr 1 1922
 that I last saw her alive on Jan. 31 1922,
 and that death occurred on the date stated above, at 6 A M.

The CAUSE OF DEATH* was as follows:

Septicæ pyæmia - following
virulent Erysipelas

(Duration) Yrs. mos. ds.

Contributory
 (Secondary)

Erysipelas

(Duration) yrs. mos. ds.

(Signed)

G W States

M. D.

Febr 1 1922 (Address) Preston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Preston Ida

DATE OF BURIAL

Feb. 3 1922

20. UNDERTAKER

W. A. Skidmore

ADDRESS

Preston Ida

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Franklin Registration District No. 27
City of Preston Primary Registration District No. 2119
No. _____ St. _____File No. 37241Registered No. 11If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Kenneth O. KellerIf death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDMaleWhitesingle
(Write the word.)

6. DATE OF BIRTH

Sept. 24 1920
(Month) (Day) (Year)

7. AGE

16 Yrs. 12 Mos. 12 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work _____
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer) _____

9. BIRTHPLACE

(State or Country) Idaho10. NAME OF
FATHERRoyal Keller11. BIRTHPLACE
OF FATHER(State or Country) Idaho12. MAIDEN NAME
OF MOTHERAnnie Oliverson13. BIRTHPLACE
OF MOTHER(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Margaret Oliverson(Address) Preston Idaho

15.

Filed Mar 6 1922Mrs. H. Lippert
Sept Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 12 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 20 1921 to Feb 12 1922
that I last saw him alive on Feb 5 1922
and that death occurred on the date stated above, at 6:49 M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia(Duration) Yrs. 5 mos. 5 ds.Contributor
(Secondary) Editha(Duration) yrs. 6 mos. 5 ds.(Signed) A. R. Custer M. D.2-13 1922 (Address) Preston Idaho*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted
if not at place of death? _____Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Franklin Idaho

DATE OF BURIAL

Feb 14 1922

20. UNDERTAKER

ADDRESS

1. PLACE OF DEATH

County of FremontCity of Ashton

If death occurs away from usual residence, give facts called for under special information.

CERTIFICATE OF DEATH

Register District No. 103Primary Registration District No. 6

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 37242

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jeddie Joseph Vannoy

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

MaleWhite(Widowed) Married

6. DATE OF BIRTH

August 29 1867
(Month) (Day) (Year)

7. AGE

54

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Quartz Miner
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

W.T. Vannoy

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Katherine Hendricks

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Samuel . T Vannoy(Address) Ashton Idaho

15.

Filed 3-28 1927

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 27th 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 1 1921 to March 27 1922that I last saw him alive on March 27 1921and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Tuberculous lungs.(Duration) 2 Yrs. mos. ds.Contributory
(Secondary)(Duration) 2 Yrs. mos. ds.(Signed) J. P. Sharpe M.D.3/28 1922 (Address) Ashton Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL
Ashton Idaho.DATE OF BURIAL
3/29/22 192220. UNDERTAKER
Lewis KiserADDRESS
Ashton Idaho.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH **Fremont**
 (County of) **Ashton**
 City of **Ashton**
 If death occurs away from usual residence, give facts called for under special information.

Registration District No. **102**
 Primary Registration District No. **6**
 (No.) **37243**
 St.) **Ashton**

2. FULL NAME **Russell Heber Smith**

File No. **37243**
 Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Single**
 (Write the word.)

6. DATE OF BIRTH **Dec. 18/ 1921**
 (Month) (Day) (Year)

7. AGE **1** **27** IF LESS than 1 day
 how many hrs.
 Yrs. Mos. ds. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

At Home

9. BIRTHPLACE

(State or Country) **Marysville Idaho**

10. NAME OF FATHER

D.A. Smith

11. BIRTHPLACE OF FATHER

(State or Country) **Wyoming**

12. MAIDEN NAME OF MOTHER

Rose Shepard

13. BIRTHPLACE OF MOTHER

(State or Country) **Idaho**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **D.A. Smith**(Address) **Felt Idaho**

15. Filed **3-17** 19 **22** **Ashton**
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March. 16th 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **March 1, 1922** to **March 16, 1922**
 that I last saw him alive on **March 16, 1922**
 and that death occurred on the date stated above, at **2 A.M.**

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) Yrs. Mos. ds.
 Contributory (Secondary) **Purulent Otitis Media**

(Duration) Yrs. Mos. ds.
 (Signed) **E. P. Hargis** M. D.

3/14 19 **22** (Address) **Ashton Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **Marysville Cemetery** DATE OF BURIAL **19**

20. UNDERTAKER **Lewis Kiser** ADDRESS **Ashton Idaho**

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of **Fremont**City of **Ashton**

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
APR 3 1922
BUREAU OF VITAL STATISTICSRegistration District No. **103**Primary Registration District No. **6**

St.)

File No. **37244**

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME **Martha A. Henderson Day**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female **White** (**Widowed** (widow or divorced))

6. DATE OF BIRTH

March **13** **1882**
(Month) (Day) (Year)

7. AGE

90 Yrs. **11** Mos. **3** ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

At Home

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

*** Henderson**

11. BIRTHPLACE OF FATHER

(State or Country)

Vermont

12. MAIDEN NAME OF MOTHER

Dont Know

13. BIRTHPLACE OF MOTHER

(State or Country)

Dont Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Fred Day(Address) **Weston Idaho.**

15.

Filed **2-16-22**

19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb. **15/1922** 19.....
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

2-14-22 to **2-15-22** 19.....that I last saw him alive on **2/14** 19.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Dont Know.

(Duration)..... mos..... ds.

Contributory (Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed)

3/15/22 19..... (Address) **Ashton, Idaho.** M. D.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

Richmond Utah

DATE OF BURIAL

2/20 19.....

20. UNDERTAKER

Lewis Kiser

ADDRESS

Ashton Idaho

DEC 17 1976

MAR 9 1981

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

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1. PLACE OF DEATH

County of *Gem*City of *Emmett*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registered District No. *6*Primary Registration District No. *6*

(Not filed)

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *37247*

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

married
(Write the word.)

6. DATE OF BIRTH

July 18 1888
(Month) (Day) (Year)

7. AGE

33 Yrs. *7* Mos. *28* ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. *Stationery Engineer*
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) *Idaho*

10. NAME OF FATHER

Isaac A. Andrew

11. BIRTHPLACE OF FATHER

(State or Country) *Utah*

12. MAIDEN NAME OF MOTHER

Sarah Ann Horn

13. BIRTHPLACE OF MOTHER

(State or Country) *Utah*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Alysin Andrew*(Address) *Indian Valley, Idaho*

15.

Filed *3/18**19 22**J. L. Reynolds*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 16 19 22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar 13 1922, to Mar 16 1922.
that I last saw him alive on *Mar 15 1922.*
and that death occurred on the date stated above, at *2 4* M.
The CAUSE OF DEATH* was as follows:*Pneumonia Bronchial*(Duration) Yrs. mos. *4* ds.Contributory (Secondary) *Influenza*(Duration) yrs. mos. *6* ds.(Signed) *J. L. Reynolds**3/18 19 22* (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Emmett Ida

DATE OF BURIAL

3/18 19 22

20. UNDERTAKER

C. D. Buckner

ADDRESS

*Emmett**Ida*

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED
APR 5 1922
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No.

Registration District No.

(No.)

(St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

37248

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED
(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

19

Local Registrar

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

1912 to May 15 1922
that I last saw him alive on May 15 1922
and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

(Duration) 10 Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. L. Reynolds M. D.

19 (Address) Emmett Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Emmett Idaho

3/17 1922

20. UNDERTAKER

ADDRESS

C. D. Bucknum

Emmett Idaho

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of *Gen*
City of *Emmett*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Serena Ann Plant

RECEIVED
APR 3 1922
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH
Registration District No.
Primary Registration District No. *6* ...
St.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. *37249*

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

widow
(Write the word.)

6. DATE OF BIRTH

July 16 19*84*
(Month) (Day) (Year)

7. AGE

74 Yrs. *7* Mos. *27* ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Housewife

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

Simpson Bonds

11. BIRTHPLACE OF FATHER

(State or Country)

Missouri

12. MAIDEN NAME OF MOTHER

Millie Ann Wisk

13. BIRTHPLACE OF MOTHER

(State or Country)

Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ida Harnie

(Address)

Emmett Idaho

15.

Filed

3/14

19*22*

J. L. Reynolds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 13 19*22*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar 8 19*22*, to *Mar 13* 19*22*.

that I last saw him alive on *Mar 12* 19*22*.

and that death occurred on the date stated above, at.....M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) Yrs. mos. *3* ds.

Contributory (Secondary)

influenza

(Duration) yrs. mos. *2* ds.

(Signed)

J. L. Reynolds

M. D.

3/14/22 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Emmett Idaho

DATE OF BURIAL

3/15/22

20. UNDERTAKER

C. R. Bucknum

(ADDRESS)

Emmett Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Gen* Registration District No. *6*
City of *Emmett* Primary Registration District No. *6*
HOSPITAL St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

BUREAU OF
STATISTICS*Edmond H. Head*File No. *37250*Registered No. *37250*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

widower
(Write the word.)

6. DATE OF BIRTH

Nov 20 1845
(Month) (Day) (Year)

7. AGE

*76 Yrs. 3 Mos. 18 ds.*IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Texas

10. NAME OF FATHER

James A. Head

11. BIRTHPLACE OF FATHER

(State or Country)

not known

12. MAIDEN NAME OF MOTHER

" "

13. BIRTHPLACE OF MOTHER

(State or Country)

" "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

F.H. Burns

(Address)

Emmett Idaho

15.

Filed

*3/10**1922**Jed Reynolds*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 8 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar 8 1922, to Mar 8 1922,
that I last saw him alive on *Mar 8 1922*
and that death occurred on the date stated above, at *11 P.M.*
The CAUSE OF DEATH* was as follows:*Influenza*(Duration) Yrs. mos. *2* ds.Contributory (Secondary) *General debility*(Duration) yrs. mos. *1* ds.(Signed) *Jed Reynolds* M. D.*3/10 1922* (Address) *Emmett Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Falk, Ida

DATE OF BURIAL

3/10 1922

20. UNDERTAKER

Ed Bucknum

ADDRESS

Emmett Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of GemCity of Emmett

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No. 6

(No.)

St.)

File No. 37251

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Henry Allison Barclay

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDmarried
(Write the word.)

6. DATE OF BIRTH

Dec 27 1891
(Month) (Day) (Year)

7. AGE

30 Yrs. 2 Mos. 9 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

Laborer

9. BIRTHPLACE

(State or Country)

Nebraska

10. NAME OF FATHER

Henry Barclay

11. BIRTHPLACE OF FATHER

(State or Country)

Indiana

12. MAIDEN NAME OF MOTHER

Mary M^cIntire

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Henry Barclay

15.

Filed 3/6 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 6 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar 3 1922 to Mar 6 1922that I last saw him alive on Mar 5 1922and that death occurred on the date stated above, at A, M.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Burton O. Clark M. D.3-6-1922 (Address) Emmett Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Emmett Idaho3/8 1922

20. UNDERTAKER

ADDRESS

Co. BucknumEmmett Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Germ*
City of *Emmett*

Registration District No. _____

Primary Registration District No. _____

(No. _____, St.) _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Infant Son of John Doherty*State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **37252**

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

*white*5. SINGLE, MARRIED, WID-
OWED OR DIVORCED*infant*

(Write the word.)

6. DATE OF BIRTH

March 12 1922
(Month) (Day) (Year)

7. AGE

2
Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)*Infant*

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

John Doherty

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Mary Doyle

13. BIRTHPLACE OF MOTHER

(State or Country)

New Jersey

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

John Doherty
Emmett Idaho

15.

Filed

*3/16 22**J. D. Reynolds*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 15 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

*Mar 12 1922 to Mar 14 1922*that I last saw him alive on *Mar 14 1922*and that death occurred on the date stated above, at *8 A. M.*

The CAUSE OF DEATH was as follows

Convulsion

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Benton O. Clark M. D.
3/16 1922 (Address) *Emmett*

*State the Disease Causing Death; or in deaths from Violent Causes, add (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Emmett Idaho

DATE OF BURIAL

3/16 1922

20. UNDERTAKER

O. D. Bucknum

ADDRESS

*Emmett**Idaho*

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Ben*
City of *Emmett*

Registration District No. *6*
Primary Registration District No. *6*
(No. *6* St.)

File No. *37253*
Registered No. *37253*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Samantha Horine

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *married*
(Write the word.)

6. DATE OF BIRTH

Apr 9 1849
(Month) (Day) (Year)

7. AGE

72 Yrs. *10* Mos. *29* ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Housewife

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

James Davis

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Levina Morrell

13. BIRTHPLACE OF MOTHER

(State or Country)

Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

E. J. Horine
Emmett Ida

15.

Filed

3/10

1922

J. L. Reynolds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 8 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar 6 1922 to *Mar 6 1922*

that I last saw her alive on *Mar 6 1922*

and that death occurred on the date stated above, at *M.*

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) Yrs. *2* mos. *2* ds.

Contributory (Secondary) *Influenza*

(Duration) Yrs. *2* mos. *2* ds.

(Signed) *R. M. Emmett*

3/10 1922 (Address) *Emmett*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. *2* mos. *2* days. In the State Yrs. *2* mos. *2* days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Emmett Ida

DATE OF BURIAL

3/10 1922

20. UNDERTAKER

R. M. Emmett

ADDRESS

Emmett Ida

✓
CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Gem
City of Emmett

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No. 4

(No. St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 37254

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Catherine Matheson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

Jan 4 1844
(Month) (Day) (Year)

7. AGE

78 Yrs. 1 Mos. 28 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

Housewife

9. BIRTHPLACE

(State or Country)

Scotland

10. NAME OF FATHER

John MacLennan

11. BIRTHPLACE OF FATHER

(State or Country)

Scotland

12. MAIDEN NAME OF MOTHER

Ann Morrison

13. BIRTHPLACE OF MOTHER

(State or Country)

Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) George Matheson

(Address)

15.

Filed

3/319 22J. L. Reynolds

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 2 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 1 1922, to Feb 28 1922that I last saw her alive on Feb 28 1922,and that death occurred on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral thrombus(Duration) Yrs. 7 mos. ds.Contributory Arterio sclerosis

(Secondary)

(Duration) yrs. mos. ds.

(Signed) R. N. Cummings M. D.3/3 1922 (Address) Emmett

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Boise Idaho

DATE OF BURIAL

3/4 1922

20. UNDERTAKER

C. B. Bucknum

ADDRESS

Emmett Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Blaine*
City of *Emmett*

Registration District No.

Primary Registration District No. *6*

(No. St.)

File No.

Registered *37255*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Moses Hess

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Male white Married
(Write the word.)

6. DATE OF BIRTH

Feb 5 1849
(Month) (Day) (Year)

7. AGE

73 Yrs. *1* Mos. *8* ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Indiana

10. NAME OF FATHER

Peter Hess

11. BIRTHPLACE OF FATHER

(State or Country)

Indiana

12. MAIDEN NAME OF MOTHER

Not known

13. BIRTHPLACE OF MOTHER

(State or Country)

" "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. B. Phelps

(Address)

Emmett Idaho

15.

Filed

3/15 1922

J. d. Reynolds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 13 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 27 1922 to Mar 18 1922
that I last saw him alive on *Mar 13 1922*,
and that death occurred on the date stated above, at..... M.
The CAUSE OF DEATH* was as follows:

apoplexy (Cerebral Hemorrhage)

(Duration) Yrs. mos. *16* ds.

Contributory (Secondary) *Arterio Sclerosis*

(Duration) yrs. mos. ds.

(Signed) *J. d. Reynolds* M. D.

3/15 1922 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Emmett Idaho

DATE OF BURIAL

3/15 1922

20. UNDERTAKER

C. D. Buckner

ADDRESS

Emmett Idaho

V CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 37256
Registered No. 37256

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of BenCity of EmmettRegistration District No. 6Primary Registration District No. 6

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Julia A. Cook

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female4. COLOR OR RACE white5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married

(Write the word.)

6. DATE OF BIRTH Sept 6 1876

(Month)

(Day)

(Year)

7. AGE 45 Yrs. 5 Mos. 5 ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION Housewife

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE Missouri

(State or Country)

10. NAME OF FATHER Miller Berger11. BIRTHPLACE OF FATHER Missouri

(State or Country)

12. MAIDEN NAME OF MOTHER Louemma Bryan13. BIRTHPLACE OF MOTHER Missouri

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Adolph Cook(Address) Emmett Ida15. 3/12 1922

Filed

1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 11 1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 8 1922 to Mar 10 1922that I last saw her alive on Mar 10 1922

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(Duration) Several yrs. mos. ds.Contributory (Secondary) Myocarditis

(Duration) yrs. mos. ds.

(Signed) J. D. Reynolds M. D.3/12 1922 (Address) Emmett

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL Emmett IdaDATE OF BURIAL 3/12 192220. UNDERTAKER W. BucknerADDRESS Emmett

Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Gooding Registration District No. 4
City of Gooding Primary Registration District No. 4
St. Idaho

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

George ReeshaFile No. 37257Registered No. _____
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH.

Dec. 9 1921
(Month) (Day) (Year)

7. AGE

2 Yrs. 23 Mos. 3 ds.IF LESS than 1 day
how many hrs. or
..... min. 2

8. OCCUPATION

(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Elias Reesha

11. BIRTHPLACE OF FATHER

(State or Country)

Syria

12. MAIDEN NAME OF MOTHER

Clotilda Ache

13. BIRTHPLACE OF MOTHER

(State or Country)

Syria

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Elias Reesha
Father

(Address)

Filed 3/10191 22J. Flannery

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar. 4 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from 12/9/21 191..... to 3/23/22 191.....that I last saw him alive on 3/3/22 191.....and that death occurred on the date stated above, at 7 A. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) G. G. Thompson M. D.3/5/22 (Address) Gooding

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....Yrs.....Mos.....Days In the State.....Yrs.....Mos.....Days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Gooding Idaho

DATE OF BURIAL

3-6 191 22

20. UNDERTAKER

G. G. Thompson

ADDRESS

Gooding

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of *Gooding*
City of *Gooding*

Registration District No. *24*

Primary Registration District No.

(No. *1*)

St.)

File No. *37258*
Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lydia Greenway

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

female white married
(Write the word.)

6. DATE OF BIRTH.

Sept. 30 1879
(Month) (Day) (Year)

7. AGE

42 Yrs. *4* Mos. *23* ds.

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife

9. BIRTHPLACE

(State or Country)

Nebraska

10. NAME OF FATHER

Jacob Barth

11. BIRTHPLACE OF FATHER

(State or Country)

Russia

12. MAIDEN NAME OF MOTHER

Regina Schelagh

13. BIRTHPLACE OF MOTHER

(State or Country)

Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Pauline Gurt

(Address)

Turin Falls, Ida

15.

3-3-1911

J. J. Thompson

Filed

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb. 22, 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Feb. 18 1922* to *Feb. 22 1922*

that I last saw her alive on *Feb. 28 1921*

and that death occurred on the date stated above, at *10:20* M.

The CAUSE OF DEATH* was as follows:

ACIDOSIS following operation for Prolapse of Uterus and

Rectoscele and removal of

Appendix. Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) *A. E. Lamb* M. D.

2/22/22 (Address) *Gooding Idaho.*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death *6 days* In the State *6* yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence *Paul, Idaho.*

19. PLACE OF BURIAL OR REMOVAL

Paul Idaho

DATE OF BURIAL

2/24 1922

20. UNDERTAKER

A. E. Thompson

ADDRESS

Gooding, Ida

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Idaho*City of *Woodland*Registration District No. *49*Primary Registration District No. *2428*File No. *37259*Registered No. *37259*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Amata Arrants

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

February 28
(Month) (Day) (Year)*1918*
(Year)

7. AGE

Four Yrs. *Two* Mos. *Two* ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Shot of a Philad

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Nebraska

10. NAME OF FATHER

Earnest H. Arrants

11. BIRTHPLACE OF FATHER

(State or Country)

Nebraska

12. MAIDEN NAME OF MOTHER

Della Hastings

13. BIRTHPLACE OF MOTHER

(State or Country)

Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Fred H. Bacon

(Address)

Woodland Idaho

15. Filled

*3/3**1922**J. Johnson*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 2
(Month) (Day) (Year)*22*
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19..... to 19.....

that I last saw him..... alive on..... 19.....

and that death occurred on the date stated above, at *6:30 A.M.*

The CAUSE OF DEATH* was as follows:

*Accidentally killed while
coasting down hill
no physician*
(Duration) Yrs..... mos..... ds.
Contributory (Secondary) Physician -
(Duration) Yrs..... mos..... ds.

(Signed)..... M. D.

19..... (Address).....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

Woodland Id

DATE OF BURIAL

3/3 19*22*

20. UNDERTAKER

J. Johnson

ADDRESS

Married Id

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

1. PLACE OF DEATH.

County of Idaho
City of Zen

Registration District No. 105Primary Registration District No. 2183(No. 105)

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Herman Van Bargaon
Herman Van Bargaon

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 37260

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

m

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH.

Sept271855

(Month)

(Day)

(Year)

7. AGE

66

Yrs.

5

Mos.

ds.

If LESS than 1 day
how many.....hrs. or
.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

Farmer

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

Koepke Vanbargaon

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Schlichling (Rebecca)

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Clara M. Hugh

(Address)

Zen, Idaho

15.

Filed

3-71922W. F. O. M.

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb261922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb. 241922to Feb. 261922that I last saw him alive on Feb. 26 1922and that death occurred on the date stated above, at 1230 P. M.

The CAUSE OF DEATH* was as follows: *

Cerebral Embolism.

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)Arterio Sclerosis

(Duration)

Yrs.

mos.

ds.

(Signed)

Wesley F. O. M.2/26 1922 (Address)Cottamwood, Ida.

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death.....yrs.....mos.....days

In the

State.....yrs.....mos.....days

Where was disease contracted
if not at place of death?.....

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Denver

DATE OF BURIAL

Feb. 28 1922

20. UNDERTAKER

E. S. Hancock

ADDRESS

Brangville

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Idaho Registration District No. 106
City of Kooskia Primary Registration District No. 2184
(No. _____ St.)

File No. **37261**

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William Kilbley Rich.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH.

February 24 1841
(Month) (Day) (Year)

7. AGE

80 Yrs. 11 Mos. 19 ds.

If LESS than 1 day
how many.....hrs. or
.....min.2

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

Carpenter

9. BIRTHPLACE

(State or Country)

Pembroke Inc.

10. NAME OF FATHER

Joseph Rick

11. BIRTHPLACE OF FATHER

(State or Country)

Do not know

12. MAIDEN NAME OF MOTHER

Harvey Wood.

13. BIRTHPLACE OF MOTHER

(State or Country)

Do not know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Bert Baker
Kooskia Ida

(Address)

15.

Filed Feb 13 1922

W. H. H. H. H.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

February 12 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 11 - 1922 to one call 1922,
that I last saw him alive on Feb 11 1922
and that death occurred on the date stated above at 8:00 P. M.
The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) _____ Yrs. _____ mos. 1 ds.

Contributory
(Secondary)

Age

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) A. F. Wohlenberg M. D.

1922 (Address) Kooskia, Ida

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Idaho Cemetery

DATE OF BURIAL

Feb 14 1922

20. UNDERTAKER

Geo. Frenay.

ADDRESS

Kooskia, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 5-25 M. 1-16-13

RECEIVED CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

APR 6 1922
Registry District No. 23

County of Jerome

BUREAU OF VITAL STATISTICS
Primary Registration District No. 1017-2017

City of Jerome

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Clair Alanya Prichett

File No.

Registered No.

35262

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

Male White (Write the word)

6. DATE OF BIRTH.

June 22 1895
(Month) (Day) (Year)

7. AGE

26 Yrs. 8 Mos. 11 ds.

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Barber

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

W. E. Prichett

11. BIRTHPLACE OF FATHER

(State or Country)

Ill

12. MAIDEN NAME OF MOTHER

Grace Bell Shipman

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. Grace Patton

(Address)

Jerome

15.

Filed

APR 4

191

E. D. Piper M. D.

Local Registrar

16. DATE OF DEATH

Feb 3 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 15, 1922, to Mar 3 1922

that I last saw him alive on Mar 3 1922

and that death occurred on the date stated above, at 1:30 P. M.

The CAUSE OF DEATH was as follows:

Epicemic Infarction

(Duration) Yrs. mos. 5 ds.

Contributory (Secondary)

Diabetes mellitus

(Duration) Yrs. mos. 6 ds.

(Signed)

Wm F. Schmershall M. D.

1922 (Address)

Jerome Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mulvane House

Feb 5 1922

20. UNDERTAKER

ADDRESS

S. A. Houson Jerome

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Rootenac
 City of Coeur d'Alene
 Registration District No. 30
 Primary Registration District No. 1037
 No. 110 Coeur d'Alene St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Brandvold

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 37264
 Registered No. 1038

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED single
 (Write the word.)

6. DATE OF BIRTH Feb. 2 1922
 (Month) (Day) (Year)

7. AGE _____ IF LESS than 1 day
 Yrs. Mos. ds. how many 4 hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE Coeur d'Alene, Idaho
 (State or Country)

10. NAME OF FATHER Joseph Brandvold

11. BIRTHPLACE OF FATHER Idaho
 (State or Country)

12. MAIDEN NAME OF MOTHER Verla Elder

13. BIRTHPLACE OF MOTHER N. Dak
 (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joe Brandvold
 (Address) _____

15. Filed 3/6 1922 St. Brea
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb. 2 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 2 1922 to Feb 22 1922
 that I last saw him alive on Feb 22 1922
 and that death occurred on the date stated above, at 8 A. M.
 The CAUSE OF DEATH* was as follows:

Premature birth

(Duration) Yrs. mos. ds.

Contributory
 (Secondary)

(Duration) yrs. mos. ds.

(Signed)

Feb 3 1922 (Address) Coeur d'Alene, Ida M. D.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Bonnet Cem. Coeur d'Alene DATE OF BURIAL 2-3 1922

20. UNDERTAKER C. Carstedt ADDRESS Coeur d'Alene

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Proterus*City of *Post Falls*

If death occurs away from usual residence, give facts called for under special information.

Registration District No. *30*Primary Registration District No. *1051*(No. *Post Falls* St.)

2. FULL NAME

*Charles Schlack*State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *37265*Registered No. *1038*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Male

4. COLOR OR RACE

*White*5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

Dec 10 1831
(Month) (Day) (Year)

7. AGE

*90 Yrs. 2 Mos. 1 ds.*IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Retired

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

Henry Schlack

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. V. Schlack

(Address)

Post Falls, Ida.

15.

Filed *3/6**1922**O. D. Drama*
Local Registrar

16. DATE OF DEATH

February 11 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

*Jan 13 1922 to Feb 10 1922*that I last saw him alive on *Feb 1st 1922*and that death occurred on the date stated above, at *6 A.M.*

The CAUSE OF DEATH* was as follows:

Gangrene following an infected toe.(Duration) Yrs. *1* mos. *29* ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

*F. L. McCaulley M. D.**2/11 1922* (Address) *Post Falls, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State *19* yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Post Falls

DATE OF BURIAL

2-13 1922

20. UNDERTAKER

P. B. Mooney

ADDRESS

Post Falls, Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of FootenRegistration District No. 30City of NeenPrimary Registration District No. 1057
(No Neen, Cataldo St.)File No. 37208Registered No. 1037

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Kangas

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male4. COLOR OR RACE White5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Single6. DATE OF BIRTH Unknown

(Month)

(Day)

(Year)

7. AGE 33

Yrs.

Mos.

ds.

IF LESS than 1 day

how many _____ hrs.

or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Timberman(b) General nature of industry, business or establishment in which employed (or employer) 14 Mack9. BIRTHPLACE Finland

(State or Country)

10. NAME OF FATHER Unknown11. BIRTHPLACE OF FATHER Unknown

(State or Country)

12. MAIDEN NAME OF MOTHER Unknown13. BIRTHPLACE OF MOTHER Unknown

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. Mack(Address) Cataldo, Ida15. Filed 3/6 19 22 D. D. Drennon

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 14 1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 _____ to 19 _____

that I last saw him _____ alive on _____ 19 _____

and that death occurred on the date stated above, at 10 A. M.

THE CAUSE OF DEATH* was, as follows:

Dropped head while working in woods near Cataldo, Ida. Valvular Heart Disease

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) D. D. Drennon M. D.2/16 1922 (Address) Cataldo, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State 3 yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Cataldo IdaDATE OF BURIAL 2/16 192220. UNDERTAKER D. D. DrennonADDRESS Cataldo, Ida.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH
in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

Registration District No.

Primary Registration District No.

(No. 1017, 2nd. Co.)

St.)

File No.

Registered No.

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF
FATHER11. BIRTHPLACE
OF FATHER

(State or Country)

12. MAIDEN NAME
OF MOTHER13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1922

Local Registrar

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

(Duration) yrs. mos. ds.

Contributory (Secondary) Digestion trouble

(Duration) yrs. mos. ds.

(Signed) M. D.

(Address) Coeur d'Alene Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

Registration District No.

Primary Registration District No.

(No.)

St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1927

Local Registrar

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at 10:31 A.M.

The CAUSE OF DEATH* was as follows:

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State 6 yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

1. PLACE OF DEATH

County of Kootenai
City of Rothelm

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED ✓ CERTIFICATE OF DEATH

Registration District No. 30
Primary Registration District No. 1037
(No. _____, _____ St.)State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37269
Registered No. 1680

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED single
(Write the word.)6. DATE OF BIRTH January 12, 1922
(Month) (Day) (Year)

7. AGE _____ Yrs. _____ Mos. _____ ds. IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. None
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Idaho10. NAME OF FATHER Roy Reinhart11. BIRTHPLACE OF FATHER Idaho

(State or Country)

12. MAIDEN NAME OF MOTHER Francine Russell13. BIRTHPLACE OF MOTHER Idaho

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Roy Reinhart
(Address) Rothelm, Idaho15. Filed Mar 6, 1922 ADDreman

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

January 13, 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Jan 12, 1922 to Jan 13, 1922 that I last saw him alive on Jan 12, 1922 and that death occurred on the date stated above, at 3:00 M.

The CAUSE OF DEATH* was as follows:

Immaturity (7 months gestation)

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Francine Russell M. D.1/13, 1922 (Address) Rothelm, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Pine Grove Cemetery, Rothelm, Idaho DATE OF BURIAL Jan 14, 192220. UNDERTAKER William Foster ADDRESS Rothelm, Idaho

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Kootenai*
City of *Coeur d'Alene*Registration District No. *30*Primary Registration District No. *1051*(No. *6th* *Acttee* St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Olga Helmina Greger*State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *37270*Registered No. *1031*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F.

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

single

(Write the word.)

6. DATE OF BIRTH

*Feb.**15**1894*

(Month)

(Day)

(Year)

7. AGE

27

Yrs.

11

Mos.

20

ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Nurse

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

N. D.

10. NAME OF FATHER

Olaf Greger

11. BIRTHPLACE OF FATHER

(State or Country)

Norway

12. MAIDEN NAME OF MOTHER

Helen Brustlett

13. BIRTHPLACE OF MOTHER

(State or Country)

Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Oscar J. Greger

(Address)

Coeur d'Alene, Idaho

15.

Filed

*3/6**1922**L. H. Greger*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb

(Month)

5

(Day)

22

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

January 15 1922 to *Feb 5 1922*that I last saw him alive on *Feb 3 1922*and that death occurred on the date stated above, at *2 P. M.*

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(Duration) *2* Yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Feb 7 1922

(Address)

*100 W. 2nd St.
Coeur d'Alene, Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Forest Cem. Coeur d'Alene

DATE OF BURIAL

2-8-22

20. UNDERTAKER

Carney

ADDRESS

Coeur d'Alene, Ida.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of BoulgnatCity of Rathdrum

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No. 38Primary Registration District No. 1051

(No. _____ St.)

Mary Elizabeth MillerState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 37272Registered No. 1033

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

F.

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

widowed
(Write the word.)

6. DATE OF BIRTH

June 22 1864
(Month) (Day) (Year)

7. AGE

57 Yrs. 8 Mos. 2 ds.
IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Iowa.

10. NAME OF FATHER

Jinks

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Chris Hanson

(Address)

Rathdrum, Idaho.

15.

Filed 3/61922D. D. Druma

Local Registrar

16. DATE OF DEATH

February 24, 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 10, 1922, to Feb 24, 1922that I last saw him alive on Feb 24, 1922and that death occurred on the date stated above, at 3:15 M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis with atherosclerosis of Coronary ArteriesSeveral Yrs. _____ mos. _____ ds.
(Duration)Contributory General Atherosclerosis
(Secondary)Several yrs. _____ mos. _____ ds.
(Duration)(Signed) Frank P. Henry, M. D.2/24/1922 (Address) Rathdrum, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Rathdrum Cemetery

DATE OF BURIAL

4/26 1922

20. UNDERTAKER

W. L. Cassidy

ADDRESS

Rathdrum

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Kootenai
City of Coeur d'AleneRegistration District No. 30Primary Registration District No. 7051

(No. _____ St.)

File No. _____

Registered No. 1034

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lyester Mudge

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

married

(Write the word.)

6. DATE OF BIRTH

Nov 10 1884
(Month) (Day) (Year)

7. AGE

78 Yrs. 3 Mos. 11 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Stationary Engineer

(b) General nature of industry, business or establishment in which employed (or employer)

retired

9. BIRTHPLACE

(State or Country) Algonac Mich

10. NAME OF FATHER

Stephen M.

11. BIRTHPLACE OF FATHER

(State or Country) Mich.

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country) Mich

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address) Charles S Mudge
Edward Blue R 15

15.

Filed 3/6 1922 St. Helena
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

2 21 22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

No Doctor 19 to 19that I last saw h. alive on 19and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

InfluenzaNo Dis. (Duration) Yrs. mos. 5 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) S. S. Druman M. D.2/21 19 (Address) Coeur d'Alene

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Forest Cemetery

DATE OF BURIAL

2/23 1922

20. UNDERTAKER

E. Cassidy

ADDRESS

Edwin, Idaho

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM "V" S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **37274**Registered No. **73**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of **Kootenai**
City of **Harrison**Registration District No. **126**Primary Registration District No. **2204**

(No.)

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mae Goodwin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married

(Write the word.)

6. DATE OF BIRTH.

Oct 24 1901
(Month) (Day) (Year)

7. AGE

20 Yrs. **3** Mos. **28** ds.IF LESS than 1 day
how many.....hrs. or
.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....**Housewife**

9. BIRTHPLACE

(State or Country)

Harrison Ida

10. NAME OF FATHER

Oley Lee

11. BIRTHPLACE OF FATHER

(State or Country)

Wis

12. MAIDEN NAME OF MOTHER

Cora E Thompson

13. BIRTHPLACE OF MOTHER

(State or Country)

Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Oley Lee
Harrison Ida

15. Filed

Mar 1 1922**J. M. Perry**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 21 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 13 1922 to **Feb 21 1922**
that I last saw her alive on **Feb 20 1922**and that death occurred on the date stated above, at **1 A** M.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Tuberculosis

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) **J. M. Perry** M. D.**221 1922** (Address) **Harrison Ida**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Harrison Ida**2-22 1922**

20. UNDERTAKER

ADDRESS

C. Cassady**Harrison**
Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

37275

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Kootenae
City of HarrisonRegistration District No. 126Primary Registration District No. 2204(No. 126)

St.)

File No. 2Registered No. 92

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Adelia F Osborn

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Sept
(Month)5
(Day)1861
(Year)

7. AGE

60 Yrs.

Mos.

ds.

IF LESS than 1 day
how many.....hrs. or
.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....Housewife

9. BIRTHPLACE

(State or Country)

Ind

10. NAME OF FATHER

Stahly Pointer

11. BIRTHPLACE OF FATHER

(State or Country)

Ky.

12. MAIDEN NAME OF MOTHER

Pointer

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

B. E. Osborn

(Address)

Harrison Ida

15.

Filed

Mar 1 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb
(Month)13
(Day)1922
(Year)17. I HEREBY CERTIFY, That I attended deceased from July 30 1921 to Feb 3 1922that I last saw her alive on Feb 13 1922 and that death occurred on the date stated above, at 11 P M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)Tumor

(Duration)

Yrs.

mos.

ds.

(Signed)

J. E. Osborn

M. D.

2-14-1921 (Address) Harrison Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death.....Yrs.....mos.....days State.....Yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

Harrison Ida

DATE OF BURIAL

2-15-1922

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Latah*City of *Moscow*Registration District No. *61*Primary Registration District No. *1011*(No. *1011*)

St.)

File No. *37276*Registered No. *12*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Julia Meador

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15. Filed

19 *22*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 27 22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 27 1922 to *Feb 27 1922*
that I last saw her alive on *Feb 27 1922*
and that death occurred on the date stated above, at *9:30 A*

The CAUSE OF DEATH* was as follows:

*Cholera*Contributory (Secondary) *Not known* Yrs. mos. ds.Contributory (Secondary) *Not known* Yrs. mos. ds.(Signed) *M. D.* (Address) *Moscow Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Asperin 19 *22*

20. UNDERTAKER

ADDRESS

Price *Moscow*

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Idaho

County of

Moscow

City of

(No. St.)

If death occurs away from

usual residence, give facts

called for under special in-

formation.

Registration District No. 61

Primary Registration District No. 1011

File No. 37277

Registered No. 11

2. FULL NAME

Mary Nelson

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F.

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Married

6. DATE OF BIRTH

Feb 20 1840

7. AGE

82

8. OCCUPATION

Housewife

9. BIRTHPLACE

(State or Country)

Sweden

10. NAME OF

FATHER

Goss

11. BIRTHPLACE

OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME

OF MOTHER

Not known here

13. BIRTHPLACE

OF MOTHER

(State or Country)

cl

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Peter Nelson

(Address)

Moscow

15. Filed

2/21 1922

barithers

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 20 1922

17. I HEREBY CERTIFY, That I attended deceased from

Feb. 18 1922, to Feb. 20 1922

that I last saw him alive on Feb. 19 1922

and that death occurred on the date stated above, at 330 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) Yrs. mos. ds.

Contributory Advanced age

(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. H. Clarke M. D.

7/21/22 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state

(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,

Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted

if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

Moscow

DATE OF BURIAL

2/22 1922

20. UNDERTAKER

Elen Price

ADDRESS

Moscow

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Idaho

County of

City of Moscow

Registration District No. 601

Primary Registration District No. 1011

(No. St.)

File No.

37278

Registered No. 10

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ellen L. Towne,

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

F

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widowed

(Write the word.)

6. DATE OF BIRTH

April 2 1874

(Month)

(Day)

(Year)

7. AGE

92

Yrs.

Mos.

ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

At Home with Children

9. BIRTHPLACE

(State or Country)

Not known here

10. NAME OF FATHER

W

W

W

11. BIRTHPLACE OF FATHER

(State or Country)

W

W

W

12. MAIDEN NAME OF MOTHER

W

W

W

13. BIRTHPLACE OF MOTHER

(State or Country)

W

W

W

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Walter Towne

(Address)

Moscow

15. 2/20

Filed

19

M. H. Barstow

Local Registrar

16. DATE OF DEATH

Feb 19 1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19

to

19

that I last saw him alive on

19

and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Natural Causes

(Duration)

Yrs.

mos.

ds.

Contributory (Secondary)

Old age

(Duration)

Yrs.

mos.

ds.

(Signed)

Ellen L. Towne

(Address)

Moscow

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

Yrs.

mos.

days

In the

State

Yrs.

mos.

days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Moscow

2/22 1922

20. UNDERTAKER

ADDRESS

Ellen L. Towne

CERTIFICATE OF DEATH

Clerk

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

Registration District No.

Primary Registration District No.

(No.

St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Price H. Dowdy

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

M

White

(Write the word.)

6. DATE OF BIRTH

March

4 1870

(Month)

(Day)

(Year)

7. AGE

51

Yrs. 11 Mos. 12 ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Virginia

10. NAME OF FATHER

Thomas P Dowdy

11. BIRTHPLACE OF FATHER

(State or Country)

Virginia

12. MAIDEN NAME OF MOTHER

Mary Munn

13. BIRTHPLACE OF MOTHER

(State or Country)

Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E M Dowdy

(Address)

Moscow

15.

Filed

2/17

1922

W Hoorithers

Local Registrar

16. DATE OF DEATH

Feb

16

1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 14 1922 to Feb 16 1923

that I last saw him alive on Feb 17 1923

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows

Pulmonary Tuberculosis

(Duration)

Went to know

Yrs.

mos.

ds.

Contributory (Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

J. H. Clarke

M. D.

2/17 1922 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs mos days In the State yrs mos days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Moscow

Feb 16 1922

20. UNDERTAKER

ADDRESS

Glen Price Moscow

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County

City of

Registration District No.

Primary Registration District No.

(No.

St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MOTHER'S NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15. Filed

1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct. 1921, to Feb. 12, 1922
that I last saw her alive on Feb. 12, 1922
and that death occurred on the date stated above, at 5:30 P. M.

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Signed)

M. D.

2/14/19

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **37281**
Registered No. **7**

1. PLACE OF DEATH

County of Satah
City of Moscow

Registration District No. 61Primary Registration District No. 1011

(No. _____ St.)

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Samuel Wesley Dimond

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDWidowed
(Write the word.)

6. DATE OF BIRTH

December 12 1853
(Month) (Day) (Year)

7. AGE

68 Yrs. 1 Mos. 26 ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of workWood worker(b) General nature of in-
dustry, business or estab-
lishment in which employ-
(or employer)Sash & Door Factory

9. BIRTHPLACE

(State or Country)

Columbus, Georgia10. NAME OF
FATHERJohn Dimond11. BIRTHPLACE
OF FATHER

(State or Country)

Augusta, Georgia12. MAIDEN NAME
OF MOTHERSarah Leonora Hallenbeck13. BIRTHPLACE
OF MOTHER

(State or Country)

Penfield, New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Charles C. Dimond

(Address)

210 North Albany St. Moscow, Ida

15.

Filed 2/81922M. H. Coarthers

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb. 5 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb. 1 1922, to Feb. 5 1922

that I last saw him alive on Feb. 4 1922

and that death occurred on the date stated above, at 5:00 A.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) _____ Yrs. _____ mos. 8 ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

J. H. Clarke

M. D.

1922

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sprague1922

20. UNDERTAKER

ADDRESS

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Katah*City of *Moscow*

If death occurs away from usual residence, give facts called for under special information.

Registration District No. *61*Primary Registration District No. *1011*

(No. _____)

(St. _____)

File No. _____

Registered No. *6*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Mary Alice Oylear

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

*Female**White**Widowed*

(Write the word.)

6. DATE OF BIRTH

July 15 1872

(Month)

(Day)

(Year)

7. AGE

49

Yrs

6

Mos

20

ds.

IF LESS than 1 day

how many _____ hrs.

or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

*—**Holmes*

11. BIRTHPLACE OF FATHER

(State or Country)

Mo

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Jess Oylear

(Address)

Moscow

15. Filed

*Feb 6 1922**M. H. Carithers*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 4th 1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 30 1922 to *Feb 4 1922*that I last saw her alive on *Jan 30 1922*and that death occurred on the date stated above, at *11:58 P.M.*

The CAUSE OF DEATH* was as follows:

*Intestinal Taphritis
Chronic Endocarditis
Chronic Endocarditis*

(Duration)

Yrs

mos

ds.

Contributory (Secondary)

(Duration)

Yrs

mos

ds.

(Signed)

4/6 1922 (Address) *Moscow, Mo.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs _____ mos _____ days. In the State _____ yrs _____ mos _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Moscow**2/9 1922*

20. UNDERTAKER

ADDRESS

Edna Price, Moscow

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Idaho
City of PalouseRegistration District No. 65Primary Registration District No. 2146

(No. St.)

File No. 37283

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Francis Nagle

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WID-

OWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

June 15 1848
(Month) (Day) (Year)

7. AGE

73

Yrs. Mos. ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Farmer

(b) General nature of industry, business or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country)

Canada

10. NAME OF FATHER

William Nagle

11. BIRTHPLACE OF FATHER

(State or Country)

Canada

12. MAIDEN NAME OF MOTHER

Eliza Nugent

13. BIRTHPLACE OF MOTHER

(State or Country)

Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs John Nagle

(Address)

Palouse Wash R2

15.

Filed Feb. 29 1922Wm. Thompson

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 28 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jun 2 1922 to Feb 28 1922that I last saw him alive on Feb 28 1922and that death occurred on the date stated above, at 8 A M.

The CAUSE OF DEATH* was as follows:

Myocardial Infarction(Duration) Several yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

P. E. Muesel

M. D.

May 19 22

(Address)

Garfield Wash

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Moscow Ida.

DATE OF BURIAL

March 12 1922

20. UNDERTAKER

E. M. Irwin

ADDRESS

Palouse

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **37284**

1. PLACE OF DEATH
County of Latah Registration District No. 66
City of Viola Primary Registration District No. 2145
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lola M. Cutton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED single
(Write the word.)

6. DATE OF BIRTH Nov 18 1918
(Month) (Day) (Year)

7. AGE 5 Yrs. 3 Mos. 7 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Infant.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE Ida.
(State or Country)

10. NAME OF FATHER Ross Cutton

11. BIRTHPLACE OF FATHER Illinois
(State or Country)

12. MAIDEN NAME OF MOTHER Pearl Estes

13. BIRTHPLACE OF MOTHER Ida.
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ross Cutton
(Address) Viola

15. Filled Feb 26 1922 J. W. Thompson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 25 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from on Feb 25 1922 to 19 that I last saw her alive on Feb 25 1922 and that death occurred on the date stated above, at 9 P. M. The CAUSE OF DEATH* was as follows:

Laryngeal Diphtheria
(Duration) — Yrs. — mos. 3 ds.

Contributory (Secondary)

(Duration) — yrs. — mos. — ds.

(Signed) E. K. Wolfe M. D.
Feb 26 1922 (Address) Palouse

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Palouse DATE OF BURIAL Feb 27 1922

20. UNDERTAKER E. H. Irwin ADDRESS Palouse

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37285
Registered No.

1. PLACE OF DEATH. Registration District No. 65
County of. Primary Registration District No. 2145
City of. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Calvin Smith

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH August 20th 1911
(Month) (Day) (Year)

7. AGE 10 yrs. 6 mos. 4 ds.
IF LESS than 1 day how many hrs. or min?

8. OCCUPATION School-Boy
(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer).

9. BIRTHPLACE Latah Co. Idaho.
(State or Country)

10. NAME OF FATHER A. A. Smith.

11. BIRTHPLACE OF FATHER Saline Co. Neb.
(State or Country)

12. MAIDEN NAME OF MOTHER Myrtle Kilgore.

13. BIRTHPLACE OF MOTHER Mo.
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. H. Thompson
(Address) Locust

15. Filed Feb 27 1922 J. H. Thompson
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Feb 24 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 2 1922 to Feb 24 1922
that I last saw him alive on Feb 23 1922
and that death occurred on the date stated above, at 1 A. M.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 21 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) E. H. Irwin M. D.

Feb 24 1922 (Address) Palouse

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Palouse Feb 27 1922
20. UNDERTAKER ADDRESS
E. H. Irwin Palouse

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 37286

Registered No. 5.

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

1. PLACE OF DEATH.

Registration District No. 50

County of Lewis

Primary Registration District No. 2129

City of Nezperce, RFD.

(No. St.)

If death occurs away from
usual residence, give facts
called for under special
information.

2. FULL NAME Violet S. Sanford Garley

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

married

(Write the word.)

6. DATE OF BIRTH.

Dec.

4

1867

(Month)

(Day)

(Year)

7. AGE

54

2

23

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work... Housewife
(b) General nature of in-
dustry, business, or estab-
lishment in which employ-
ed (or employer).....

9. BIRTHPLACE

(State or Country) Boone Co., Iowa.

10. NAME OF

FATHER John Herman Sanford

11. BIRTHPLACE
OF FATHER

(State or Country) Ill.

12. MAIDEN NAME

OF MOTHER Mary Jane Nelson

13. BIRTHPLACE
OF MOTHER

(State or Country) Michigan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15.

Filed

7/22

1922

R. E. Duvall

Local Registrar

16. DATE OF DEATH

Feb.

27

1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from
Dec. 1917 to Feb. 27 1922.

that I last saw her alive on Feb. 26 1922.

and that death occurred on the date stated above, at 10 AM.

The CAUSE OF DEATH* was as follows:

Uraemia

(Duration) Yrs. mos. 3 ds.

Contributory Pyelitis, Pyelonephritis
(Secondary)
cystitis Some
(Duration) Yrs. mos. ds.

(Signed) R. E. Duvall M. D.
7/27/22 (Address) Cozquind

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted
if not at place of death?.....

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Foot cemetery

3/1 1922

20. UNDERTAKER

ADDRESS

Star Funeral Co

Cozquind

FORM V. S. No. 5-25 M. 1-16-13

✓ CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 37287

Registered No. 77

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Lewis
City of NampaRegistration District No. 47
Primary Registration District No.
(No. St.)If death occurs away from usual residence, give facts called for under special information.
Route 3

2. FULL NAME

Peter R. Gibbons

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

widowed
(Write the word.)

6. DATE OF BIRTH.

Sept 25 1836
(Month) (Day) (Year)

7. AGE

86 Yrs. Mos. ds.

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...

Farming

9. BIRTHPLACE

(State or Country)

Ind

10. NAME OF FATHER

Y. Gibbons

11. BIRTHPLACE OF FATHER

(State or Country)

Ind

12. MAIDEN NAME OF MOTHER

Harriet A. Harris

13. BIRTHPLACE OF MOTHER

(State or Country)

Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Joseph W. Gibbons
Nampa Idaho

15.

Filed 3-14-1922

Local Registrar

16. DATE OF DEATH

Mar 1 10 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar 8 1921 to Mar 10 1922

that I last saw him alive on March 8 1922

and that death occurred on the date stated above, at 4 M.

The CAUSE OF DEATH* was as follows:

Paralysis

(Duration) Yrs. mos. 3 ds.

Contributory
(Secondary)

Arterio-sclerosis

(Duration) Yrs. mos. ds.

(Signed)

J. W. Gibbons

M. D.

Mar 1922 (Address) Nampa Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Nampa Cemetery

3-11-1922

20. UNDERTAKER

ADDRESS

Albert Huff

Nampa Idaho

RECEIVED CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 37288

Registered No. 76

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Lewis
City of Nezperce State of Idaho
Registration District No. 47
Primary Registration District No. 47
St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Reginald Voshies

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female White Married

6. DATE OF BIRTH.

Nov 22 1841
(Month) (Day) (Year)

7. AGE

50 Yrs. - Mos. - ds.

IF LESS than 1 day
how many hrs. or min.

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Farming

9. BIRTHPLACE

(State or Country)

Moble Co Ohio

10. NAME OF FATHER

Mr Groves

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Old Co

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Sam Voshies

(Address)

Nezperce Ida

15.

Filed 3-2 1922

Albas Huff
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

2-28 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1920 1922 to 2-28 1922

that I last saw him alive on 2-28 1922

and that death occurred on the date stated above, at 6-40 P.M.

The CAUSE OF DEATH* was as follows:

Bronchitis

(Duration) 3 yrs. 2 mos. ds.

Contributory (Secondary)

Hypertension

(Duration) 4 yrs. 4 mos. 4 ds.

(Signed)

H. A. Taylor

M. D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Athena Oregon

191

20. UNDERTAKER

ADDRESS

W. A. Shaw

Oxford Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Madison
 City of Rexburg,

If death occurs away from
 usual residence, give facts
 called for under special in-
 formation.

Registration District No. 100Primary Registration District No. 2178

(No. _____, _____ St.)

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 37290Registered No. 14

If death occurred in a hos-
 pital, institution or camp,
 give its NAME instead of
 street and number.

2. FULL NAME ALBERT ROSS BROWN

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX MALE 4. COLOR OR RACE WHITE 5. SINGLE, MARRIED, WID-
 OW MARRIED ORCED

(Write the word.)

6. DATE OF BIRTH

MAY 21st 1922
 (Month) (Day) (Year)

7. AGE

23 9 12
 Yrs. Mos. ds.

IF LESS than 1 day
 how many _____ hrs.
 or _____ min.?

8. OCCUPATION

(a) Trade, profession or
 particular kind of work. Farmer
 (b) General nature of in-
 dustry, business or estab-
 lishment in which employ-
 ed (or employer)

9. BIRTHPLACE

(State or Country) Madison County

10. NAME OF FATHER

Albert Ross Brown

11. BIRTHPLACE OF FATHER

(State or Country) Kentucky

12. MAIDEN NAME OF MOTHER

Effie Violate Hill

13. BIRTHPLACE OF MOTHER

(State or Country) Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Albert Ross Brown(Address) Madison County, Idaho

15.

Filed 3/7 1922Local Registrar G. E. [Signature]

16. DATE OF DEATH

March 5, 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 4, 1922, to March 5, 1922
 that I last saw him alive on March 5, 1922
 and that death occurred on the date stated above, at 11⁴⁵ A. M.

The CAUSE OF DEATH* was as follows:

Fracture of the base
of the skull

(Duration) _____ Yrs. _____ mos. 18 ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) G. E. [Signature] M. D.19. (Address) Rexburg, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state
 (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted
 if not at place of death?

Former or
 usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Burton, Cemetery1922

20. UNDERTAKER

ADDRESS

Rexburg

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Madison
City of RexburgRegistration District No. 100Primary Registration District No. 2178File No. 37291Registered No. 13

If death occurs away from usual residence, give facts called for under special information.

BUREAU OF VITAL STATISTICS

2. FULL NAME William Eugene Heller (By adoption)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH

August 25th 1910
(Month) (Day) (Year)

7. AGE

11 Yrs. 6 Mos. 1 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Student

9. BIRTHPLACE

(State or Country)

Salt Lake City, Utah

10. NAME OF FATHER

William J. Scott

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Ruth Fowler

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed 3/1 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

2 - 26 - 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from 2 - 16 - 1922, to 2 - 26 - 1922.that I last saw him alive on 2 - 26 - 1922, and that death occurred on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia(Duration) _____ Yrs. _____ mos. 9 ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. 5 ds.

(Signed)

3/1 1922

(Address)

Rexburg Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Super City Ida3/7 1922

20. UNDERTAKER

ADDRESS

D. R. YoungRexburg

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37292
Registered No. 12

1. PLACE OF DEATH

County of Madison
City of Rexburg

Registration District No. 100Primary Registration District No. 2178

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME John Leslie Nelson

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCED
Single
(Write the word.)

6. DATE OF BIRTH

January 17th 1922
(Month) (Day) (Year)

7. AGE

2 Yrs. 1 Mos. 11 ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

Child

9. BIRTHPLACE

(State or Country) Idaho10. NAME OF
FATHERAnthon Nelson11. BIRTHPLACE
OF FATHER(State or Country) Iowa12. MAIDEN NAME
OF MOTHERCornelia Harriman13. BIRTHPLACE
OF MOTHER(State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Arthur Nelson(Address) Rexburg, Ida.

15.

Filed 3/11922Local Registrar L. G. Hooper

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb. 28 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb. 26 1922 to Feb. 28 1922

that I last saw him alive on Feb. 28 1922

and that death occurred on the date stated above, at 11:35 AM

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia(Duration) _____ Yrs. _____ mos. 8 ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W. J. Parkinson D.19 (Address) Rexburg, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Canyon Creek

DATE OF BURIAL

3-2-1922

20. UNDERTAKER

David R. Young

ADDRESS

Rexburg

1. PLACE OF DEATH

County of MadisonCity of Rexburg

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lilla Stoddard

CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

(No.)

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

(Write the word.)

6. DATE OF BIRTH

May 10th1921

(Month)

(Day)

(Year)

7. AGE

9 Yrs. 16 Mos. ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Roy Stoddard

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Phyllis Oldahm

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15. Filed

2/271922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb271922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 22 1922 to Feb 27 1922that I last saw her alive on Feb 26 1922and that death occurred on the date stated above, at 5:30 AM.

The CAUSE OF DEATH* was as follows:

Staphylococcal Infection

(Duration)

Yrs.

mos. 4 ds.Contributory
(Secondary)None

(Duration)

yrs.

mos. ds.

(Signed)

E. J. Parkinson M. D.

19

(Address)

Rexburg, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

yrs.

mos.

In the

days

State

yrs.

mos.

days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Rexburg, Ida.

DATE OF BURIAL

2/28 1922

20. UNDERTAKER

David W. Young

ADDRESS

Rexburg

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Statistics

1. PLACE OF DEATH

County of MadisonCity of Lyman

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100Primary Registration District No. 2178(No. 10)

St.)

File No.

Registered No. 10

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ross L. Bowen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Single

(Write the word.)

6. DATE OF BIRTH

December 31

(Month)

(Day)

1921

(Year)

7. AGE

1 Yrs. 21 Mos. 21 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Child

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Lyman, Ida.

10. NAME OF FATHER

Lee Bowen

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Cora Lucy Arnold

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Earl Bowen(Address) Lyman, Idaho15. 2/22Filed 192222

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

February

(Month)

21

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19

to

19

that I last saw h. _____ alive on _____ 19 _____

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

No Physician in attendance

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

19 (Address) _____

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lyman, Ida.2-22 1922

20. UNDERTAKER

ADDRESS

David P. Young
Rebberg

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37295
Registered No. 7

1. PLACE OF DEATH

County of Madison
City of Hibbard

Registration District No. 100

Primary Registration District No. 2178

St.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lillis Sommer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

(Write the word.)

6. DATE OF BIRTH

February 20th 1921
(Month) (Day) (Year)

7. AGE

11 ds. 12
Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Child

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Edward Sommer

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Alice Hendricks

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Edward Sommer
Hibbard, Ida.
(Address)

15.

2/13 1922
Filed

W. H. H. H.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb. 12 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 30 1922, to Feb 9 1922
that I last saw h. er alive on Feb 9 1922,

and that death occurred on the date stated above, at 4 A. M.

The CAUSE OF DEATH* was as follows:

Bronch pneumonia.

(Duration) Yrs. mos. 10 ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) Loring T. Hef M. D.

2/13 1922 (Address) Keensburg Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Keensburg, Ida.

DATE OF BURIAL

2/14 1922

20. UNDERTAKER

David R. Young

ADDRESS

Keensburg

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Jefferson*

City of *Amis*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED

Registration District No. *100*

MAjor Registration District No. *2178*

BUREAU

ST. A

Violate Kilian

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. *37290*
Registered No. *15*
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widow
(Write the word.)

6. DATE OF BIRTH

July 14 1851
(Month) (Day) (Year)

7. AGE

70 Yrs. *6* Mos. *15* ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Lewis Gardner

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Betsy Gardner

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Andrew H. Miller
Larry G. B. F.

15. FILED

1/30 1922

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 29 1922
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from

Jan 29 1922 *Jan 29 1922*

that I last saw *her* alive on *Jan 29 1922*

and that death occurred on the date stated above, at *79* M.

The CAUSE OF DEATH* was as follows

Strangulated Umbilical Hernia

(Duration) *Life* Yrs. mos. ds.

Contributory (Secondary)

(Duration) *Life* Yrs. mos. ds.

(Signed) *Thos. B. Mord* M. D.

19 (Address) *Meriden*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death ... yrs. ... mos. ... days, State ... yrs. ... mos. ... days

Where was disease contracted

If not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Amis

DATE OF BURIAL

1/30 1922

20. UNDERTAKER

J. H. Hany

ADDRESS

Barley

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37297
Registered No. 759

1. PLACE OF DEATH
County Blaine Registration District No. 96
City of Lewiston Primary Registration District No. 1009
(No. 10 St.)
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME Clifford L. Tilley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED <u>Single</u> (Write the word.)
6. DATE OF BIRTH <u>October 8</u> <u>1888</u> (Month) (Day) (Year)		
7. AGE <u>33</u> Yrs. <u>3</u> Mos. <u>28</u> ds.		IF LESS than 1 day how many <u>18</u> hrs. or <u> </u> min.?
8. OCCUPATION (a) Trade, profession or particular kind of work <u>Farmer</u> (b) General nature of industry, business or establishment in which employed (or employer)		
9. BIRTHPLACE <u>Saratoga, Missouri</u> (State or Country)		
10. NAME OF FATHER <u>William L. Tilley</u>		
11. BIRTHPLACE OF FATHER <u>Louisville, Kentucky</u> (State or Country)		
12. MAIDEN NAME OF MOTHER <u>Mary Frances Lane</u>		
13. BIRTHPLACE OF MOTHER <u>Fairfield Co. Baltimore, Ohio</u> (State or Country)		
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs. M. F. Tilley</u> (Address) <u>1417 7th Ave. Lewiston, Idaho</u>		
15. Filed <u>Mar 10</u> <u>1922</u> <u>Sam E. Bruce</u> Local Registrar		

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Jan 31 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 20 1922 to Jan 30 1922
that I last saw him alive on Jan 31 1922
and that death occurred on the date stated above, at 2:30 P.M.
The CAUSE OF DEATH* was as follows:
Streptococcus Cellulitis and Septicemia
(Duration) Yrs. 1 mos. 10 ds.
Contributory (Secondary) Carbuncle of neck
(Duration) yrs. 3 mos. ds.
(Signed) Edgar L. White M. D.
Feb 1 1922 (Address) Lewiston 2de

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL
Lewiston Idaho
20. UNDERTAKER
ASSAR UNDERTAKING CO
DATE OF BURIAL
2/2 1922
ADDRESS
Lewiston

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **37298**
Registered No. **760**

1. PLACE OF DEATH

County of **Lewiston**
City of **May Grove**

Registration District No. **96**
Primary Registration District No. **1009**
(No. **3** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Josiah A. Guinn

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Married**
(Write the word.)

6. DATE OF BIRTH

Mar 18 1887
(Month) (Day) (Year)

7. AGE

64 Yrs. **10** Mos. **13** ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Retired

9. BIRTHPLACE

(State or Country)

Tenn

10. NAME OF FATHER

Guinn

11. BIRTHPLACE OF FATHER

(State or Country)

Tenn

12. MAIDEN NAME OF MOTHER

Mary Whistler

13. BIRTHPLACE OF MOTHER

(State or Country)

Tenn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. L. Gregory

(Address)

2000 Walla Walla Ave

15.

2/1/22

Filed

Mar 10 1922

Susan E. Bruce

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 1 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 25 1922 to **Feb 1** 1922

that I last saw him alive on **Feb 1** 1922

and that death occurred on the date stated above, at **11 P.M.**

The CAUSE OF DEATH was as follows:

**Valvular heart disease.
Hypertrophic cirrhosis.
Nephritis**

(Duration) **2** Yrs. mos. ds.

Contributory
(Secondary)

Same

(Duration) yrs. mos. ds.

(Signed)

Edgar White M. D.

Feb 1 1922 (Address) **Lewiston Ida**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Walla Walla 19

20. UNDERTAKER

ADDRESS

Wassar and Co **Lewiston Ida**

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau 37295

1. PLACE OF DEATH

County of *Boise*
City of *Lewiston*

Registration District No. *96*
Primary Registration District No. *1009*
(No. _____ St.)

File No. _____
Registered No. *761*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lawrence M. Skinner

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*
(Write the word.)

6. DATE OF BIRTH

_____. _____ 19_____
(Month) (Day) (Year)

7. AGE

Yrs. *3* Mos. _____ ds. IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Infant

9. BIRTHPLACE

(State or Country)

Ida.

10. NAME OF FATHER

Ralph D. Skinner

11. BIRTHPLACE OF FATHER

(State or Country)

S. Dak.

12. MAIDEN NAME OF MOTHER

Myrtle Sharrah

13. BIRTHPLACE OF MOTHER

(State or Country)

Kans.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ralph Skinner

(Address)

705-15-st

15.

Filed

Mar 10 1922 Susan E Bruce

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 2 19*22*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Jan 31* 19*22* to *Feb 2* 19*22* that I last saw him alive on *Feb 2* 19*22* and that death occurred on the date stated above, at *2:30* P.M. The CAUSE OF DEATH* was as follows:

Grippe with Bowell complication

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

L. F. Skinner M. D.

19

(Address)

Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Lewiston, Idaho

DATE OF BURIAL

2/3 1921

20. UNDERTAKER

ADDRESS

Lewiston, Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **37300**Registered No. **762**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of **Lafayette** Registration District No. **95**
City of **Lafayette** Primary Registration District No. **1009** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary E. Maynard

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Widowed**

6. DATE OF BIRTH

March 18th 1859
(Month) (Day) (Year)

7. AGE

62 Yrs. 10 Mos. 15 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)**at Home**

9. BIRTHPLACE

(State or Country)

Wis.

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Marshall Maynard**
(Address) **Lafayette, Idaho**15. Filed **Mar 10 1922** **Laura E. Bruce**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 8th 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from **Jan 25 1922** to **Feb 2 1922**that I last saw her alive on **Feb 3 1922**
and that death occurred on the date stated above, at **P. M.**

The CAUSE OF DEATH* was as follows:

Branches Pneumonia(Duration) Yrs. mos. **9** ds.Contributory **Ascending Paralysis of Cord**(Duration) **10** yrs. mos. ds.(Signed) **John W. Alby** M. D.**2-4 1922** (Address) **Lewis, Mo.**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Clarkston, Wash.

DATE OF BURIAL

Feb 5th 1922

20. UNDERTAKER

ADDRESS

VASSAR UNDERTAKING CO. Clarkston, Idaho

M. 1-19.

PLACE OF DEATH

County of MyerCity of Lewiston

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 96Primary Registration District No. 1009

(No.) (St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 37301Registered No. 763

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Wallace H. Laughrey

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

(Write the word.)

6. DATE OF BIRTH

Jan 16

(Month)

(Day)

1855
(Year)

7. AGE

67 Yrs. no Mos. 21 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Farmer

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

James Laughrey

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Jane Best

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

L. J. Fuller
Lewiston Idaho.

15.

Filed

Mar 10 - 1922Ernest E. Bruce

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb6th1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 1 1922, to Feb 6 1922that I last saw him alive on Feb 6 1922

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

..... (Duration) Yrs. mos. ds.

Contributory
(Secondary)

..... (Duration) yrs. mos. ds.

(Signed)

J. H. H. H. H.

M. D.

19

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lewiston Idaho2/6 1922

20. UNDERTAKER

ADDRESS

Lewiston Idaho

F No. 5-36 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *My Perce*
City of *Lewiston*Registration District No. *96*Primary Registration District No. *1009*(No. *1009* St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Robert Robinson*Harris
State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *37302*Registered No. *764*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male *White* *Married*
(Write the word.)

6. DATE OF BIRTH

Oct *1860*
(Month) (Day) (Year)

7. AGE

61 Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

Laborer
Common

9. BIRTHPLACE

(State or Country)

Canada

10. NAME OF FATHER

Geo Robinson

11. BIRTHPLACE OF FATHER

(State or Country)

Canada

12. MAIDEN NAME OF MOTHER

Maggie Whitebark

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Mrs R. P. English
Lewiston, Id.

15.

Filed

Mar 10 1922 *Eusan E. Bruce*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb *6* *1922*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 31 1922 to *Feb 6 1922*
that I last saw him alive on *Feb 5 1922*and that death occurred on the date stated above, at *7-42M.*

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(Duration) Yrs. mos. ds.

Contributory (Secondary) *Fatty Degeneration*

(Duration) yrs. mos. ds.

(Signed) *R. P. Ham* M. D.*46 1922* (Address) *Lewiston*

State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lewiston, Ida *7-9 1922*

20. UNDERTAKER

ADDRESS

Wasson Mnd. Co. Lewiston

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **37303**Registered No. **765**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of *Neperce*
City of *Lewiston*RECEIVED
MAR 10 1922Registration District No. *96*Primary Registration District No. *1609*

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Alice May Robinson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

Oct 11 1870
(Month) (Day) (Year)

7. AGE

*51 Yrs. 3 Mos. 26 ds.*IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Housewife

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Miss.

10. NAME OF FATHER

James Knight

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Phoebe Butts

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. R. P. English

(Address)

Clarkston Bldg. #1

15.

Filed *Mar 10 1922* *James E. Bruce*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 7th 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19..... to 19.....

that I last saw him alive on 19.....

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

(Duration) Yrs. mos. ds.

Contributory
(Secondary)*Influenza*

(Duration) yrs. mos. ds.

(Signed)

John W. Alley M. D.

19..... (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Lewiston, Idaho

DATE OF BURIAL

2/9 1922

20. UNDERTAKER

ADDRESS

Lewiston Idaho

✓ CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No. 766

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of *Blaine*City of *Leaverton*Registration District No. *96*Primary Registration District No. *1009*

(No. _____)

(St. _____)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Leah Smith

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Anna M. Smith*(Address) *Leaverton Idaho*

15. Filed

*Mar 10 - 1922**19 22 19**Eugene E. Bruce*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb - 7 19 *22*
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *Dec 14* 19 *22* to *Feb 7* 19 *22*
that I last saw him alive on *Feb 7* 19 *22*
and that death occurred on the date stated above, at *4 P.* M.
The CAUSE OF DEATH* was as follows:*Acute dilatation of heart*
(Duration) _____ Yrs. _____ mos. _____ ds.
Contributory (Secondary) *Acute dilatation of heart*
(Duration) _____ Yrs. _____ mos. _____ ds.
(Signed) *Dr. C. C. C. C.* M. D.
(Address) *Leaverton Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Kendrick & Co.**19*

20. UNDERTAKER

ADDRESS

*Vassar and Co.**Leaverton Idaho*

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of *Myer*
City of *Lewiston*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Arthur Newman Brinkley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Jan 26 1922
(Month) (Day) (Year)

7. AGE

18 Yrs. Mos. ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Infant

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Robt. C. Brinkley

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Ethel Watson

13. BIRTHPLACE OF MOTHER

(State or Country)

Wash

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

H. B. Watson

(Address)

Lewiston, Idaho.

15.

Filed

*Mar 10 1922**Simon E. Bruce*
Local Registrar

CERTIFICATE OF DEATH

Registration District No. *96*Primary Registration District No. *1009*STA (NO. *55*)

St.)

File No.

*37306*Registered No. *768*State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 12 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 24 1922 to *2-12 1922*
that I last saw him alive on *2-12 1922*

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

*Stomachic closure
of orotate
Blue baby*

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

John Haller
A. D.*7/3 1922* (Address) *Lewiston, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Lewiston Idaho.

DATE OF BURIAL

2/13 1922

20. UNDERTAKER

ADDRESS

Lewiston Idaho

FORM V. S. No. 5-25 M. 1-19.

✓
CERTIFICATE OF DEATHBraddock
State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **37307**Registered No. **769**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

Registration District No. **96**
County of **Boise** Primary Registration District No. **1409**
City of **Lewiston** (No. **1**) St.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jerry Has Seeley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Married**
(Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

68

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).**Retired**
Farming Turnover

9. BIRTHPLACE

(State or Country)

California

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

Jerry Seeley Sr
Ill

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Matilde Rodnick
Chicago Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Geo Seeley
Clarkston, Ga.

15.

Filed

Mar 10 1922**Susan E Bruce**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 12 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 21 1922 to Feb 12 1922
that I last saw him alive on **Feb 12 1922**
and that death occurred on the date stated above, at **A.M.**

The CAUSE OF DEATH* was as follows:

Carcinoma of Pancreas(Duration) Yrs. **6** mos. **6** ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) **J G Braddock** M. D.**2-13 1922** (Address) **Lewiston Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lewiston Idaho**2/14/1922**

20. UNDERTAKER

ADDRESS

Vassar Und Co**Lewiston Idaho**

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Carassaw
State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

37508

File No. _____
Registered No. 770

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Nez Perce
City of LeicesterRegistration District No. 96
Primary Registration District No. 1009
(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary Eliza Fuller

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widow
(Write the word.)

6. DATE OF BIRTH

Aug 13 1841
(Month) (Day) (Year)

7. AGE

80 Yrs. 6 Mos. 28 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)at home

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

Stetson Eaton

11. BIRTHPLACE OF FATHER

(State or Country)

N. H.

12. MAIDEN NAME OF MOTHER

Alana Blodgett

13. BIRTHPLACE OF MOTHER

(State or Country)

N. H.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

F B Gano

(Address)

Leicester, Oregon

15.

Filed Mar 10 1922 Ernest E Bruce
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 15 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 _____, to 19 _____
that I last saw her alive on Feb 14 1922
and that death occurred on the date stated above, at 1230 a.m.

The CAUSE OF DEATH* was as follows:

Hemiplegia(Duration) Yrs. _____ mos. 1 ds.Contributory Cerebral Hemorrhage
(Secondary)(Duration) yrs. _____ mos. 1 ds.(Signed) O C Carassaw M. D.19 _____ (Address) Leicester Idy

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. _____ mos. _____ days. In the State yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Leicester, Ida.

DATE OF BURIAL

2/17 1922

20. UNDERTAKER

Carassaw Mnd Co. Leicester

ADDRESS

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Lyle

37309

1. PLACE OF DEATH

County of Myer
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. St.)

File No.
Registered No. 771

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Edgar J. Smith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the words)

6. DATE OF BIRTH

Aug 19 1906
(Month) (Day) (Year)

7. AGE

15 Yrs. 3 Mos. 21 ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Student
Grade School

9. BIRTHPLACE

(State or Country)

Indiana

10. NAME OF FATHER

Joseph Smith

11. BIRTHPLACE OF FATHER

(State or Country)

Indiana

12. MAIDEN NAME OF MOTHER

Florence

13. BIRTHPLACE OF MOTHER

(State or Country)

Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. N. Roberts

(Address)

906-9th St City

15.

Filed

Mar 10 1922 Rusan E Bruce

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 15 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-15-1922 to 2-15-1922

that I last saw him alive on 2-15-1922

and that death occurred on the date stated above, at 12 noon

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) 36 hrs

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. M. Lyle M. D.

217 19th (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Tark City Mont.

DATE OF BURIAL

2/17/1922

20. UNDERTAKER

ADDRESS

Lewiston, Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **37310**Registered No. **772**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of **Nez Perce**
City of **Lewiston**Registration District No. **96**Primary Registration District No. **1009**

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jean Edward Hendershott

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Dec 1 1922
(Month) (Day) (Year)

7. AGE

1 Yrs. _____ Mos. _____ ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Infant.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

E. C. Hendershott

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Elva Graham

13. BIRTHPLACE OF MOTHER

(State or Country)

Mich.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wm. E. C. Hendershott

(Address)

Lewiston Ida

15.

Filed

Mar 10 1927**Susan E. Bruce**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Febr. 16 1927
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 31 1922 to Feb 16 1922that I last saw him alive on **Feb 16 1922**and that death occurred on the date stated above, at **5:30 P.M.**

The CAUSE OF DEATH* was as follows:

Tubercular Meningitis(Duration) _____ Yrs. _____ mos. **16** ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

O. C. Harrison

M. D.

19

(Address)

Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Lewiston Ida

DATE OF BURIAL

2/18 1927

20. UNDERTAKER

Passar and Co. Lewiston

ADDRESS

Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

2 #6
90
BORN 1920

✓ CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **37311**
Registered No. **773**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of **Nez Perce**
City of **Lewiston**Registration District No. **96**Primary Registration District No. **1009**

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary Edith Brown

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Nov 15 1895
(Month) (Day) (Year)

7. AGE

26 Yrs. 3 Mos. 7 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

At Home

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Wash.

10. NAME OF FATHER

J. H. Brown

11. BIRTHPLACE OF FATHER

(State or Country)

Oregon

12. MAIDEN NAME OF MOTHER

Lucille Mack

13. BIRTHPLACE OF MOTHER

(State or Country)

Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. H. Brown

(Address)

Edmond, Idaho

15.

Filed **9 Mar 1922****Ernest E. Bruce**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 27 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 21 1922, to Feb 22 1922that I last saw him alive on **Feb 22 1922**and that death occurred on the date stated above, at **7 P.M.**

The CAUSE OF DEATH* was as follows:

Surgical shock following hysterectomy(Duration) Yrs. **1** mos. **1** ds.Contributory **Pelvic Rupture**

(Secondary)

(Duration) yrs. **1** mos. **1** ds.(Signed) **E. J. Braddock** M. D.**Feb 23 1922** (Address) **Lewiston Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Spokane, Wash

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

Lewiston, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of *Lewiston*City of *Lewiston*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No. *96*Primary Registration District No. *1009*(No. *1009* St.)*Marcia Zimmerman*

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *37312*Registered No. *774*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Feb

(Month)

1922

(Day)

1922

(Year)

7. AGE

Yrs. *8*Mos. *8*

ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Infant

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

P.A. Zimmerman

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Emma M. Erickson

13. BIRTHPLACE OF MOTHER

(State or Country)

North Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

P.A. Zimmerman

(Address)

Spalding Idaho

15.

Filed

*Mar 10 1922**Susan E. Bruce*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 27

(Month)

1922

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 23 1922 to *Feb 27 1922*that I last saw him alive on *Feb 27 1922*

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

premature birth (8 months)
marion

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

Paul W. Johnson

M. D.

2/28/22 (Address) *2/28/22*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

Yrs.

mos.

In the

days

State

Yrs.

mos.

days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Lewiston, Idaho

DATE OF BURIAL

2/29 1922

20. UNDERTAKER

ADDRESS

Star Undertaking Co. Lewiston Idaho

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

✓
CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Myer
City of LewistonRegistration District No. 96Primary Registration District No. 1009(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

LenahTelcherState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 37313Registered No. 775

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female White

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married

6. DATE OF BIRTH

June 5 1887
(Month) (Day) (Year)

7. AGE

37 Yrs. 8 Mos. 22 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

at home

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Mo

10. NAME OF FATHER

W H Wilson

11. BIRTHPLACE OF FATHER

(State or Country)

Tenn

12. MAIDEN NAME OF MOTHER

Julia Krager

13. BIRTHPLACE OF MOTHER

(State or Country)

Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mr Ralph Telcher

(Address)

Grangeville Idaho

15.

Filed

Mar 10 1922Ernest E Bruce
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 27 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Feb 27 1922 to Feb 27 1922that I last saw him alive on Feb 26 1922and that death occurred on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J B Carson M. D.Feb 28 1922

(Address)

Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Grangeville Idaho

DATE OF BURIAL

 19

20. UNDERTAKER

ADDRESS

Lewiston Idaho

1. PLACE OF DEATH

County of *Jefferson*City of *Gifford*

If death occurs away from usual residence, give facts called for under special information.

RECEIVED

APR 3 1922

CERTIFICATE OF DEATH

Registration District No. *92*Primary Registration District No. *2170*(No. *2170*)

37314

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *5*Registered No. *43*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Phileander H. Clark

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

*White*5. SINGLE, MARRIED, WID-
OWED OR DIVORCED*Married*
(Write the word.)

6. DATE OF BIRTH

June 4 1863
(Month) (Day) (Year)

7. AGE

58 Yrs. *9* Mos. *8* ds.
IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)*Telephone Operator*

9. BIRTHPLACE

(State or Country)

Pennesse

10. NAME OF FATHER

Phileander H. Clark

11. BIRTHPLACE OF FATHER

(State or Country)

Pennesse

12. MAIDEN NAME OF MOTHER

Margaret Dearmon

13. BIRTHPLACE OF MOTHER

(State or Country)

Pennesse

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mrs. P. H. Clark*(Address) *Gifford Idaho*

15.

Filed *3-13* 1922*E. E. Watts*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 12 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *2-28* 1922, to *3-12* 1922that I last saw him alive on *3-12* 1922and that death occurred on the date stated above, at *10-a* M.

The CAUSE OF DEATH* was as follows:

Pneumonia(Duration) *1* Yrs. *14* mos. *14* ds.

Contributory (Secondary)

(Duration) *1* yrs. *14* mos. *14* ds.(Signed) *E. E. Watts* M. D.*3-13-1922* (Address) *Gifford*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Gifford *Mar 13 1922*

20. UNDERTAKER ADDRESS

W. E. Anderson *Gifford*

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

APR 3 1922

CERTIFICATE OF DEATH

37315

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Myrtle Registration District No. 92
City of Myrtle (No. _____, _____ St.)
If death occurs away from usual residence, give facts called for under special information.File No. 5
Registered No. 42
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Donald J. Gower

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Nov 1914

(Month)

(Day)

1910
(Year)

7. AGE

X 11 Yrs. 03 Mos. 20 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Scholar

9. BIRTHPLACE

(State or Country)

Douglas Co Oregon

10. NAME OF FATHER

Ollie A Gower

11. BIRTHPLACE OF FATHER

(State or Country)

Latah Co Idaho

12. MAIDEN NAME OF MOTHER

Ethel Mc Fall

13. BIRTHPLACE OF MOTHER

(State or Country)

Garfield Co. W. N.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) X H. E. Reed

(Address)

Spokane Idaho

15.

Filed 3-13 1922E. E. Watts

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

X March 6

(Month)

(Day)

1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____ 19____, to _____ 19____
that I last saw him alive on _____ 19____
and that death occurred on the date stated above, at 2 p.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia
and Leakage of the Heart
no physician in charge
(Duration) _____ Yrs. _____ mos. 8 ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

E. E. Watts

M. D.

3-13-1922 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Myrtle Cemetery

DATE OF BURIAL

8th 1922

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
37317
File No. 3
Registered No. 3

1. PLACE OF DEATH

Registration District No. 26
County of Quida
Primary Registration District No. 2069
City of Malad (No. 1) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Fern Warner

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Girl 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Single

(Write the word.)

6. DATE OF BIRTH

July 14 1901
(Month) (Day) (Year)

7. AGE

14 Yrs. 8 Mos. 8 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Student

9. BIRTHPLACE

(State or Country)

Robinson Utah

10. NAME OF FATHER

George R Warner

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Mary Cella

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Geo Warner

(Address)

Malad Ida

15.

Filled

Mar 15 1922

R. W. Warner M.P.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 8 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 1 1922 to Feb 8 1922
that I last saw her alive on Feb 8 1922
and that death occurred on the date stated above, at 1 a M.

The CAUSE OF DEATH* was as follows:

Sarcoma of left ovary

(Duration) Yrs. 2 mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Feb 8 1922 (Address) Malad, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Malad, Idaho

DATE OF BURIAL

2-13 1922

20. UNDERTAKER

D. C. Johnson

ADDRESS

Malad

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

37318

1. PLACE OF DEATH

County of Oneida
City of MaladRegistration District No. 26
Primary Registration District No. 2069
(No. 1 St.)File No. 4
Registered No. 4

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Helma Bennett

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F.

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Write the words

6. DATE OF BIRTH

Dec. 2 1922
(Month) (Day) (Year)

7. AGE

X Yrs. 2 Mos. 12 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

infant

9. BIRTHPLACE

(State or Country)

Malad Ida

10. NAME OF FATHER

Albert Nephi Bennett

11. BIRTHPLACE OF FATHER

(State or Country)

Albion Idaho

12. MAIDEN NAME OF MOTHER

Martha Jenkins

13. BIRTHPLACE OF MOTHER

(State or Country)

Malad Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Nephi Bennett

(Address)

Malad Ida

15.

Filed

Mar. 15 1922R. W. Mauer M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb. 14 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
Feb. 12 1922, to Feb. 14 1922
that I last saw her alive on Feb. 13 1922
and that death occurred on the date stated above, at 3 P. M.
The CAUSE OF DEATH* was as follows:Empyema(Duration) Yrs. mos. 10 ds.Contributory
(Secondary)Tonsillitis(Duration) yrs. mos. 6 ds.

(Signed)

R. W. Mauer M. D.
Malad Ida (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Malad Ida 2-17 1922

20. UNDERTAKER

ADDRESS

W. E. Johnson Malad

✓
CERTIFICATE OF DEATH.State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **37319**Registered No. **5**

1. PLACE OF DEATH.

County of Owyhee
City of St JohnRegistration District No. 26
Primary Registration District No. 2069
(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

James Ashworth

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word)

6. DATE OF BIRTH.

Nov 10 1861
(Month) (Day) (Year)

7. AGE

61 Yrs. 3 Mos. 11 ds.IF LESS than 1 day
how many.....hrs. or
.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....Farmer

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

Edmond Ashworth

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Betsy Maden

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emily Kanergh Ashworth
(Address) St John, Idaho

15.

Filed Mar. 15 1922R. M. M. D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 21 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 2 1922 to Feb 21 1922
that I last saw him alive on Feb 21 1922
and that death occurred on the date stated above, at 11:55 A.M.

The CAUSE OF DEATH* was as follows:

Cancer of jaw(Duration) Yrs. 2 mos. _____ ds.Contributory
(Secondary)Influenza(Duration) yrs. _____ mos. 7 ds.

(Signed)

R. M. M. D.Feb 21 1922 (Address) Malad, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

St John, Idaho
D. P. WoodlandFeb 23 1922
Malad

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bannock
City of DowneyRegistration District No. 83
Primary Registration District No. 3160
(No. 101 St.)State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
37320
File No. 6
Registered No. 6

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary Jane Evans

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married

6. DATE OF BIRTH

Aug 14 1886
(Month) (Day) (Year)

7. AGE

35 Yrs. 6 Mos. 7 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

Housewife

9. BIRTHPLACE

(State or Country)

Malad Ida

10. NAME OF FATHER

John S Owens

11. BIRTHPLACE OF FATHER

(State or Country)

Ogden Ut

12. MAIDEN NAME OF MOTHER

Mary Jane Thomas

13. BIRTHPLACE OF MOTHER

(State or Country)

Bingham City Ut

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Harry J Owens

(Address)

Malad Ida

15.

Filed

Feb-21-1933

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 21 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb. 15, 1933, to Feb. 21, 1933.
that I last saw him alive on Feb. 20, 1922.
and that death occurred on the date stated above, at 3:40 AM.

The CAUSE OF DEATH* was as follows:

Influenza Pneumonia(Duration) _____ Yrs. _____ mos. 8 ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

J. H. Hartigan M. D.(Address) Downey Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Malad Ida

DATE OF BURIAL

2-22-1922

20. UNDERTAKER

W. E. Johnson

ADDRESS

Malad

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **37321**
Registered No. **13**

1. PLACE OF DEATH

Registration District No. **4**
County of **Payette** Primary Registration District No. **1008**
City of **Payette** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

August C Wahlbrucht

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male **White** **Single**
(Write the word.)

6. DATE OF BIRTH

Jan 14 1893
(Month) (Day) (Year)

7. AGE

29 Yrs. **1** Mos. **14** ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Dep. Sheriff

9. BIRTHPLACE

(State or Country)

Ida

10. NAME OF FATHER

John Wahlbrucht

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Ella Opitz

13. BIRTHPLACE OF MOTHER

(State or Country)

Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

A. C. Wahlbrucht
Payette, Ida

15.

Filled

March 1 1922
J. C. Woodward
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 1 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Feb 27 1922** to **March 1 1922** that I last saw him alive on **March 1 1922** and that death occurred on the date stated above, at **12:30** M.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

1922

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual Residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Payette **Ida** **Mar 3 1922**

20. UNDERTAKER

ADDRESS

A. C. Woodward **Payette, Ida**

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **37322**
Registered No. **14**

1. PLACE OF DEATH

County of **Payette** Registration District No. **4**
City of **Payette** Primary Registration District No. **1008** St.)

If death occurs away from usual residence, five facts called for under special information.

2. FULL NAME

Amanda Morrison

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WID-OWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Nov 16 1884
(Month) (Day) (Year)

7. AGE

37 Yrs. **3** Mos. **18** ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

Invalid

9. BIRTHPLACE

(State or Country)

Indo

10. NAME OF FATHER

Morrison

11. BIRTHPLACE OF FATHER

(State or Country)

Don't know

12. MAIDEN NAME OF MOTHER

Patience M. Ferguson

13. BIRTHPLACE OF MOTHER

(State or Country)

Indo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Geo Garvey
Payette Idaho

15.

Filed

March 8 1922
J. C. Woodward
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 4 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____ 19 _____ to _____ 19 _____
that I last saw him _____ alive on _____ 19 _____
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH was as follows:

Gun shot wound in head suicidal

_____ (Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

H. F. Knight
March 4 1922 (Address) **Plymouth Ida**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Payette Idaho

DATE OF BURIAL

3-6-1922

20. UNDERTAKER

Glenn C Landon

ADDRESS

Payette Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37323

1. PLACE OF DEATH
County of *Payette*
City of *Payette*
Registration District No. *4*
Primary Registration District No. *1008*
St. *Idaho*

Registered No. *16*

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Richard B Canfield

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*
(Write the word.)

6. DATE OF BIRTH

Jan 4 1922
(Month) (Day) (Year)

7. AGE

0 Yrs. *2* Mos. *6* ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Infant

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Victor Canfield

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Ethel M Burnett

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Victor Canfield

(Address)

Payette, Idaho

15.

File

Mar 13 1922

J. C. Woodward
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 10 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Called after child's death
that I last saw *alive* on *19*

and that death occurred on the date stated above, at *4:00* M.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. C. Woodward D.

3/13/1922 (Address) *Payette, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Payette Ida *Mar 11 1922*

20. UNDERTAKER

ADDRESS

J. A. Cedar *Payette Ida*

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

BUREAU OF VITAL STATISTICS

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 37324

Registered No. 16

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

March 11, 1922 to March 12, 1922

that I last saw him alive on March 11, 1922

and that death occurred on the date stated above, at 1:27 P. M.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) yrs. mos. 3 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. C. Woodward M. D.

3/13/1922 (Address) Payette Ida.

State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Payette Ida 3-13-1922

20. UNDERTAKER

ADDRESS

J. C. Woodward Payette Ida

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **37325**
Registered No. **17**

1. PLACE OF DEATH

Registration District No. **4**
County of **Payette** Primary Registration District No. **1008**
City of **Payette** (No. **1**) St.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Emma Hells

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Widowed**

6. DATE OF BIRTH

Sep 18 1892
(Month) (Day) (Year)

7. AGE

29 Yrs. **6** Mos. **14** ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

Wm Coates

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Not known

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

B. L. Wells

(Address)

Payette

15.

Filed

March 13 1922

J. C. Woodward

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

3 (Month) **2** (Day) **1922** (Year)

17. I HEREBY CERTIFY, That I attended deceased from **you** **1915** to **Mar 2** **1922**
that I last saw him alive on **Mar 1** **1922**
and that death occurred on the date stated above, at **4 a.m.**

The CAUSE OF DEATH* was as follows:

Seriously
Lab or Pneumonia

(Duration) Yrs. mos. **7** ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. C. Woodward M. D.

3/12/22 (Address) **Payette, Ida**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Payette Ida

Mar 5 1922

20. UNDERTAKER

ADDRESS

J. C. Woodward Payette Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNEADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED
APR 19 1922
BUREAU OF VITAL STATISTICS
Registration District No. 4
Primary Registration District No. 1008
St.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37326
Registered No. 18

1. PLACE OF DEATH
County of *Payette*
City of *Payette*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Morris Ida Huntleff*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WID-OWED OR DIVORCED *Married*
(Write the word.)

6. DATE OF BIRTH *Nov 13 1898*
(Month) (Day) (Year)

7. AGE *23* Yrs. *4* Mos. *7* ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION *Housewife*
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE *Idaho*
(State or Country)

10. NAME OF FATHER *J. J. Kenepp*

11. BIRTHPLACE OF FATHER *Iowa*
(State or Country)

12. MAIDEN NAME OF MOTHER *Katharine Nelson*

13. BIRTHPLACE OF MOTHER *Missouri*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *x S. J. Kenepp*
(Address) *Payette Idaho*

15. Filled *Mar 24 1922*
J. C. Woodward
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *Mar 20 1922*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Mar 20 1922* to *Mar 20 1922* that I last saw him alive on *Mar 20 1922* and that death occurred on the date stated above, at *7 P. M.* The CAUSE OF DEATH* was as follows:
Pulmonary tuberculosis

(Duration) Yrs. mos. *5 mos.*
Contributory (Secondary) *Pulmonary tuberculosis*
(Duration) *2* yrs. mos. ds.
(Signed) *W. L. Woodward* M. D.
3/26/1922 (Address) *Payette Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Payette Ida* DATE OF BURIAL *Mar 23 1922*
20. UNDERTAKER *J. W. Adair* ADDRESS *Payette Ida*

1. PLACE OF DEATH

County of *Payette*

City of _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED
MAR 24 1922
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. _____

County Registration District No. _____

St.) _____

File No. _____

Registered No. _____

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

37327

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

If LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from
Jan 14 1922, to Jan 20 1922
that I last saw her alive on Jan 20 1922
and that death occurred on the date stated above, at 2⁰⁰ P.M.
The CAUSE OF DEATH* was as follows:

(Duration) _____ Yrs. _____ mos. _____ ds.
Contributory (Secondary) _____

(Signed)

19

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Payette
City of PeyetteRegistration District No. 4Primary Registration District No. 1008City of Peyette (No. 151)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Elmer BruceFile No. 37328Registered No. 4

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widowed
Write the word.

6. DATE OF BIRTH

Oct 27 1887
(Month) (Day) (Year)

7. AGE

84 Yrs. 3 Mos. — ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Bancker

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Geo H Bruce

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Luise McCann
Not known

13. BIRTHPLACE OF MOTHER

(State or Country)

Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Payette

15.

Filed Jan 31 1922

Local Registrar

16. DATE OF DEATH

16. DATE OF DEATH

Jan 27 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 1 1920, to Jan 27 1922
that I last saw him alive on Jan 27 1922and that death occurred on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) Yrs. mos. ds.

Contributory
(Secondary)Cytilis

(Duration) 1 yrs. mos. ds.

(Signed)

S R Woodward M. D.1/30 1922 (Address) Payette, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

PayetteJan 29 1922

20. UNDERTAKER

ADDRESS

S R Woodward Payette Ida

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **37329**
Registered No. **8**

1. PLACE OF DEATH
County of **Payette**
City of **Payette**
Registration District No. **4**
Primary Registration District No. **1008**
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Ozias Cree**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Married**

6. DATE OF BIRTH **Jan 15 1887**
(Month) (Day) (Year)

7. AGE **70** Yrs. **12** Mos. **12** ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION **Farmer**
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer) **Retired 10 yrs**

9. BIRTHPLACE **Ill**
(State or Country)

10. NAME OF FATHER **Thomas Cree**

11. BIRTHPLACE OF FATHER **Virginia**
(State or Country)

12. MAIDEN NAME OF MOTHER **Nancy Bowman**

13. BIRTHPLACE OF MOTHER **Not Known**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) **A. O. Scritchfield**
(Address) **Triner, Idaho**

15. Filed **Jan 31 1922**
Local Registrar **J. C. Woodward**

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **January 27 1922**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Dec 21 1921** to **Jan 26 1922** that I last saw him alive on **Dec 9 1921** and that death occurred on the date stated above, at **12:30** M.

The CAUSE OF DEATH* was as follows:
Starvation

(Duration) Yrs. mos. ds.
Contributory (Secondary) **Diabetes Mellitus**
(Duration) Yrs. mos. ds.
(Signed) **J. C. Woodward** M. D.
1/31/1922 (Address) **Payette, Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **Payette** DATE OF BURIAL **Jan 29 1922**

20. UNDERTAKER **J. N. Udair** ADDRESS **Payette, Ida**

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **37330**
Registered No. **89**

1. PLACE OF DEATH

County of *Payette*
City of *Payette*

Registration District No. *4*Primary Registration District No. *1008*

(No. St.)

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Burtha Ann Syme

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

*White*5. SINGLE, MARRIED, WID-
OWED OR DIVORCED*Married*

6. DATE OF BIRTH

*August**February 22**1884*

(Month)

(Day)

(Year)

7. AGE

37 Yrs. *5* Mos. *10* ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.*Farmers Wife*(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer).

9. BIRTHPLACE

(State or Country)

Near Astoria
*Oregon*10. NAME OF
FATHER*Samuel Browning*11. BIRTHPLACE
OF FATHER

(State or Country)

*England*12. MAIDEN NAME
OF MOTHER*Jane Vineyard*13. BIRTHPLACE
OF MOTHER

(State or Country)

Troy
Madison Co Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs Anna E. Gardner(Address) *501 Bidwell Ave Portland Ore*

15.

Filed *Feb 2**1922**J C Woodward*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

*Feb**2**1922*

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 10 *1921* to *Feb 2* *1922*that I last saw her alive on *Jan 10* *1922*and that death occurred on the date stated above, at *8 a* M.

The CAUSE OF DEATH* was as follows:

*Cancer of Sigmoid**recurrent from Cancer of Cervix*
uteri (Duration) *3* Yrs. *8* mos. *ds.*Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *William Weese* M. D.*2* *1922* (Address) *Clinton, Ore**State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Payette Idaho

DATE OF BURIAL

Feb 5 1922

20. UNDERTAKER

Elmer C Landon

ADDRESS

Payette Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Payette, the*
City of *Payette*

Registration District No. *4*
Primary Registration District No. *1008*
(No. *4* St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Susan Weaver

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. *37331*
Registered No. *10*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widowed
(Write the word.)

6. DATE OF BIRTH

July 11 1842
(Month) (Day) (Year)

7. AGE

81
(Years) (Months) (Days)

IF LESS than 1 day

how many *hrs.*
or *min.?*

8. OCCUPATION

None
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

Penn
(State or Country)

10. NAME OF FATHER

George Dunkelburg

11. BIRTHPLACE OF FATHER

Penn
(State or Country)

12. MARRIAGE NAME OF MOTHER

Don't know

13. BIRTHPLACE OF MOTHER

Penn
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. W. Goetz
(Address) *Payette Idaho*

15. Filed

Feb 22 1922 J. C. Woodward
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb. 21 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb. 19 1922 to Feb. 21 1922

that I last saw him *Er.* alive on *Feb. 20 1922*

and that death occurred on the date stated above, at *9 A.M.*

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) *4* Yrs. *4* mos. *4* ds.

Contributory (Secondary)

Senility

(Duration) *4* yrs. *4* mos. *4* ds.

(Signed)

J. L. McDonald M. D.

221 102 (Address) *Payette Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death *4* yrs. *4* mos. *4* days. In the State *4* yrs. *4* mos. *4* days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Boise Idaho

DATE OF BURIAL

Feb 25 1922

20. UNDERTAKER

Sherrill E. Landon

ADDRESS

Payette Ida

1. PLACE OF DEATH

County of *Payette*City of *Payette*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED
MAR 20 1922
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. *4*Primary Registration District No. *1008*

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. *37332*Registered No. *11*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Unmarried

6. DATE OF BIRTH

July 21 1830
(Month) (Day) (Year)

7. AGE

*91 Yrs. 7 Mos. 1 ds.*IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).*Housewife*

9. BIRTHPLACE

(State or Country)

Ind.

10. NAME OF FATHER

Redok Stewart

11. BIRTHPLACE OF FATHER

(State or Country)

Scotland

12. MAIDEN NAME OF MOTHER

Jolly Coff

13. BIRTHPLACE OF MOTHER

(State or Country)

Tenn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. F. Anttrim
(Address) *Payette Idaho*

15.

Filed *Feb 27 1922**J. C. Woodward*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

February 22 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
Feb. 21 1922, to *Feb. 22 1922*
that I last saw her alive on *Feb. 22 1922*
and that death occurred on the date stated above, at *6:30 M.*
The CAUSE OF DEATH* was as follows:*Influenza*(Duration) Yrs. *3* mos. *3* ds.Contributory *Senility*
(Secondary)(Duration) yrs. *3* mos. *3* ds.(Signed) *J. A. McDonald* M. D.*3-1 19 22* (Address) *Payette, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Payette Ida *Feb 24 1922*

20. UNDERTAKER

ADDRESS

J. A. McDonald Payette Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH
County of *Payette*
City of *Payette*

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
MAR 3 1922

CERTIFICATE OF DEATH

Registration District No. *4*
Primary Registration District No. *1008*
St. _____

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. *37333*
Registered No. *12*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME *Irene L Wayne*

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *married*
(Write the word.)

6. DATE OF BIRTH *July 28 1892*
(Month) (Day) (Year)

7. AGE *29* Yrs. *7* Mos. *—* ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. *Housewife*
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE *Iowa*
(State or Country)

10. NAME OF FATHER *Robert R. Abrams*

11. BIRTHPLACE OF FATHER *Iowa*
(State or Country)

12. MAIDEN NAME OF MOTHER *Cora L. Purcell*

13. BIRTHPLACE OF MOTHER *Iowa*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *Henry R Wayne*
(Address) *Payette Idaho*

15. Filed *Mar 1* 19 *22* *J. C. Woodward*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *Feb 28 1922*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Feb 21 1921* to *Feb 25 1922* that I last saw him alive on *Feb 27 1922* and that death occurred on the date stated above, at *4 a. m.*
The CAUSE OF DEATH* was as follows:

Bright's Disease

(Duration) Yrs. *6* mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) *J. R. Woodward* M. D.
3/1 1922 (Address) *Payette, Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Payette Idaho* DATE OF BURIAL *March 2 1922*

20. UNDERTAKER *Glenn C Landon* ADDRESS *Payette, Ida*

CERTIFICATE OF DEATH.

1. PLACE OF DEATH.

County of PowerCity of American Falls, Idaho (No. 2072 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edward Ellsworth Geesey37335 State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 3Registered No. 45

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widowed

(Write the word.)

6. DATE OF BIRTH.

Dec81861

(Month)

(Day)

(Year)

7. AGE

60

Yrs.

2

Mos.

9

ds.

IF LESS than 1 day

how many.....hrs. or

.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....Farmer

9. BIRTHPLACE

(State or Country) Iowa

10. NAME OF FATHER

Geo William Geesey

11. BIRTHPLACE OF FATHER

(State or Country)

N.Y.

12. MAIDEN NAME OF MOTHER

Julia Billingshurst

13. BIRTHPLACE OF MOTHER

(State or Country)

N.Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address) American Falls, Idaho

15.

Filed

2-271922Richard J. Nott
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb

(Month)

17

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 17 1922 to Feb 17 1922that I last saw him alive on Feb 17 1922and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration)

Yrs.

mos.

3 1/2 hrs.Contributory
(Secondary)arterio-sclerosis

(Duration)

yrs.

mos.

ds.

(Signed)

C. F. Schmitt

M. D.

Address Amer. Falls, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death.....yrs.....mos.....days.

In the

State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

American Falls, Ida

DATE OF BURIAL

Feb 17 1922

20. UNDERTAKER

Acadame

ADDRESS

American Fall
Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

1. PLACE OF DEATH.

County of PowerCity of American Falls, Idaho

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No. 2072

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 3Registered No. 144

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Albert T. CazierBetham Hospital

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.Single

(Write the word.)

6. DATE OF BIRTH.

Aug 23 1903
(Month) (Day) (Year)

7. AGE

18 Yrs. 5 Mos. 15 ds.

IF LESS than 1 day
how many hrs. or
..... min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

Student

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF

FATHER

Wm D. Cazier11. BIRTHPLACE
OF FATHER

(State or Country)

Utah

12. MAIDEN NAME

OF MOTHER

Lula Tanner13. BIRTHPLACE
OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. D. Cazier(Address) American Falls, Idaho

15.

Filed 2-27 191

Richard J. Nolt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 8 1912
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 30 1912 to Feb 8 1912

that I last saw him alive on Feb 8 1912

and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Empyema(Duration) Yrs. mos. 2 ds.

Contributory

(Secondary)

other lung collapse
from previous empyema

(Duration) Yrs. mos. ds.

(Signed)

C. F. Schults M. D.2/9 1912 (Address) Amer. Falls, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted
If not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

American Falls, Ida2/10/22 191

20. UNDERTAKER

ADDRESS

W. D. Cazier
Amer. Falls, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of PowerCity of American Falls, IdahoRegistration District No. 2072Primary Registration District No. 2072
Bethany Hospital St.File No. 3Registered No. 143

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph F. Gish

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.Married

(Write the word.)

6. DATE OF BIRTH.

Oct161873

(Month)

(Day)

(Year)

7. AGE

48317

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs. or
min.

8. OCCUPATION

(a) Trade, profession or particular kind of work...

Mgr Cigar Store

(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE

(State or Country)

IowaU.S.

10. NAME OF FATHER

Michel Gish

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Jane Davis

13. BIRTHPLACE OF MOTHER

(State or Country)

Ind

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mr. J. F. Gish

(Address)

American Falls, Idaho

15.

Filed

2-271922Richard J. Nott

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb
(Month)3rd
(Day)1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 26 1922 to Feb 3 1922that I last saw him alive on Feb 3 1922

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Peritonitis,

(Duration) Yrs. mos. ds.

Contributory
(Secondary)Acute appendicitis

(Duration) Yrs. mos. ds.

(Signed)

C. F. Schick M. D.24 1922 (Address) Amer. Falls, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

American Falls, Idaho2/6/22191

20. UNDERTAKER

W. DavisAddress American Falls, Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **37338**
Registered No. **6**

1. PLACE OF DEATH

County of Latah
City of Driggs

REC

Registration District No. 77Primary Registration District No. 2176

BUREAU

STATE

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Elizabeth L. Driggs

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH

April 22 1871
(Month) (Day) (Year)

7. AGE

50 Yrs. 29 Mos. 29 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

Fred Langton

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Elizabeth Downes

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Bessie Driggs

(Address)

Driggs, Idaho

15.

Filed March 8th 1922

Martin Marker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

February 21 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 27 1922, to Feb 21st 1922

that I last saw her alive on " 21 " 1922,
and that death occurred on the date stated above, at 9:30 A. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

Chas Martin M. D.

Feb 19 22 (Address) Driggs, Id.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Driggs Cemetery

DATE OF BURIAL

2-23 1922

20. UNDERTAKER

W. Driggs

ADDRESS

Driggs

1. PLACE OF DEATH

County of Teton
 City of Driggs

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No. 77
 Primary Registration District No. 2176
 (No. _____ St.)

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 37339
 Registered No. 1111

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female white Infant Single
 (Write the word.)

6. DATE OF BIRTH

Sept-21- 1918
 (Month) (Day) (Year)

7. AGE

3 Yrs. 4 Mos. 24 ds.
 IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

Infant

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

John Cowan Jr.
Utah

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Jean Brown
Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

John Cowan Jr.

15.

Filed Mar 8th 1922

Martha Marker
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 14 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 24 1922, to Feb 14 1922
 that I last saw her alive on Feb 14 1922
 and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH was as follows:

Acute Endocarditis
 (Duration) _____ Yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) Chas. H. Martin M. D.

Feb 14 1922 (Address) Driggs Id

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Driggs Cemetery 2-16 1922

20. UNDERTAKER

ADDRESS

W. O. Martin Driggs

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Twin Falls*Registration District No. *36*City of *Kimberly*

Primary Registration District No.

(No.) (St.)

File No. *37340*Registered No. *2*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Miss Minnie Peterson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

*July**10**1850*

(Month)

(Day)

(Year)

7. AGE

7 Yrs. *7* Mos. *✓* ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Retired.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Sweden.

10. NAME OF FATHER

Daniel Johnson

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME OF MOTHER

Don't Know

13. BIRTHPLACE OF MOTHER

(State or Country)

✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Erastus Peterson

(Address)

Kimberly, Ida.

15.

Filed *Feb 6 1922**J. N. Davis*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

*Feb**11**1922*

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19....., to

19.....

that I last saw h..... alive on..... 19.....

and that death occurred on the date stated above, at *3:45 P.M.*

The CAUSE OF DEATH* was as follows:

Chloroform heart disease

(Duration)..... Yrs..... mos..... ds.

Contributory
(Secondary)*Old age*

(Duration)..... yrs..... mos..... ds.

(Signed)

J. N. Davis

M. D.

2/12/22 (Address) *Kimberly Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Twin Falls

DATE OF BURIAL

2-13-1922

20. UNDERTAKER

T. J. Grosman

ADDRESS

Twin Falls Ida.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Twin FallsRegistration District No. 37City of Idaho FallsPrimary Registration District No. 2085

(No. St.)

File No. 37341

Registered No.

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Henry SharesIf death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDMarried
(Write the word.)

6. DATE OF BIRTH

March

(Month)

1

(Day)

1878

(Year)

AGE

44 Yrs.

Mos.

ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.Farmer(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country)

MinneapolisMinnesota10. NAME OF
FATHERAndrew Shore11. BIRTHPLACE
OF FATHER

(State or Country)

TorontoCanada12. MAIDEN NAME
OF MOTHERMary Grace13. BIRTHPLACE
OF MOTHER

(State or Country)

Toronto Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. A. Shore

(Address)

Twin Falls

15.

Filed

Mar 91928John S. Dougherty

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

2-26

(Month)

(Day)

1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 1920 to Feb 26 1922that I last saw him alive on 4 P.M. Feb 26 1922and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs(3 years)

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)none

(Duration)

Yrs.

mos.

ds.

(Signed)

Dr. McJinnis

19

(Address)

415 - 7th St & Twin Falls*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Twin Falls Idaho

DATE OF BURIAL

2-28 1922

20. UNDERTAKER

F. E. Smith

ADDRESS

Twin Falls Idaho

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **37342**

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

Registration District No. **37**County of **Jerui**Primary Registration District No. **1085**City of **" "**(No. **La Merend Hospital** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Abner Thoru Jr.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male**White****Married**
(Write the word.)

6. DATE OF BIRTH

Oct**"****1889**

(Month)

(Day)

(Year)

7. AGE

32 Yrs. 4 Mos. 22 ds.

IF LESS than 1 day

how many _____ hrs.

or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Farmer

(b) General nature of industry, business or establishment in which employed (or employer).

Owner

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Abner Thoru A.

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Mary L. Clyde

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Abner Thoru

(Address)

Springville, Utah

15.

Filed

Mar 7 - 1922**John F. Coughlin**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar - 3 - 22

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 1 1922 to March 3 1922that I last saw him alive on **March 3 1922**and that death occurred on the date stated above, at **6 A.** M.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

John F. Coughlin M. D.
4/3 1922 (Address) **Jerui, Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Jerui Falls**3/6 1922**

20. UNDERTAKER

ADDRESS

J. F. Coughlin Jerui Falls, Idaho

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. **37343**

1. PLACE OF DEATH

 County of Turn Falls Registration District No. 37
 Primary Registration District No. 1085
 City of Turn Falls (No. 1085 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Emery Lahue

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

 3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single

6. DATE OF BIRTH

June 7 1915
 (Month) (Day) (Year)

7. AGE

6 Yrs. 6 Mos. 25 ds.
 IF LESS than 1 day how many..... hrs. or..... min.?

8. OCCUPATION

 (a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)
School Boy

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Leo Lahue

11. BIRTHPLACE OF FATHER

(State or Country)

Texas

12. MAIDEN NAME OF MOTHER

May Haddock

13. BIRTHPLACE OF MOTHER

(State or Country)

Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Geo. Lahue

(Address)

309 E. 2nd Turn Falls Id

15. Filed

Mich. 7-1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 5- 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

3/4 1922 to 3/5 1922
 that I last saw him alive on 3/4 1922
 and that death occurred on the date stated above, at 8 A.M.
 The CAUSE OF DEATH* was as follows:

Mitral Insufficiency
 (Duration) yrs. 3 mos. ds.

Contributory (Secondary)

Cholera
 (Duration) yrs. 3 mos. ds.

(Signed)

3/6 1922 (Address) Turn Falls Id

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Turn Falls

DATE OF BURIAL

Mar 6, 1922

20. UNDERTAKER

J. E. Sweet

ADDRESS

Turn Falls

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Twin FallsRegistration District No. 311City of Idaho FallsPrimary Registration District No. 1065

(No. St.)

File No.

Registered No. 37344

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Donald Buck

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single

6. DATE OF BIRTH

July 27 1922
(Month) (Day) (Year)

7. AGE

1 Yrs. 6 Mos. 13 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Farmer

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

M. R. Buck

11. BIRTHPLACE OF FATHER

(State or Country)

Iowa

12. MAIDEN NAME OF MOTHER

Martha Smith

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. M. R. Buck

(Address)

Twin Falls, Idaho

15. Filed

March 9 - 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

February 10 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb. 1 - 1922 to Feb. 10 1922that I last saw him alive on Feb. 10 1922and that death occurred on the date stated above, at 12:30

The CAUSE OF DEATH* was as follows:

Diphtheria(Duration) Yrs. mos. 14 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Dr. J. R. Morgan M. D.2-10-1922 (Address) Twin Falls, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Twin Falls7/31/1922

20. UNDERTAKER

ADDRESS

J. R. Morgan Twin Falls

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Twin FallsCity of Twin FallsRegistration District No. 37Primary Registration District No. 1085

(No. St.)

File No. 37345Registered No. 37345

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant Husted

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

WT

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Mar 2

(Month)

(Day)

1922
(Year)

7. AGE

0 Yrs.0 Mos.0 ds.IF LESS than 1 day
how many 9 hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

none

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Twin Falls

10. NAME OF FATHER

Ralph E. Husted

11. BIRTHPLACE OF FATHER

(State or Country)

Id

12. MAIDEN NAME OF MOTHER

Iva E. Hirsch

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ralph E. Husted

(Address)

Twin Falls

15.

Filed

Mar 7 - 19221922John S. Langhorne

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 2

(Month)

(Day)

1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar 2 1922 to Mar 2 1922that I last saw him alive on Mar 2 1922and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Incomplete development(Duration) 0 Yrs. 0 mos. 0 ds.Contributory Premature birth
(Secondary)(Duration) yrs. mos. ds.(Signed) E. H. Van Gort M. D.3-2-1922 (Address) Twin Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. 0 days. In the State yrs. mos. 0 days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cremated3-3-1922

20. UNDERTAKER

ADDRESS

GrossmanTwin Falls

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Twin Falls*Registration District No. *37*Primary Registration District No. *1085*City of *"*(No. *"*)St. *"*File No. *37346*Registered No. *"*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Emeline Town*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widowed
(Write the word.)

6. DATE OF BIRTH

July 24

(Month)

(Day)

(Year)

7. AGE

78

Yrs.

Mos.

ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Canada

10. NAME OF FATHER

Leronza Town

11. BIRTHPLACE OF FATHER

(State or Country)

Canada

12. MAIDEN NAME OF MOTHER

Adelia Chadison

13. BIRTHPLACE OF MOTHER

(State or Country)

Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Leronza Town

(Address)

Marion B.C.

15.

Filed

*March 7 1922**John S. Connelley*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb - 25

(Month)

(Day)

1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb. 1st 1921 to *2-25-1922*that I last saw him alive on *2-25-1922*and that death occurred on the date stated above, at *1 A.M.*

The CAUSE OF DEATH* was as follows:

Organic Heart Disease(Duration) *3* Yrs. *3* mos. *3* ds.

Contributory (Secondary)

Rheumatism(Duration) *2* yrs. *3* mos. *3* ds.

(Signed)

Geo. Jennings

M. D.

225 1922

(Address)

Buhl Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death *3* yrs. *3* mos. *3* days. In the State *3* yrs. *3* mos. *3* days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Twin Falls Ida

DATE OF BURIAL

7/27 1922

20. UNDERTAKER

J. J. Crossman

ADDRESS

Twin Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **37348**

1. PLACE OF DEATH. Registration District No. **37**
County of **Twin Falls** Primary Registration District No. **1185**
City of **Twin Falls** (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mr. Nealey

Registered No. _____

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH.

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Single**
(Write the word.)

6. DATE OF BIRTH **Feb. 20 1922**
(Month) (Day) (Year)

7. AGE _____ yrs. _____ mos. **2** ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Twin Falls Ida

10. NAME OF FATHER

Roy H. McNealey

11. BIRTHPLACE OF FATHER

(State or Country)

Colo.

12. MAIDEN NAME OF MOTHER

Elizabeth M. Hansen

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Roy H. McNealey

(Address)

Twin Falls

15.

Filed

March 9 1922
John H. Houghlin
Local Registrar

16. DATE OF DEATH **Feb. 22 1922**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **2/20 1922**, to **2/22 1922**
that I last saw h. _____ alive on _____ 1922
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Premature birth.

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

_____ (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) **E. D. Weaver** M. D.
2/22 1922 (Address) **Twin Falls**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,
If not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Twin Falls

Feb 22 1922

20. UNDERTAKER

ADDRESS

No

Twin Falls

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of *Jerome*City of *Hazelton*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED CERTIFICATE OF DEATH

Registration District No. *37*Primary Registration District No. *2085*

(No. _____)

St. _____

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. *37349*

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

7

4. COLOR OR RACE

*white*5. SINGLE, MARRIED, WID-
OWED OR DIVORCED*Single*

(Write the word.)

6. DATE OF BIRTH

Feb 25

(Month)

(Day)

1922
(Year)

7. AGE

Yrs. _____

Mos. _____

20 min

IF LESS than 1 day

how many _____ hrs.

or *20* min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work *none*

(b) General nature of industry, business or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country) *Hazelton, Ida.*

10. NAME OF FATHER

Chas. Hohmhorst

11. BIRTHPLACE OF FATHER

(State or Country) *Mo.*

12. MAIDEN NAME OF MOTHER

Agnes Charles

13. BIRTHPLACE OF MOTHER

(State or Country) *Mo.*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Chas. Hohmhorst*(Address) *Hazelton, Ida.*

15.

Filed *Feb 9**1922**John F. Cooper*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb

(Month)

25

(Day)

1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

*Feb 25**1922*

to

*Feb 25**1922*that I last saw her alive on *Feb 25* *1922*and that death occurred on the date stated above, at *12:30* M.

The CAUSE OF DEATH* was as follows:

Asphyxia neonatorum
Premature birth.

(Duration) _____

Yrs. _____

mos. *20 min.*

ds. _____

Contributory
(Secondary) _____

(Duration) _____

yrs. _____

mos. _____

ds. _____

(Signed) *E. L. Berry*

M. D.

225 *1922*(Address) *Hazelton, Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Feb 26 *1922*

20. UNDERTAKER

ADDRESS

Mo.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **37353**

1. PLACE OF DEATH.....
County of Washington Registration District No.....
City of Cambridge Primary Registration District No.....
(No. St.)

Registered No.....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Phyllis Evelyn

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Unascertained
(Month) (Day) (Year)

7. AGE About 25 yrs IF LESS than 1 day how many hrs. or mins.
..... yrs. mos. ds.

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE Unascertained
(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. L. Allison
(Address) Cambridge, Ida.

15. Filed 3/15/22 191 22 R. W. Whitman
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 2 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3/2/22 191, to 3/2/22 191, that I last saw him alive on Mar 2 191, and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

Similarity
(Duration) yrs. mos. ds.
Contributory (Secondary)
(Signed) R. W. Whitman M. D.
19..... (Address) Cambridge, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Cambridge Ida DATE OF BURIAL Mar 3 19122
20. UNDERTAKER R. W. Whitman ADDRESS Cambridge

WITH UNFADING INK—THIS IS A PERMANENT RECORD. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICAL State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact state- OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **37354**

1. PLACE OF DEATH. Registration District No. _____
County of Washington Primary Registration District No. _____
City of Cambridge (No. _____ St.)

Registered No. _____
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph Ellis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH May 30 1896
(Month) (Day) (Year)

7. AGE 26 yrs. 9 mos. 2 ds. IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Saw Mill Man
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Kentucky

10. NAME OF FATHER Randolph Ellis

11. BIRTHPLACE OF FATHER
(State or Country) Kenn

12. MAIDEN NAME OF MOTHER Robinson

13. BIRTHPLACE OF MOTHER
(State or Country) Kenn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Lora Ellis
(Address) _____

15. 3/5/28 191. P. M. Whitman
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar 2 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
191. to 191.
that I last saw h. alive on 191.
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH follows:
Symptoms (Christian Science) No medical attention
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary) _____
(Duration) _____ mos. _____ ds.
(Signed) P. M. Whitman M. D.
19. (Address) Cambridge

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death. _____ yrs. _____ mos. _____ days. In the State. _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____
Former or usual residence. _____

19. PLACE OF BURIAL OR REMOVAL Cambridge Ida DATE OF BURIAL March 3 1922

20. UNDERTAKER Joe Anderson ADDRESS Cambridge

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

1. PLACE OF DEATH

County of Washington
City of Medvale

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED
CERTIFICATE OF DEATH.
Registration District No. 87
Primary Registration District No. 87
BUREAU OF
STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37355
Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

male white married
(Write the word.)

6. DATE OF BIRTH.

May 20 1922
(Month) (Day) (Year)

7. AGE

78 Yrs. 9 Mos. ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...

Farmer

9. BIRTHPLACE

(State or Country)

Mo

10. NAME OF FATHER

Samuel Sommers

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Lockett

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Ed Sommers

(Address)

Council Bluffs

15.

Filed 8-20 1922

F. J. Schmitt

Local Registrar

16. DATE OF DEATH

May 20 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 17 1922, to May 20 1922, that I last saw him alive on May 17 1922, and that death occurred on the date stated above, at 12:00 P. M.

The CAUSE OF DEATH* was as follows:

Spanish Influenza

(Duration) Yrs. mos. 5 ds.

Contributory (Secondary)

Smelly

(Duration) yrs. mos. ds.

(Signed) F. J. Schmitt M. D.

320 1922 (Address) Medvale

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Medvale

May 21 1922

20. UNDERTAKER

ADDRESS

C. R. B. Sommers Medvale

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED
APR 9 1922
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH.
Registration District No. 87
County of Washington
City of Medvale
(No.) (St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37356
Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Alexander Towell*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

male *white* *widowed*
(Write the word.)

6. DATE OF BIRTH.

April *30* *1835*
(Month) (Day) (Year)

7. AGE

86 Yrs. *10* Mos. *6* ds.

If LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...

Farmer

9. BIRTHPLACE

(State or Country)

Iand

10. NAME OF FATHER

Isaac Towell

11. BIRTHPLACE OF FATHER

(State or Country)

Va

12. MAIDEN NAME OF MOTHER

Page

13. BIRTHPLACE OF MOTHER

(State or Country)

Va

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Effie J Keithley
Medvale Idaho

15.

Filed

4-1 *1922* *F. A. Schumacher*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May *6* *1922*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to *191*,
that I last saw him alive on *191*

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Spanish Influenza

(Duration) Yrs. mos. *7* ds.

Contributory (Secondary)

smelly

(Duration) yrs. mos. ds.

(Signed)

F. A. Schumacher M. D.

19. (Address)

Medvale Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days In the State. yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Keckley Creek

May 8 1922

20. UNDERTAKER

ADDRESS

Chas B. Schumacher

Medvale

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 87
County of Washington Primary Registration District No. _____
City of Madras St. _____

File No. 37357
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

male white married (Write the word.)

6. DATE OF BIRTH.

Dec 6 1860
(Month) (Day) (Year)

7. AGE

61 Yrs. 2 Mos. 4 ds.

IF LESS than 1 day
how many hrs. or
..... min. >|

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

Farmer

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Simon Woods

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Eva M. Woods

(Address)

15.

Filed

4-1- 1922

1922

Falchmug

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

2 10 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 1 1921, to 2-10- 1922, that I last saw him alive on 2-10- 1922, and that death occurred on the date stated above, at 3 P. M. The CAUSE OF DEATH* was as follows:

Pneumonia Lobes

(Duration) Yrs. mos. 2 ds.

Contributory Chronic Bright's disease
(Secondary)

(Duration) yrs. 3 mos. ds.

(Signed) F. A. Schmitt M. D.

2-11-1922 (Address) Madras Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Madras

Feb 18 1922

20. UNDERTAKER

ADDRESS

F. R. P. Schmitt Madras

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **37358**

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Washington
City of MinneapolisRegistration District No. 87

Primary Registration District No. _____

City of _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Laura E B Burnett

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female whiteWidowed
(Write the word.)

6. DATE OF BIRTH.

any 23 1858
(Month) (Day) (Year)

7. AGE

6.3 Yrs. 4 Mos. 2.3 ds.IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....House Keeping
Farmer

9. BIRTHPLACE

(State or Country)

Indiana

10. NAME OF FATHER

Hickson Gray

11. BIRTHPLACE OF FATHER

(State or Country)

—

12. MAIDEN NAME OF MOTHER

Hicks

13. BIRTHPLACE OF MOTHER

(State or Country)

—

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

J H Burnett

15.

Filed

4-1- 1922Falschmidt

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

1 16 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from 1-16-1922, to 1-16-1922, that I last saw him alive on 1-16-1922 and that death occurred on the date stated above, at 12 A.M.

The CAUSE OF DEATH* was as follows:

Uremic Coma
Bright Disease(Duration) Yrs. mos. 30 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Falschmidt M. D.1-17-22 (Address) Minneapolis Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

MinneapolisJan 18 1922

20. UNDERTAKER

ADDRESS

L R F FalschmidtMinneapolis

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFAADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Washington
 City of Wenatchee

Registration District No. 86Primary Registration District No. 1010

(No. _____)

St.) _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Rebecca Gross

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 37359Registered No. 11

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widowed
(Write the word.)

6. DATE OF BIRTH

Feb111833

(Month)

(Day)

(Year)

7. AGE

89

Yrs. —

Mos. 3

ds.

IF LESS than 1 day

how many _____ hrs.

or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Penn.

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Lizzie Canary

(Address) _____

15.

Filed 2/211922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb. 14th

(Month)

(Day)

1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb. 1, 1922, to Feb. 14th 1922that I last saw him alive on Feb. 14 1922and that death occurred on the date stated above, at 12:50 P.M.

The CAUSE OF DEATH* was as follows:

Semile debility.(Duration) 1 Yrs. ✓ mos. ✓ ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

C. J. Gorman

M. D.

2/15 1922 (Address) Weiser Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hillcrest Cemetery2/16 1922

20. UNDERTAKER

ADDRESS

Northam McCannWeiser Ida

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **37360**Registered No. **12**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of **Washington**
City of **Weiser**Registration District No. **86**
Primary Registration District No. **2/12**
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William Cooper

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male **white** **Married**
(Write the word.)

6. DATE OF BIRTH

Aug **25** **1874**
(Month) (Day) (Year)

7. AGE

47 Yrs. **6** Mos. **1** ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)**Farmer**

9. BIRTHPLACE

(State or Country)

Neb.

10. NAME OF FATHER

John Cooper

11. BIRTHPLACE OF FATHER

(State or Country)

Neb.

12. MAIDEN NAME OF MOTHER

Cooper

13. BIRTHPLACE OF MOTHER

(State or Country)

Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

A. P. Carpenter
Weiser Ida

15.

Filed **3/3** **1922****J. P. Hamill**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb **25** **1922**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

..... 19....., to 19.....

that I last saw him..... alive on..... 19.....

and that death occurred on the date stated above, at **12 A.M.**

The CAUSE OF DEATH* was as follows:

ACCIDENTAL. Kicked by a horse and died before Medical aid was procured,

..... (Duration) Yrs..... mos..... ds.

Contributory
(Secondary)

..... (Duration) yrs..... mos..... ds.

(Signed)

Jas. V. McCann **Coroner****2/28 1922**(Address) **Weiser Ida,**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL
Manns Creek CemeteryDATE OF BURIAL
2/28 **1922**20. UNDERTAKER
Northam & McCannADDRESS
Weiser Ida,

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **37361**

Registered No. **13**

If death occurs in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Washington Registration District No. 86
City of Weiser Primary Registration District No. 1010
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Maddie Hiatt

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH

March 17 1918
(Month) (Day) (Year)

7. AGE

13 Yrs. 10 Mos. 29 ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

None

9. BIRTHPLACE

(State or Country)

Ida

10. NAME OF FATHER

Elvon C. Hiatt

11. BIRTHPLACE OF FATHER

(State or Country)

Iowa

12. MAIDEN NAME OF MOTHER

Martha Charlotte Jones

13. BIRTHPLACE OF MOTHER

(State or Country)

Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

E. C. Hiatt
Weiser, Ida.

15.

Filed 2/21 1922

W. P. Hamilton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

February 16 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 15th 1922, to Feb 16th 1922, that I last saw her alive on Feb 16th 1922, and that death occurred on the date stated above, at 2:30 A.M. The CAUSE OF DEATH* was as follows:

Uncertain
Probably poisoning
from canned corn
(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

E. C. Hiatt A. D. O.
2-1619-22 (Address) Weiser, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Payette, Idaho

DATE OF BURIAL

2/17 1922

20. UNDERTAKER

Northrup McCann

ADDRESS

Weiser, Ida

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Washington
 City of Wensen

Registration District No. 86
 Primary Registration District No. 1010
 (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jesse Sheridan Knight

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 37362
 Registered No. 15

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
 (Write the word.)

6. DATE OF BIRTH

March 7 1864
 (Month) (Day) (Year)

7. AGE

57 Yrs. 11 Mos. 28 ds.

IF LESS than 1 day
 how many _____ hrs.
 or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Building Contractor

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Mt. Vernon, Ind.

10. NAME OF FATHER

David Knight

11. BIRTHPLACE OF FATHER

(State or Country) England

12. MAIDEN NAME OF MOTHER

Mary Moore

13. BIRTHPLACE OF MOTHER

(State or Country) Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ray V. Lacey

(Address) Wensen, Idaho

15.

Filed 3/8 1922

H. P. Hamilton
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 4 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 4 1922 to Mar 4 1922

that I last saw him alive on Mar 4 1922
 and that death occurred on the date stated above, at 7:4 A.M.

The CAUSE OF DEATH* was as follows:

angina pectoris

(Duration) 3 Yrs. _____ mos. _____ ds.

Contributory
 (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W. H. Marshall M. D.

Mar 7 1922 (Address) Spencer

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Three Oaks Cemetery

DATE OF BURIAL

4/7 1922

20. UNDERTAKER

Northrup McLean

ADDRESS

Wensen Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **37365**
Registered No. **14**

1. PLACE OF DEATH

County of **Washington**
City of **Winn**

Registration District No. **86**
Primary Registration District No. **1010**
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Tomiko Matsuda

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **Mong** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Single**

6. DATE OF BIRTH

June 18 1919
(Month) (Day) (Year)

7. AGE

2 Yrs. **8** Mos. **16** ds.

If LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

Idaho

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

Katsumosuke Matsuda

11. BIRTHPLACE OF FATHER

(State or Country)

Japan

12. MAIDEN NAME OF MOTHER

Kyo Tatsuka

13. BIRTHPLACE OF MOTHER

(State or Country)

Japan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Katsumosuke Matsuda

(Address)

Winn, Ida

15.

Filed **3/8** 19**22**

H. R. Hamilton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 4 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **March 3rd 1922** to **March 4th 1922** that I last saw him alive on **March 4th 1922** and that death occurred on the date stated above, at **9:00** M. The CAUSE OF DEATH* was as follows:
Pneumonia (Acute)

(Duration) Yrs. mos. **3** ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) **H. R. Hamilton** M. D.

3/4 1922 (Address) **Winn, Ida**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Hillcrest Cemetery

DATE OF BURIAL

4/5 1922

20. UNDERTAKER

Wm Thayer McCann

ADDRESS

Winn, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact nature of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED CERTIFICATE OF DEATH

Count State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37364
Registered No. 16

1. PLACE OF DEATH

County of

City of

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Registration District No.

Primary Registration District No.

ST. (No.)

St.)

Registered No.

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many hrs.

or min. ?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF
FATHER11. BIRTHPLACE
OF FATHER

(State or Country)

12. MAIDEN NAME
OF MOTHER13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

to

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

1922 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **37365**
Registered No. **117**

1. PLACE OF DEATH, Registration District No. **86**
County of **Washington** Primary Registration District No. **1010**
City of **Wenatchee** (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Louise Payson Suet

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Widow**
(Write the word.)

6. DATE OF BIRTH

June 3 1876
(Month) (Day) (Year)

7. AGE

85 Yrs. **9** Mos. **1** da.

IF LESS than 1 day
how many _____ hrs.
or _____ min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Ill.

10. NAME OF FATHER

Constant Abbott

11. BIRTHPLACE OF FATHER

(State or Country)

Vermont

12. MAIDEN NAME OF MOTHER

Ruby Sallet

13. BIRTHPLACE OF MOTHER

(State or Country)

Vermont

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **W. M. Patton**
(Address) **Wenatchee Ida**

15.

Filed **3/9** 19**22**

W. P. Hamilton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

3-4-22 19**22**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **3-4-22** 19**22**, to **3-4-22** 19**22**.

that I last saw him alive on **3-4-22** 19**22**, and that death occurred on the date stated above, at **7:45 P.M.**

The CAUSE OF DEATH* was as follows:

**Rupture Aortic
Aneurysm**

(Duration) _____ Yrs. _____ mos. **1** ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) **C. G. Farant** M. D.

3/4/22 19**22** (Address) **Wenatchee Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hillcrest Cemetery

3/7 19**22**

20. UNDERTAKER

ADDRESS

Northam McCann

Wenatchee Ida

1. PLACE OF DEATH

County of WashingtonCity of Wheat

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No. 86Primary Registration District No. 1010

(No. St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37366Registered No. 18

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

June 29 1895
(Month) (Day) (Year)

7. AGE

26 Yrs. 8 Mos. 10 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).House wife

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

J. C. Thompson

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed 9/3 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 7 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Dec 16th 1921, to March 7th 1922 that I last saw him alive on March 7th 1922 and that death occurred on the date stated above, at 1 P. M.
The CAUSE OF DEATH* was as follows:Tuberc Pneumonia(Duration) Yrs. 2 mos. 13 ds.
Contributory (Secondary) Influenza(Duration) yrs. mos. 5 ds.
(Signed) M. R. Hummel M. D.1923. (Address) Wheat, Id.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Greely Colo. 3/10 1922

20. UNDERTAKER

ADDRESS

Northam & McCann Wheat, Id.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Washington
City of WenatcheeRegistration District No. 86Primary Registration District No. 1010No. 1010

St.)

File No. 37367Registered No. 19

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John David Olobaugh

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male W W W
(Write the word.)

6. DATE OF BIRTH

June 2 1844
(Month) (Day) (Year)

7. AGE

72 Yrs. 9 Mos. 2 ds.
IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Merchant

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Clyde Hixon

(Address)

Wenatchee, Ida

15.

Filed

8/15 1922J. R. Hamilton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 4 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 1914 to 3/4 1922
that I last saw him alive on 3/4 1922
and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus(Duration) 10 Yrs. mos. ds.Contributory
(Secondary)Myocarditis and
Nephritis (Duration) 1 yrs. mos. ds.

(Signed)

Ernest C. Finney M. D.
3/6 1922 (Address) Wenatchee, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wenatchee Cemetery 7/6 1922

20. UNDERTAKER

ADDRESS

Northrup McEwen Wenatchee

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.

Primary Registration District No.

File No. 37368

County of Idaho
City of Warren(No. Unity Mine Warren Ida) Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Kagler

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male White Single
(Write the word.)

6. DATE OF BIRTH

March 12 1885
(Month) (Day) (Year)

7. AGE

37 Yrs. 18 Mos. 18 ds.IF LESS than 1 day
how many.....hrs.
or.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Mine

(b) General nature of industry, business or establishment in which employed (or employer)

Bilaj Grooten
Austria

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

Wick Kagler

11. BIRTHPLACE OF FATHER

(State or Country)

Bilaj Grooten
Austria

12. MAIDEN NAME OF MOTHER

Katerina Mudrovich

13. BIRTHPLACE OF MOTHER

(State or Country)

Austria

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

John Rukavina
Boise Idaho

15.

Filed 44 19 44

Local Registrar

16. DATE OF DEATH

March 30 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I ^{saw} ~~attended~~ deceased ~~from~~ dead March 30 1922that I last saw him alive on March 30 1922,
and that death occurred on the date stated above, at 11:25 P.M.

The CAUSE OF DEATH* was as follows:

Accident in Unity Mine in
step falling of a rock killed
instantly no doctor in
attendance.
(Duration) Yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

John Alch Frieman
Warren Ida
19 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

Boise Ida

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Boise Idaho4/4 1922

20. UNDERTAKER

ADDRESS

Schreier & HidenfadenBoise

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH RECEIVED

County of Ada APR 5 1922 Registration District No. _____
City of Boise BUREAU OF VITAL STATISTICS 1411 No 16. Registration District No. _____ St.)File No. 37369Registered No. 71

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Caroline A. Doolittle

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married

6. DATE OF BIRTH.

May 18 1853
(Month) (Day) (Year)

7. AGE

68 Yrs. 9 Mos. 25 ds.IF LESS than 1 day
how many.....hrs. or
.....min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....at Home

9. BIRTHPLACE

(State or Country)

Illinois

10. NAME OF FATHER

Stephen Williams

11. BIRTHPLACE OF FATHER

(State or Country)

Penn.

12. MAIDEN NAME OF MOTHER

Elmira M. Cune

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

M. R. Doolittle

(Address)

1200 2nd

15.

Filed

191

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar. 15 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept. 29, 1921, to March 15, 1922.that I last saw him alive on March 15 1922.and that death occurred on the date stated above, at 6:15 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis(Duration) 12 Yrs. mos. ds.Contributory
(Secondary)Angina Pectoris

(Duration) yrs. mos. ds.

(Signed) Ernest E. Lamb D.3/16/1922 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Monticello Cem

DATE OF BURIAL

Mar 17 1922

20. UNDERTAKER

Summers & Scho.

ADDRESS

Boise Idaho

CERTIFICATE OF DEATH

BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada
City of BoiseRegistration District No. 2Primary Registration District No. 1004(No. 152615 Mo. 9 St.)File No. 37371Registered No. 114

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ruby G. Rowlinson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F.

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(write the word.)

6. DATE OF BIRTH.

June 15 1884.
(Month) (Day) (Year)

7. AGE

38 Yrs. 10 Mos. 12 ds.IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)at home

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Joseph O. Young

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Martha Hyde

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Oswell Rowlinson

(Address)

15.

Filed

4-281922R. H. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Apr 27 1922.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 9 1922, to April 27 1922.that I last saw him alive on April 27 1922.and that death occurred on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH was as follows:

Lobar Pneumonia

(Duration) Yrs. Mos. ds.

Contributory
(Secondary)Influenza

(Duration) Yrs. Mos. ds.

(Signed)

Dr. H. H. H. D.

(Address)

Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENCE CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs mos days In the State yrs mos days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Morris Hill Cem.

DATE OF BURIAL

Apr 30 1922

20. UNDERTAKER

Summers & Co.

ADDRESS

Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada
City of Bonne

Registration District No.

Primary Registration District No.

(No. 401 S 11st St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jesse Welch BlueFile No. 37375

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

M White Married
(Write the words)

6. DATE OF BIRTH

Nov. 6 1860
(Month) (Day) (Year)

7. AGE

61 Yrs. 5 Mos. 26 Ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Labourer

9. BIRTHPLACE

(State or Country)

Arkansas

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address) 401 S. 11th St. Boise, Ida

15.

Filed 5-4 19 22

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

5-2 19 22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

2-22 19 22, to 5-2 19 22that I last saw him alive on 5-2 19 22and that death occurred on the date stated above, at 10:20 M.

The CAUSE OF DEATH* was as follows:

Angina pectoris
few hours

(Duration) Yrs. mos. ds.

Contributory (Secondary) Chronic Myocarditis +
nephritis(Duration) 10 years mos. ds.(Signed) W. S. L. L. M. D.5-5 19 22 (Address) Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery May 8 1922

20. UNDERTAKER

ADDRESS

Summers & Kubs Boise, Idaho

CERTIFICATE OF DEATH

1. PLACE OF DEATH

Registration District No.

County of Ada

Primary Registration District No.

City of Boss(No. 617 N. 18 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

James B. SamuelState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 37374

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

M whiteSingle
(Write the word.)

6. DATE OF BIRTH

June 10 1835
(Month) (Day) (Year)

7. AGE

86 Yrs. 10 Mos. 24 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Farmer

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Estelle Seagull

(Address)

617 N. 18th St.

15.

Filed 5-5 1922P. H. R.
Local Registrar

16. DATE OF DEATH

May 22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 1st 1922 to May 4 1922
that I last saw him alive on May 4 1922
and that death occurred on the date stated above, at 4:30 PM

The CAUSE OF DEATH* was as follows:

Senility.

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. D. Springer M. D.
5-6-1922 (Address) Baile Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Marre's Burial May 6 1922

20. UNDERTAKER

ADDRESS

James H. Hays Baile Idaho

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Ada Registration District No. _____
 City of Boise Primary Registration District No. _____
 (No. 1222 E. Franklin St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

E. S. Mendell

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 37375
 Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
 (Write the word.)

6. DATE OF BIRTH

Oct 6 1871
 (Month) (Day) (Year)

7. AGE

50 Yrs. 6 Mos. 24 ds.

IF LESS than 1 day
 how many _____ hrs.
 or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

Letter

9. BIRTHPLACE

(State or Country)

New York

10. NAME OF FATHER

Not obtainable

11. BIRTHPLACE OF FATHER

(State or Country)

Not obtainable

12. MAIDEN NAME OF MOTHER

Not obtainable

13. BIRTHPLACE OF MOTHER

(State or Country)

Not obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs E. E. Wooden
 (Address) Boise, Idaho.

15.

Filed 5-5 19 22

O. H. R.
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 1st 19 22
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 9th 1922 to May 1st 1922
 that I last saw him alive on Apr 25th 1922
 and that death occurred on the date stated above, at 3:45 A.M.

The CAUSE OF DEATH* was as follows:

Hemiplegia

(Duration) Yrs. 10 mos. _____ ds.
 Contributory (Secondary) Complication of disease

(Duration) yrs. _____ mos. 23 ds.

(Signed) J. E. Froese M. D.

5-4-22 (Address) Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Williamstown, N.H. DATE OF BURIAL 5/5/22

20. UNDERTAKER Schmidt & Sons ADDRESS Boise

RECEIVED
MAY 8 1922
Jenny

FORM V. S. No. 1-65 M. 1-19.

BUREAU OF

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37376
Registered No.

1. PLACE OF DEATH

County of Ada
City of Boise

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Hattie E. Miller

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married

6. DATE OF BIRTH

July 22 1982
(Month) (Day) (Year)

7. AGE

64 Yrs. 9 Mos. 9 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

at home

9. BIRTHPLACE

(State or Country)

Illinois

10. NAME OF FATHER

Robert B. Little

11. BIRTHPLACE OF FATHER

(State or Country)

So. Carolina

12. MAIDEN NAME OF MOTHER

Emily Taylor

13. BIRTHPLACE OF MOTHER

(State or Country)

Tennessee

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

H. F. Miller
Boise, Idaho

15.

Filed 5 4 1922 P. H. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 1 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 22 to May 1 1922

that I last saw her alive on May 1 1922 and that death occurred on the date stated above, at 8:30 P.M.

The CAUSE OF DEATH was as follows:

Intestinal obstruction

(Duration) 3 Yrs. 3 mos. 3 ds.
Contributory (Secondary) Carcinoma of Colon

(Duration) 3 yrs. 3 mos. 3 ds.
(Signed) Dr. J. J. J. J. M. D.
Boise, Idaho (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 3 yrs. 3 mos. 3 days. In the State 3 yrs. 3 mos. 3 days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Morris Hill Cem.

DATE OF BURIAL

May 3 1922

20. UNDERTAKER

Swimmingpool Co.

ADDRESS

Boise, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

Registration District No.

Primary Registration District No.

(No.)

St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

19

Local Registrar

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Signed)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

1. PLACE OF DEATH **RECEIVED** MAY 8 1922
 County of Ada Registration District No. _____
 City of Boise **BUREAU** Primary Registration District No. _____
 (No. 1010 E. Washington St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Charles Warren Smith

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 37378
 Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
 (Write the word.)

6. DATE OF BIRTH

Nov 1st 1855
 (Month) (Day) (Year)

7. AGE

66 Yrs. 6 Mos. 6 ds.

IF LESS than 1 day
 how many _____ hrs.
 or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

Barber, retired

9. BIRTHPLACE

(State or Country)

Baltimore, Md.

10. NAME OF FATHER

Dont Know

11. BIRTHPLACE OF FATHER

(State or Country)

Dont Know

12. MAIDEN NAME OF MOTHER

Dont Know

13. BIRTHPLACE OF MOTHER

(State or Country)

Dont Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Harry W. Richards Jr.

(Address)

11010 East Washington

15.

Filed

5-1

1922

P. H. Pratt

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 30th 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 19 1922, to April 10 1922 that I last saw him alive on April 10 1922 and that death occurred on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration
Broken compensation

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Robert Taylor M.D.

5/1 1922 (Address) Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

Boise, Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St John's Cemetery

5/2 1922

20. UNDERTAKER

ADDRESS

Schreiber & Widengren

Boise, Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics1. PLACE OF DEATH
County of Ada
City of BoiseRegistration District No.
Primary Registration District No.
(No. 1520 1/2 Grave St St.)File No. 37379
Registered No.If death occurs away from
Usual residence, give facts
called for under special in-
formation.If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.2. FULL NAME John Montgomery

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Widower
(Write the word.)6. DATE OF BIRTH July 12 - 1834
(Month) (Day) (Year)7. AGE 87 Yrs. 9 Mos. 16 ds.
IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer).Rancher.

9. BIRTHPLACE

(State or Country)

Penn10. NAME OF
FATHERDon't Know11. BIRTHPLACE
OF FATHER

(State or Country)

Scotland12. MAIDEN NAME
OF MOTHERDon't Know13. BIRTHPLACE
OF MOTHER

(State or Country)

Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W McBratney(Address) Boise Idaho

15.

Filed 4-27 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April - 28 - 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
April 27 1922 to April 28 1922
that I last saw him alive on April 27 1922
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Uremic poisoning(Duration) Chronic Interstitial
Yrs. mos. ds.Contributory
(Secondary)(Duration) suppuration
Yrs. mos. ds.

(Signed)

4/29/22 (Address) Boise Idaho*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Council, Idaho

DATE OF BURIAL

5/1/22

20. UNDERTAKER

W McBratney

ADDRESS

Boise, Ida

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 37381

Registered No. 113

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

1. PLACE OF DEATH

County of Ada
City of Boise
Registration District No. 10
Primary Registration District No. 1504
St. ()If death occurs away from
usual residence, give facts
called for under special in-
formation.BUREAU OF VITAL
STATISTICS

2. FULL NAME

Anna A. Tomlinson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

F White Widowed (Write the word.)

6. DATE OF BIRTH May 17 - 1870

(Month) (Day) (Year)

7. AGE IF LESS than 1 day

101 Yrs. 11 Mos. 9 ds. how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

at Home

9. BIRTHPLACE

(State or Country)

Sweden

10. NAME OF
FATHER

Englehardt

11. BIRTHPLACE
OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME
OF MOTHER

Unknown

13. BIRTHPLACE
OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Anna A. Price

(Address)

15. Filed Apr 25 1922 R. L. Pratt

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 26 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
April 20 1922 to April 26 1922

that I last saw h. or alive on April 20 1922

and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. B. B. M. D.

4-26-22 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Meridian Idaho Apr 19

20. UNDERTAKER

ADDRESS

Summers & Schenck Boise Idaho

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH *Adelphi*
 County of *Ada*
 City of *Bonanza*
 Registration District No. *11 St.*
 Primary Registration District No. *432*
 (No. *432* St.)

File No. *37382*
 Registered No. *103*

If death occurs away from
 usual residence, give facts
 called for under special
 information.

2. FULL NAME

Lydia S. Wierman

If death occurred in a hos-
 pital, institution or camp,
 give its NAME instead of
 street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *F* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED. *Widow*

6. DATE OF BIRTH.

1886
 (Month) (Day) (Year)

7. AGE

36

Yrs. Mos. ds.

IF LESS than 1 day
 how many hrs. or
 min.?

8. OCCUPATION

(a) Trade, profession or
 particular kind of work.
 (b) General nature of in-
 dustry, business, or estab-
 lishment in which employ-
 ed (or employer).

Cook

9. BIRTHPLACE

(State or Country)

Canada

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

H. L. Tucker

(Address)

432 - 1 - 11th

15.

Filed

*Apr 14*191*22*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 12 191*22*
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
April 12 191*22*, to 191*22*,
 that I last saw h..... alive on 191*22*,
 and that death occurred on the date stated above, at *8 P.* M.

The CAUSE OF DEATH* was as follows:

Bright's disease

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Clayde E. Summers

4/14 191*22* Address *Bonanza, Idaho*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
 MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted
 if not at place of death?.....

Former or
 usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Worreston's Cemetery *Apr 14* 191*22*

20. UNDERTAKER

ADDRESS

Summers & Krebs *Bonanza, Idaho*

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS
 should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement
 of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH
County of Ada Registration District No. _____
City of Bosse Primary Registration District No. _____
(No. 410 St.)

If death occurs away from usual residence, give facts called for under special information.

- 2. FULL NAME Eloy Larrondo

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37383
Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH Sept 4 1918
(Month) (Day) (Year)

7. AGE 3 Yrs. 7 Mos. 16 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. none
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE Guernsey La
(State or Country)

10. NAME OF FATHER Hilario Larrondo

11. BIRTHPLACE OF FATHER Spain
(State or Country)

12. MAIDEN NAME OF MOTHER Maria Gutierrez

13. BIRTHPLACE OF MOTHER Spain
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Hilario Larrondo
(Address) Guernsey La

15. Filed _____ 19 _____

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 20 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4/9 1922 to 4/20 1922
that I last saw him alive on 4/20 1922
and that death occurred on the date stated above, at 9 A.M.
The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration) Yrs. mos. ds.
Contributory (Secondary) Influenza

(Duration) Yrs. mos. ds.
(Signed) Frederick A. Kellogg M. D.
Apr 19 1922 (Address) Bosse

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death? Guernsey La
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Guernsey La DATE OF BURIAL 4/22 1922

20. UNDERTAKER Schubert Widener ADDRESS Bosse La

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 37384
Registered No. 187If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

1. PLACE OF DEATH.

County of Ada
City of South Boise

Registration District No.

Primary Registration District No.

(No. South Boise St.)If death occurs away from
usual residence, give facts
called for under special
information.

2. FULL NAME

Charles Lord

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.Married
(Write the word.)

6. DATE OF BIRTH.

Ths. 28 18836
(Month) (Day) (Year)

7. AGE

86 Yrs. 1 Mos. 21 ds.IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work...
(b) General nature of in-
dustry, business, or estab-
lishment in which employ-
ed (or employer).....Miner & Farmer

9. BIRTHPLACE

(State or Country)

England10. NAME OF
FATHERLord11. BIRTHPLACE
OF FATHER

(State or Country)

England12. MAIDEN NAME
OF MOTHERUnknown13. BIRTHPLACE
OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Thomas Lord

(Address)

Boise, Idaho P. M. U. S.

15.

Filed

4/181917

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 19 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 18 1922, to April 19 1922,that I last saw him alive on April 19 1922,and that death occurred on the date stated above, at 6 A M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Dr. H. W. Morris M. D.4/19/22 (Address) 204 1st Ave*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted
if not at place of death?.....Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Morris Hill Cemetery

DATE OF BURIAL

Apr 21 1922

20. UNDERTAKER

Summers & Tribe

ADDRESS

Boise, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS
should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement
of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. RECEIVED

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics1. PLACE OF DEATH
County of Ada
City of BoiseRegistration District No.
Primary Registration District No.
(No. 110 E Barnack St.)File No. 37385
Registered No. 109

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Hinton Wallace

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH.

May 27 1834
(Month) (Day) (Year)

7. AGE

87 Yrs. 10 Mos. 24 ds.IF LESS than 1 day
how many hrs. or
..... min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....Miner

9. BIRTHPLACE

(State or Country)

Mo

10. NAME OF FATHER

Joseph Wallace

11. BIRTHPLACE OF FATHER

(State or Country)

Tenn

12. MAIDEN NAME OF MOTHER

Mary Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Tenn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

A. E. Area
Boise Idaho

15.

Filed

4-22-1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 20 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from April 18th 1922 to Apr 20th 1922, that I last saw him alive on Apr 20th 1922, and that death occurred on the date stated above, at 6:20 PM.

The CAUSE OF DEATH* was as follows:

Hemorrhage of bladder following perineal cystotomy for urethral obstruction

(Duration) Yrs. mos. ds.

Contributory (Secondary)

Enlarged prostate

(Duration) yrs. mos. ds.

(Signed) L. M. Taylor M. D.# 22 1922. (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery Apr 23 1922
20. UNDERTAKER Summers & Krebs Boise Idaho
ADDRESS

RECEIVED
CERTIFICATE OF DEATH.State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada Registration District No. 2
City of Bosse Primary Registration District No. 1004
(No. 110 E Bannock St.)File No. 37386
Registered No. 110

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Claude J. Howers

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.M | White | Single
(Write the word.)

6. DATE OF BIRTH.

1894
(Month) (Day) (Year)

7. AGE

28 Yrs. Mos. ds.IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).
Inspector for Western Livestock Loan Co.

9. BIRTHPLACE

(State or Country)

Unknown

10. NAME OF FATHER

Henry Howers

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H. Chapman
(Address) 1620 Ada St

15.

Filed 4-22 1912

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Apr 20 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
Apr 11 1922, to Apr 19 1922,that I last saw him alive on Apr 19 1922
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolism

(Duration) Yrs. mos. ds.

Contributory (Secondary) Pneumonia

(Duration) Yrs. mos. ds.

(Signed) James H. Thompson M. D.Date May 19 (Address) Bosse, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Provo Utah DATE OF BURIAL Apr 22 1922

20. UNDERTAKER

Summers & Kops Boise Id ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

Registration District No.

Primary Registration District No.

(No.)

St.)

File No.

Registered No.

If death occurs away from
usual residence, give facts
called for under special
information.

2. FULL NAME

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

6. DATE OF BIRTH.

7. AGE

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work....
(b) General nature of in-
dustry, business, or estab-
lishment in which employ-
ed (or employer).....

9. BIRTHPLACE

(State or Country)

10. NAME OF
FATHER11. BIRTHPLACE
OF FATHER

(State or Country)

12. MAIDEN NAME
OF MOTHER13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15.

Filed

1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Signed)

1922 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted
if not at place of death?.....Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS
should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement
of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada Registration District No. _____
City of Boise Primary Registration District No. _____
(No. 4/10 State _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Juan ArmaicheaFile No. 37388Registered No. 115

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)6. DATE OF BIRTH Feb 3/20 1916
(Month) (Day) (Year)7. AGE 6 Yrs. 2 Mos. 15 ds.
IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work none
(b) General nature of industry, business or establishment in which employed (or employer) _____9. BIRTHPLACE Boise, Idaho
(State or Country)10. NAME OF FATHER Eustasio Armaichea11. BIRTHPLACE OF FATHER Spain
(State or Country)12. MAIDEN NAME OF MOTHER Guilberina Ysursa13. BIRTHPLACE OF MOTHER Spain
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. Armaichea
(Address) Boise, Idaho15. Filed 4.15 1922 R. H. Pratt
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

16. DATE OF DEATH

April 15 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 1922 to July 5 1922
that I last saw him alive on June 14 1922
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) E. Armaichea M. D.

_____ 19____ (Address) _____

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL St. Johns CemeteryDATE OF BURIAL 7/17 1922

20. UNDERTAKER

Schreiber & Videna

ADDRESS

Boise, Idahocollister

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.
County of Ada RECD MA 8 Primary Registration District No.
City of Boise (No. 917 Pueblo. St.)File No. 37389
Registered No. 112

If death occurs away from usual residence, give facts called for under special information.

BUREAU

2. FULL NAME

Mary E. Coolittle

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F. 4. COLOR OR RACE White. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widowed
(Write the word.)

6. DATE OF BIRTH.

June 4 1891
(Month) (Day) (Year)

7. AGE

90 Yrs. 11 Mos. 19 ds.IF LESS than 1 day
how many hrs. or
..... min. 2)

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....At Home

9. BIRTHPLACE

(State or Country) New York.

10. NAME OF FATHER

Jesse Wilcox

11. BIRTHPLACE OF FATHER

(State or Country) New York.

12. MAIDEN NAME OF MOTHER

Orrilla

13. BIRTHPLACE OF MOTHER

(State or Country) New York.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H. C. Coolittle

(Address)

15.

Filed 4-24 1912

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Apr 23 1912
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Mar 2nd 1912 to Apr 22nd 1912, that I last saw her alive on Apr 22 1912 and that death occurred on the date stated above, at 6:15 A. M.

The CAUSE OF DEATH* was as follows:

Old age with gradual giving away of all functions

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) R. S. Gregory M. D.19. (Address) 1107 W. 8th St Boise, Id.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Morris Hill Cem

DATE OF BURIAL

Apr 24 1912

20. UNDERTAKER

Summers & Sells

ADDRESS

Boise, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-11

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Ada
City of Boise

Registration District No.
Primary Registration District No.
(No. 1310 Ridenbaugh St.)

File No. 37390
Registered No. 111

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Louisa Eddy

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F. 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widow
(Write the word.)

6. DATE OF BIRTH.

May 1 1857
(Month) (Day) (Year)

7. AGE

64 Yrs. 11 Mos. 22 ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

At Home

9. BIRTHPLACE

(State or Country) Oregon

10. NAME OF FATHER

Eli Eddy, Officer

11. BIRTHPLACE OF FATHER

(State or Country) Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. F. Eddy

(Address) Rt # 1 Boise

15.

Filed 1-24 1912 R. H. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Apr 22 1912
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 17, 1912 to April 10, 1912, that I last saw him alive on 1912 and that death occurred on the date stated above, at 4:45 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar Rt. Side

(Duration) Yrs. mos. 8 ds.

Contributory Indisposition
(Secondary)

(Duration) 7 yrs. mos. ds.

(Signed) D. J. M. Daines M. D.

19 (Address) Boise, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Dry Creek Cemetery Apr 23 1912

20. UNDERTAKER

ADDRESS

Summers & Trib. Boise Ida

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Ada*City of *Boise*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No.

Primary Registration District No.

(No. *Boise City Nat. Bank Bldg.* St.)State of Idaho
BOARD OF HEALTH

Bureau of Vital Statistics

File No. *37391*Registered No. *109*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

July = 12 = 1871
(Month) (Day) (Year)

7. AGE

50 Yrs. *9* Mos. *5* ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).*Farmer*

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

Norman Carpenter

11. BIRTHPLACE OF FATHER

(State or Country)

Vermont

12. MAIDEN NAME OF MOTHER

Mary Parker

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. McBratney

(Address)

Boise, Idaho

15.

Filed *1922*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Apr. - 17 - 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar 10 1922 to Apr. 17 1922
that I last saw him alive on *16 1922*
and that death occurred on the date stated above, at *5 a. m.*

The CAUSE OF DEATH* was as follows:

chronic malaria, malarial circulatory infection

(Duration) Yrs. mos. ds.

Contributory (Secondary) *phlebitis, gastric and hepatic*

(Duration) Yrs. mos. ds.

(Signed) *H. L. Frazier* M. D.*4/17/22* (Address) *Boise Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Nampa - Idaho

DATE OF BURIAL

4/18 1922

20. UNDERTAKER

W. McBratney

ADDRESS

Boise Idaho

Track.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 37392
Registered No. 102

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED

CERTIFICATE OF DEATH.

1. PLACE OF DEATH.
County of Ada
City of Bosse
Registration District No.
Primary Registration District No.
(No. 110 E Bannock St.)

1. death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anna Bel Watkins

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH. July-19-1876
(Month) (Day) (Year)

7. AGE 45 Yrs. 8 Mos. 22 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION at Home
(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE Kansas
(State or Country)

10. NAME OF FATHER J. Ransom

11. BIRTHPLACE OF FATHER Kentucky
(State or Country)

12. MAIDEN NAME OF MOTHER Hann

13. BIRTHPLACE OF MOTHER Germany
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C. F. Watkins
(Address) Barber Idaho

15. Filed 7-13-1912
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 12 1912
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 17 1912 to April 12 1912, that I last saw her alive on April 12 1912 and that death occurred on the date stated above, at 2:30 P. M.

The CAUSE OF DEATH* was as follows:
Probable cerebral embolism

(Duration) Yrs. mos. ds.
Contributory (Secondary) Hypertension Mar 24, 1912
(Duration) Yrs. mos. ds.
(Signed) Robert F. Fall M. D.
4/12/1912 Address Bosse

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death. yrs. mos. days In the State. yrs. mos. days
Where was disease contracted if not at place of death?.....
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Morris Hill Cemetery DATE OF BURIAL April 12 1912
20. UNDERTAKER Summers & Traps ADDRESS Bosse Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED

CERTIFICATE OF DEATH.

Pettigrew

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 37393

Registered No. 101

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Ada
City of Bosse

Registration District No.

Primary Registration District No.

(No. 410 State St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Wilson Pittenger

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word)

6. DATE OF BIRTH.

April 21 1863
(Month) (Day) (Year)

7. AGE

58 Yrs. 11 Mos. 21 ds.IF LESS than 1 day
how many hrs. or
..... min. 2)

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)Farmer

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

John Pittenger

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Lunila Pickens

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

R. W. Pittenger
1411 Jefferson

15.

Filed

4-12-1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

4 12 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

4/7 1922 to 4/12 1922
that I last saw him alive on 4/11 1922and that death occurred on the date stated above, at 1 A M.

The CAUSE OF DEATH* was as follows:

Acute dilatation Stomach
(Post operative)

(Duration) Yrs. mos. ds.

Contributory (Secondary)

Operation Gall Bladder

(Duration) yrs. mos. ds.

(Signed)

Frank A. Pittenger D.42 1922 (Address) Bosse

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Manila Idaho

DATE OF BURIAL

Apr 14 1922

20. UNDERTAKER

Summers & Trep

ADDRESS

Bosse Ida

CERIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH **RECEIVED**
 County of **Ada** MAY 8
 City of **Bosse** (No. **503** **Grove** St.)
 Registration District No. _____
 Primary Registration District No. _____

File No. **37394**
 Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME **Emily Werth**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **F** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED. **Widow**
 (Write the word.)

6. DATE OF BIRTH. **1892**
 (Month) (Day) (Year)

7. AGE **70** IF LESS than 1 day
 Yrs. Mos. ds. how many hrs. or min. 2

8. OCCUPATION **at Home**
 (a) Trade, profession or particular kind of work...
 (b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE **Unknown**
 (State or Country)

10. NAME OF FATHER **Unknown**

11. BIRTHPLACE OF FATHER **Unknown**
 (State or Country)

12. MAIDEN NAME OF MOTHER **Unknown**

13. BIRTHPLACE OF MOTHER **Unknown**
 (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) **Chas. E. Summers**
 (Address) **Boise Idaho**

15. Filed **4** 1912
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **April 8 1922**
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I **saw** deceased from **April 8 1922** to **191**,
 that I last saw h. **alive on** **191**,
 and that death occurred on the date stated above, at **M.**

The CAUSE OF DEATH* was as follows:
Valvular Heart disease

(Duration) Yrs. mos. ds.
 Contributory (Secondary) **Influenza**

(Duration) yrs. mos. ds.
 (Signed) **Chas. E. Summers**
4/4 1922 (Address) **Boise Idaho**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **Morris Hill Cemetery** DATE OF BURIAL **Apr 11 1922**

20. UNDERTAKER **Summers & Krefe** ADDRESS **Boise Idaho**

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain language so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 37395

Registered No. 43

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

 1. PLACE OF DEATH. **RECEIVED**
 County of Ada Registration District No. _____
 City of Boise Primary Registration District No. _____
 (No. 1916 W. 15 St.) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Victoria Jane Francis

PERSONAL AND STATISTICAL PARTICULARS

 3. SEX F 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED. Married
 (Write the word.)

6. DATE OF BIRTH.

July 16, 1868
 (Month) (Day) (Year)

7. AGE

34 Yrs. 1 Mos. 15 ds.

 IF LESS than 1 day
 how many hrs. or
 min.?

8. OCCUPATION

 (a) Trade, profession or particular kind of work.
 (b) General nature of industry, business, or establishment in which employed (or employer).
At Home

9. BIRTHPLACE

(State or Country)

Penn.

10. NAME OF FATHER

William Prout

11. BIRTHPLACE OF FATHER

(State or Country)

Wales

12. MAIDEN NAME OF MOTHER

Rhoda Parfet

13. BIRTHPLACE OF MOTHER

(State or Country)

Danish Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Abbie W. Prout
Council Idaho

15.

Filed

4-3 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

4 1 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

3/22 1922 to 4/1 1922
 that I last saw her alive on 4/1 1922
 and that death occurred on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolism

(Duration) Yrs. mos. ds.

Contributory (Secondary) of Carcinoma Breast

(Duration) yrs. mos. ds.

4/1 (Signed) Frank A. Tuttle M. D.
1922 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Marrio Hill Cemetery Apr. 4, 1922

20. UNDERTAKER

ADDRESS

Summers & Kups Boise Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

County of Ada
City of Bosse

Registration District No.
Primary Registration District No.
(No. 110 E. Banquet St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

James Marion Grisham

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 37396

Registered No. 14

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH.

Sept 10, 1854
(Month) (Day) (Year)

7. AGE

67 Yrs. 6 Mos. 22 ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Janitor

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

Houston Grisham

11. BIRTHPLACE OF FATHER

(State or Country)

Illinois

12. MAIDEN NAME OF MOTHER

Rebecca Wheeler

13. BIRTHPLACE OF MOTHER

(State or Country)

Texas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

J. M. Grisham

(Address)

904 W. 27th Boise Idaho

15.

Filed

4-3

1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

4 2 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

3/31 1922 to 4/7 1922
that I last saw him alive on 4/1 1922
and that death occurred on the date stated above, at 1230 M.

The CAUSE OF DEATH* was as follows:

Uremia

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

Parotidectomy

(Duration) yrs. mos. ds.

(Signed) Frederick A. Pienk M. D.

4-2 1922 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery

April 7 1922

20. UNDERTAKER

ADDRESS

Summer & Sons Boise Id

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 37397

Registered No. 15

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Ada
City of Boise
Registration District No. 1415
St. Bannock St.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

George A Chapman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH

May 31 — 1841
(Month) (Day) (Year)

7. AGE

80 Yrs. 10 Mos. 5 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Deputy Sheriff

9. BIRTHPLACE

(State or Country)

Conn

10. NAME OF FATHER

Newton Chapman

11. BIRTHPLACE OF FATHER

(State or Country)

Conn

12. MAIDEN NAME OF MOTHER

Salome Sauchy

13. BIRTHPLACE OF MOTHER

(State or Country)

Conn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Wm C Bratney
Boise Idaho.

15.

Filed

47 1922

R H Pitt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Apr, 6 — 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 19 21 to Apr 6 1922

that I last saw him alive on Apr 6 1922

and that death occurred on the date stated above, at 2:30 P. M.

The CAUSE OF DEATH* was as follows:

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

H C Pitt (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Main Hill Cemetery

DATE OF BURIAL

4/9 1922

20. UNDERTAKER

Wm C Bratney

ADDRESS

Boise Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada
City of BoseRegistration District No. _____
Primary Registration District No. _____
(No. 110 E Barnett St.)File No. 37398
Registered No. 26

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Carolina Huffman

If death occurred in a hospital, institution or camp, give its name instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widow
(Write the word.)

6. DATE OF BIRTH.

June 15 1884
(Month) (Day) (Year)

7. AGE

77 Yrs. 9 Mos. 20 ds.IF LESS than 1 day
how many.....hrs. or
.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).At Home

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

Christian Blechl

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Elyabeth Kern

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Ernest D. Dickel

(Address) _____

15.

Filed 4-8 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 5 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 3 1922 to April 5 1922
that I last saw him alive on April 5 1922
and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Abscess of Liver

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed) W. B. Bunker M. D.4-6 1922 (Address) Bose, Ida

*State the DISEASE CAUSING DEATH; or in death from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery June 9 1922

20. UNDERTAKER

ADDRESS

Huffman & Krebs Bose, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1

RECEIVED

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH MAY 8 1922

Registration District No.

County of Ada

BUREAU OF

Primary Registration District No.

City of Boise

(No. 1815 State St.)

St.)

File No.

37399

Registered No. 97

If death occurs away from
usual residence, give facts
called for under special
information.

2. FULL NAME

Laura May Le Clair Piper

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

F.

4. COLOR OR RACE

White.

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.married
(Write the word.)

6. DATE OF BIRTH

Sep 13

(Month)

(Day)

1898
(Year)

7. AGE

22 Yrs. 6 Mos. 33 ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work...
(b) General nature of in-
dustry, business, or estab-
lishment in which employ-
ed (or employer).....

At Home.

9. BIRTHPLACE

(State or Country)

Iowa.

10. NAME OF
FATHER

Joseph Le Clair

11. BIRTHPLACE
OF FATHER

(State or Country)

France.

12. MAIDEN NAME
OF MOTHER

Elizabeth Musser.

13. BIRTHPLACE
OF MOTHER

(State or Country)

Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

R. H. Pratt

(Address)

15.

Filed

48

1922

R. H. Pratt
Local Registrar

16. DATE OF DEATH

Apr 5 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Apr. 3 1922 to Apr. 5 1922
that I last saw her alive on Apr. 4 1922
and that death occurred on the date stated above, at 3:30 AM.

The CAUSE OF DEATH* was as follows:

Apoplexy;
subarachnoid hemorrhage

(Duration) Yrs. mos. ds.

Contributory (Secondary) General Tubercular
Asthma (Kyphosis)

(Duration) Yrs. mos. ds.

(Signed) C. L. Dutton M. D.

Address: Meridian, Idaho

*State the DISEASE CAUSING DEATH; or in death from VIOLENT CAUSES, state (1)
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cem.

Apr 7 1922

20. UNDERTAKER

ADDRESS

Summers & Co.

Boise, Idaho.

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 37400
Registered No. 12

1. PLACE OF DEATH.

County of Ada
City of Boise
Registration District No. 1
Primary Registration District No. St. Alphonsus Hospital
(No. St. Alphonsus Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant Jones.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F. 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single

6. DATE OF BIRTH.

Aug 8 1922
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

None

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Thomas D. Jones.

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Lillie M. Jones.

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

J. D. Jones

(Address)

Boise Idaho

15.

Filed

7-12

1922

R. A. Carr

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Apr 8 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Apr 8 1922, to Apr 8 1922,

that I last saw him alive on Apr 8 1922,

and that death occurred on the date stated above, at 11 A. M.

The CAUSE OF DEATH* was as follows:

Monstrosity

(Duration) Yrs. mos. ds.

Contributory (Secondary)

Underdevelopment

(Duration) Yrs. mos. ds.

(Signed)

Fred M. D.

4/10 1922 (Address)

Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cem

Apr 9 1922

20. UNDERTAKER

ADDRESS

Sumner & Webb

Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. _____		RECEIVED _____		PLACE OF DEATH		State of _____	
1. PLACE OF DEATH		Registration District _____		County of <u>Ada</u>		Primary Registration District No. _____	
City of <u>Boise</u>		(No. <u>St. Alphonsus Hospital</u>)		File No. <u>37401</u>		Registered No. <u>99</u>	
If death occurs away from usual residence, give facts called for under special information.				If death occurred in a hospital, institution or camp, give its NAME instead of street and number.			
2. FULL NAME <u>James M. Glenn</u>							
PERSONAL AND STATISTICAL PARTICULARS				MEDICAL CERTIFICATE OF DEATH			
3. SEX <u>M.</u>		4. COLOR OR RACE <u>White</u>		5. SINGLE, MARRIED, WIDOWED OR DIVORCED. <u>Married</u> (Write the word.)			
6. DATE OF BIRTH. <u>Feb 1</u> 18 <u>89</u> (Month) (Day) (Year)				16. DATE OF DEATH <u>Apr 10</u> 19 <u>22</u> (Month) (Day) (Year)			
7. AGE <u>63</u> Yrs. <u>2</u> Mos. <u>9</u> ds.		IF LESS than 1 day how many hrs. or min.?		17. I HEREBY CERTIFY, That I attended deceased from <u>Apr 9</u> 19 <u>22</u> to <u>Apr 10</u> 19 <u>22</u> that I last saw him alive on <u>Apr 10</u> 19 <u>22</u> and that death occurred on the date stated above, at <u>2 P</u> M.			
8. OCCUPATION <u>Butcher</u>				The CAUSE OF DEATH* was as follows: <u>Perforating ulcer of stomach</u>			
9. BIRTHPLACE (State or Country) <u>Iowa</u>				(Duration) Yrs. mos. <u>2</u> ds.			
10. NAME OF FATHER <u>Charles Glenn</u>				Contributory (Secondary) <u>Gall stones, chronic appendicitis</u>			
11. BIRTHPLACE OF FATHER (State or Country) <u>Iowa</u>				(Duration) Yrs. mos. ds.			
12. MAIDEN NAME OF MOTHER <u>Rebecca Reebler</u>				(Signed) <u>M. H. Faldman</u> M. D.			
13. BIRTHPLACE OF MOTHER (State or Country) <u>Iowa</u>				7/10 1922 (Address) <u>Boise Idaho</u>			
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Chas J Glenn</u>				*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SURGICAL, or HOMICIDAL.			
(Address) _____				18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)			
15. Filed <u>4-11</u> 19 <u>22</u> <u>R. H. Rath</u> Local Registrar				At place of death yrs mos days In the State yrs mos days			
				Where was disease contracted if not at place of death? _____			
				Former or usual residence _____			
				19. PLACE OF BURIAL OR REMOVAL <u>Morris Street Cemetery</u>		DATE OF BURIAL 19 <u>22</u>	
				20. UNDERTAKER <u>Sumner & Sons</u>		ADDRESS <u>Boise Ida</u>	

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 37402
Registered No. 41

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Ada
City of Ther Base

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Hugh C Bates

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
Write the word.)

6. DATE OF BIRTH.

Mar 22 1857
(Month) (Day) (Year)

7. AGE

65 Yrs. 0 Mos. 23 ds.IF LESS than 1 day
how many.....hrs. or
.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).Farmer

9. BIRTHPLACE

(State or Country)

Indiana

10. NAME OF FATHER

Bates

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Geo. A. Bates

(Address)

Praini Idaho

15.

Filed

4-17 1912R. H. G.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 10 1912
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 1911 to Apr 10 1912that I last saw him alive on April 27 1912
and that death occurred on the date stated above, at 2 1/2 M.

The CAUSE OF DEATH* was as follows:

Central stenosis
myocarditis(Duration) 10 Yrs. 10 mos. 10 ds.Contributory (Secondary) Gall stones(Duration) 2 yrs. 10 mos. 10 ds.(Signed) W. H. Gallman M. D.117 1912 (Address) Basis, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Morris Hill Cemetery

DATE OF BURIAL

Apr-18 1912

20. UNDERTAKER

Summers & Tribe Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
MAY 8

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Ada
City of BoiseRegistration District No.
Primary Registration District No. Ada County Hospital
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John H. MarlinState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 37403Registered No. 70

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Don't know.
(Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

72 Yrs. — Mos. — ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Stage Driver

9. BIRTHPLACE

(State or Country)

Oregon

10. NAME OF FATHER

Henry Marlin

11. BIRTHPLACE OF FATHER

(State or Country)

Penn

12. MAIDEN NAME OF MOTHER

Emma Olney

13. BIRTHPLACE OF MOTHER

(State or Country)

Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

W. M. Bratney
Boise Idaho

15.

Filed 4-15 1922R. H. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Apr 15 - 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 1919, to Apr 15 1922
that I last saw him alive on Apr 14 1922
and that death occurred on the date stated above, at 11:30 AM.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage(Duration) Yrs. mos. 18 mos.
Contributory (Secondary) Respiratory Paralysis(Duration) yrs. mos. 1 hr. ds.(Signed) T. M. Bratney M. D.4/15/22 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

County Cemetery

DATE OF BURIAL

4/17 1922

20. UNDERTAKER

W. M. Bratney

ADDRESS

Boise Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada Registration District No. _____
City of Boise Primary Registration District No. Ada County Hospital (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Joseph RolendsFile No. 37404

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Don't know
(Write the word.)

6. DATE OF BIRTH

(Month) _____ (Day) _____ (Year) 1

7. AGE

83 Yrs. _____ Mos. _____ ds. IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)None

9. BIRTHPLACE

(State or Country)

Austria

10. NAME OF FATHER

Don't know

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

W. M. Bratney
Boise Idaho

15.

Filed 7.1.22 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 13 - 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 1919 to Apr 13 1922
that I last saw him alive on Apr 11 1922
and that death occurred on the date stated above, at 7:30 AM.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis(Duration) 3 Yrs. 4 mos. ds.

Contributory (Secondary)

Pulmonary Edema(Duration) _____ yrs. _____ mos. 2 ds.

(Signed)

T. J. Bratney M. D.4/13/22 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF REMOVAL

DATE OF BURIAL

County Cemetery 4/14/22

20. UNDERTAKER

ADDRESS

W. M. Bratney Boise Idaho

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics1. PLACE OF DEATH. *Boise*

Registration District No.

County of *Boise*

Primary Registration District No.

City of *Boise*(No. *On Boise River* St.)File No. *37405*

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Charles H Booth

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH.

Feb-9-1886
(Month) (Day) (Year)

7. AGE

36 Yrs. *1* Mos. *1* ds.IF LESS than 1 day
how many hrs. or
..... min. 2)

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)*Miner*

9. BIRTHPLACE

(State or Country)

Wyoming

10. NAME OF FATHER

Thomas Booth

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Ella Gaddis

13. BIRTHPLACE OF MOTHER

(State or Country)

Id.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Thomas Booth

(Address)

Boise Idaho

15.

Filed *4-12* 1912

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Probably first part of April, 1922
Anderson
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 12, 1922 to *191*that I last saw him alive on *191*and that death occurred on the date stated above, at *M.*

The CAUSE OF DEATH* was as follows:

Killed in snow slide
No doctor or coroner was at place of accident
Contributory (Secondary)

(Duration yrs. mos. ds.)

(Signed) *Chas. E. Summers* *Coroner**4/12/1922* (Address) *Boise Idaho*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Morris Hiebeling**Apr 12 1922*

20. UNDERTAKER

ADDRESS

Summers & Tib Boise Id.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Boise
City of Boise

Registration District No.

Primary Registration District No.

(No. On Boise River St.)File No. 37406Registered No. 27

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Carrie Jenkins Booth

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH.

1903
(Month) (Day) (Year)

7. AGE

19 Yrs. Mos. ds.IF LESS than 1 day
how many hrs. or
.... min.?)

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....at Home

9. BIRTHPLACE

(State or Country)

Texas

10. NAME OF FATHER

Travis Jenkins

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Thomas Booth
Boise Idaho

15.

Filed

4-131922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Probably first part of April 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from April 12 1922, to 191,
that I last saw him alive on 191,
and that death occurred on the date stated above, at 191 M.

The CAUSE OF DEATH* was as follows:

Fell in snow slide.No doctor or coroner of Boise County was at the scene.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Clyde E. Summers4-12-22 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death....yrs....mos....days In the State....yrs....mos....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Married Hill CemeteryApr 13 1922

20. UNDERTAKER

ADDRESS

Summers & Sons Boise Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

 1. PLACE OF DEATH. *Idaho*
 Registration District No.
 County of *Ada* Primary Registration District No.
 City of *Boise* (No. *5 Miles S. W. of Boise* St.)

 File No. *37407*
 Registered No. *12*

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME *Loren C. Lane*

PERSONAL AND STATISTICAL PARTICULARS

 3. SEX *M* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. *married*
 (Write the word.)

 6. DATE OF BIRTH. *June 26 1851*
 (Month) (Day) (Year)

 7. AGE *70 9 21* IF LESS than 1 day how many... hrs. or min. *21*

8. OCCUPATION

 (a) Trade, profession or particular kind of work...
 (b) General nature of industry, business, or establishment in which employed (or employer)
Farmer
 9. BIRTHPLACE
 (State or Country)
Ohio

10. NAME OF FATHER

Lane
 11. BIRTHPLACE OF FATHER
 (State or Country)
Unknown

12. MAIDEN NAME OF MOTHER

Ellen Webster
 13. BIRTHPLACE OF MOTHER
 (State or Country)
Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

L. C. Lane

(Address)

P.R. #4 Boise Idaho

15.

Filed

*4 19 1922**1922**1922*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 17 1922
 (Month) (Day) (Year)

 17. I HEREBY CERTIFY, That I attended deceased from *April 17 1922* to *April 17 1922*

 that I last saw him alive on *April 17 1922* and that death occurred on the date stated above, at *3 P* M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) *Chas E. Summers*(Address) *Boise Idaho*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death... yrs... mos... days In the State... yrs... mos... days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Marion Hill Cemetery

DATE OF BURIAL

Apr 19 1922

20. UNDERTAKER

Summers & Thoms

ADDRESS

Boise Idaho

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED

MAY 8 1922

CERTIFICATE OF DEATH

Colleen

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 37408

Registered No. 522

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Ada
City of Near Boise
Registration District No. 3
Primary Registration District No. 3
(No. 3 Miles NW of Boise St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Eliza A. Hopson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widow

(Write the word.)

6. DATE OF BIRTH

Sept 6 1840
(Month) (Day) (Year)

7. AGE

81 Yrs. 6 Mos. 29 ds.

IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

At Home

9. BIRTHPLACE

(State or Country)

Virginia

10. NAME OF FATHER

Christian Paynter

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

L. M. Hobson

(Address)

Boise Idaho R. F. D. 3

15.

Filed

1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 5 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 21 1912 to April 5 1922

that I last saw her alive on April 5 1922

and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

4/6 1922 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Dry Creek Cemetery

DATE OF BURIAL

Apr 7 1922

20. UNDERTAKER

Burrumore & Thibbs

ADDRESS

Boise Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 124
County of Ada MAY 6 1922
Primary Registration District No. 2202
City of BUREAU OF VITAL ST. 4 miles N.W. of Tropic

File No. 37410
Registered No. 43

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Christine Nagel

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

married
(write the word.)

6. DATE OF BIRTH

July 3 1867
(Month) (Day) (Year)

7. AGE

55 Yrs. 2 Mos. 23 ds.

IF LESS than 1 day
how many hrs. or
min.

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...

At Home

9. BIRTHPLACE

(State or Country)

Sweden

10. NAME OF FATHER

Sven. Niel

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME OF MOTHER

Anderson

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Fred F. Nagel

(Address)

Meridian 3.

15.

Filed

5-4

1922

W. E. Summers

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 26 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased

April 26 1922 to 191

that I last saw her alive on 191

and that death occurred on the date stated above, at 11 A. M.

The CAUSE OF DEATH* was as follows:

Suicide. Jumped in
Cistern and was drowned

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) E. E. Summers

4/28/22 (Address) Boise Id

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

New Idaho Apr. 28 1922

20. UNDERTAKER

ADDRESS

Summers & Co Boise Id

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
MAY 1 1922
BUREAU OF VITAL STATISTICS
District No. 9410
Registration District No. 10
City of Star (No. Village of Star St.)

2. FULL NAME John Buckmaster

37412 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6
Registered No. 11
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widowed (Write the word.)

6. DATE OF BIRTH Jan. 14, 1833 (Month) (Day) (Year)

7. AGE 89 Yrs. 3 Mos. 11 ds. (IF LESS than 1 day how many hrs. or min.?)

8. OCCUPATION Farmer

9. BIRTHPLACE Ohio (State or Country)

10. NAME OF FATHER Richard Buckmaster

11. BIRTHPLACE OF FATHER Ohio (State or Country)

12. MAIDEN NAME OF MOTHER Eliza Madox

13. BIRTHPLACE OF MOTHER Ohio (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Wm. McBratney (Address) Boise Idaho.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 25, 1922 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10:00 AM to 10:30 AM 1922 that I last saw him alive on April 20, 1922, and that death occurred on the date stated above, at 4:30 P. M. The CAUSE OF DEATH* was as follows: Senility.

(Duration) 10 yrs. mos. ds. (Contributory) Accidental fracture (Secondary) Ribs (Duration) 1 yr. mos. 7 ds. (Signed) W. McBratney M. D. 4/25/22 (Address) Star, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Star Cemetery DATE OF BURIAL 4/26 1922

20. UNDERTAKER Wm. McBratney ADDRESS Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B. - Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A-25 M. 1-19. Father's name amended 3-7-85 fc
CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **37413**
Registered No. **6**

1. PLACE OF DEATH

County of **Ada** District No. **11**
City of **Murdan** Registration District No. **11**
STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jennie C Tucker

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Married**
(Write the word.)

6. DATE OF BIRTH

July - 11 - 1862
(Month) (Day) (Year)

7. AGE

60 Yrs. **29** Mos. **29** ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country) **Missouri**

10. NAME OF FATHER

Julian B Gibbons

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country) **Levy, Petit**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. F. Tucker

(Address)

Murdan Idaho

Filed **Mar. 13** 19**22**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar. 11 - 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 1921 to **March 8 1922**
that I last saw her alive on **March 8 1922**
and that death occurred on the date stated above, at **5 P.M.**

The CAUSE OF DEATH* was as follows:

mitral stenosis

(Duration) **15** Yrs. **15** mos. **15** ds.

Contributory (Secondary)

Influenza

(Duration) **2** yrs. **2** mos. **2** ds.

(Signed) **W. H. Sullivan** M. D.

Boise
(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death **15** yrs. **15** mos. **15** days. In the State **15** yrs. **15** mos. **15** days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Murdan Cemetery

DATE OF BURIAL

Mar. 13 1922

20. UNDERTAKER

W. B. Mather, Murdan

ADDRESS

IDAHO DEPARTMENT OF HEALTH AND WELFARE
Bureau of Vital Statistics, Standards, and Local Health Services
AFFIDAVIT TO CORRECT OR AMEND AN ORIGINAL CERTIFICATE

State of _____ }
County of _____ } ss.

Certificate No. 37413
Date Filed _____

The undersigned does solemnly swear that certain facts on the certificate of death

for Jennie Tucker who died on Mar 8 1922
(Name on Original Certificate) (Was Born, Died, etc.) (Date of Event)
in Meridian are erroneous or were omitted:
(Place of Event)

ITEMS TO BE CORRECTED	FROM	TO
<u>Name of father</u>	<u>Givens</u>	<u>Gibbons</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Subscribed and sworn to before me this 7th day of
March, 1925.

Notary Public, Florence Curtright
Residing at Borah
My commission expires 4-20-26
(Seal)

La Verne A. Brown
Signature of Applicant
Permit A. Harkness
Street Address, City, State

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of _____ }
County of _____ } ss.

(Must be completed ___)
(Is not necessary ___)

The undersigned does solemnly swear that he has knowledge of the facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this _____ day of
_____, 19____.

Notary Public, _____
Residing at _____
My commission expires _____
(Seal)

Supporting Signature

Street Address, City, State

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. _____
County of Ada Primary Registration District No. 11
City of Meridian (No. _____ St.)File No. 37414Registered No. 5If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Ellen Marie FitzgeraldIf death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH

Feb. 12 1922
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many 6 hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work X
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer) _____

9. BIRTHPLACE

(State or Country) Meridian Idaho10. NAME OF
FATHERWilmer C. Fitzgerald11. BIRTHPLACE
OF FATHER(State or Country) Nebraska12. MAIDEN NAME
OF MOTHERBerulah Crystal Froeseback13. BIRTHPLACE
OF MOTHER(State or Country) Wash

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mc Fitzgerald
(Address) Meridian Idaho15. 2/14 1922 H F Neal
Filed Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb. 12 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
Feb. 12 1922 to Feb. 12 1922that I last saw him alive on Feb. 12 1922
and that death occurred on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Premature birth

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

H F Neal M. D.2/14 1922 (Address) Meridian Idaho*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)At place of death yrs. mos. 2 In the State yrs. mos. daysWhere was disease contracted
if not at place of death? Fairfield IdahoFormer or usual residence Fairfield Idaho

19. PLACE OF BURIAL OR REMOVAL

Meridian cemetery

DATE OF BURIAL

Feb. 14 1922

20. UNDERTAKER

None

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 37415
Registered No. 4

1. PLACE OF DEATH

County of Ada
City of Meridian

Registration District No. _____

Primary Registration District No. 11

(No. _____) (St. _____)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary M. Graham

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(write the word)

6. DATE OF BIRTH

Oct. 5 1917
(Month) (Day) (Year)

7. AGE

4 Yrs. 3 Mos. 27 ds.
IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. none.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Fairfield Idaho

10. NAME OF FATHER

C. E. Graham

11. BIRTHPLACE OF FATHER

(State or Country)

Kansas

12. MAIDEN NAME OF MOTHER

Anna Britthart

13. BIRTHPLACE OF MOTHER

(State or Country)

Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

C. E. Graham
(Address) Fairfield Idaho

15. Filed

Feb. 3 1922 H. F. Neal

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb. 2 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 1 1922 to Feb. 2 1922

that I last saw her alive on Feb. 2 1922
and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Cardiac Paralysis

(Duration) Yrs. mos. ds.
Contributory (Secondary) diphtheria probably(Duration) Yrs. mos. ds.
(Signed) H. F. Neal M. D.

Feb. 2 1922 (Address) Meridian

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. days

Where was disease contracted if not at place of death? Fairfield Idaho

Former or usual residence Fairfield Idaho

19. PLACE OF BURIAL OR REMOVAL Meridian

DATE OF BURIAL Feb. 4 1922

20. UNDERTAKER

ADDRESS

W. S. Martin Meridian

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Ada
City of Meridian

Registration District No.

Primary Registration District No. 11

(No.) (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jess M ParkerState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 37416

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male White Married
(Write the word.)

6. DATE OF BIRTH

Jan 11 1860
(Month) (Day) (Year)

7. AGE

62 Yrs. 2 Mos. ds.IF LESS than 1 day
how many hrs.
or min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Indiana

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country) Indiana

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country) Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Bessie A. Carson
Baker City Oregon15. Filed Mar 13 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 11 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar 6, 1922 to Mar 11, 1922that I last saw him alive on Mar 11, 1922

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Robert pneumonia(Duration) Yrs. mos. 2 ds.

Contributory (Secondary)

(Duration) Yrs. mos. 4 ds.(Signed) H. F. Neal M. D.3-12-1922 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris HillMar 13, 1922

20. UNDERTAKER

ADDRESS

W. J. Mateer

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37417
Registered No. 4

1. PLACE OF DEATH

County of Ada Registration District No. _____
City of Meridian Primary Registration District No. 11
(No. _____) (St.) _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Wilbur F. Tucker

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED widower
(Write the word.)

6. DATE OF BIRTH

Aug 8 1848
(Month) (Day) (Year)

7. AGE

73 Yrs. 7 Mos. 4 ds. IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Virginia

10. NAME OF FATHER

William P Tucker

11. BIRTHPLACE OF FATHER

(State or Country) Virginia

12. MAIDEN NAME OF MOTHER

Anna Rogers

13. BIRTHPLACE OF MOTHER

(State or Country) Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address) Meridian Idaho

15. Filed

Mar 17 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 15 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from called just before death 19 22
that I last saw him alive on Mar 15 19 22
and that death occurred on the date stated above, at 5 P. M.
The CAUSE OF DEATH* was as follows:
Robert pneumonia

(Duration) Yrs. _____ mos. _____ ds.
Contributory (Secondary) Fun

(Duration) yrs. _____ mos. _____ ds.
(Signed) H. F. Neal M. D.

Mar 16 1922 (Address) Meridian Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mar 17 19 22

20. UNDERTAKER

ADDRESS

107 S. 1st St. Meridian Idaho

CERTIFICATE OF DEATH

1. PLACE OF DEATH

Ada, BURLEY
County of Meridian, IDAHO
City of Meridian, IDAHO

Registration District No.

Primary Registration District No.

(No. R. R. 1. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Edmund M. Clark

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 37418

Registered No. 9

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Male white

Married

6. DATE OF BIRTH

Jul. 18 1876
(Month) (Day) (Year)

7. AGE

46 Yrs. 28 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country) Missouri

10. NAME OF FATHER

Isaac P. Clark

11. BIRTHPLACE OF FATHER

(State or Country) Missouri

12. MAIDEN NAME OF MOTHER

Jennie Schaffer

13. BIRTHPLACE OF MOTHER

(State or Country) Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. E. M. Clark

(Address)

Meridian, Idaho R. 2

15.

Filed Mar 19 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 16 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

3-8 1922 to 3-16 1922

that I last saw him alive on 3-15-1922

and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(Duration) Yrs. mos. 8 ds.
Contributory (Secondary) Influenza

(Duration) yrs. mos. ds.

(Signed) J. F. May M. D.

19 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Adair

Mar 17 1922

20. UNDERTAKER

ADDRESS

W. B. Mather Meridian

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Ada
City of Meridian

Registration District No.

Primary Registration District No. 11

(No.)

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Elizabeth M. ForsythState of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37419Registered No. 10

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female WhiteMarried (Write full word.)

6. DATE OF BIRTH

Dec. 1 1845
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day
how many hrs.
or min.?77 Yrs. 3 Mos. 22 ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Housekeeper

9. BIRTHPLACE

(State or Country)

Scotland

10. NAME OF FATHER

James Galloway

11. BIRTHPLACE OF FATHER

(State or Country)

Scotland

12. MAIDEN NAME OF MOTHER

Elizabeth Swenson

13. BIRTHPLACE OF MOTHER

(State or Country)

Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

W. E. Fox
Meridian, Idaho

15.

Filed

March 23 1922J. H. Neal

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 22 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 1921, to Mar. 22 1922that I last saw her alive on Mar 21 1922and that death occurred on the date stated above, at 9 A M.

The CAUSE OF DEATH* was as follows:

Cardiac failure(Duration) Yrs. mos. 2 ds.
Contributory (Secondary) Cerebral hemorrhage - Myocarditis(Duration) yrs. mos. 27 ds.(Signed) J. R. Lumbert M. D.May 23 1922 (Address) Meridian, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Meridian, Ida Mar 23 1922

20. UNDERTAKER

ADDRESS

W. E. Fox Meridian, Ida

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37420
Registered No. _____

1. PLACE OF DEATH

County of Adams
City of Council

Registration District No. _____
Primary Registration District No. _____
(No. _____ St.)

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Thomas Harvey McCumsey

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Single

(Write the word.)

6. DATE OF BIRTH

June 10 1850
(Month) (Day) (Year)

7. AGE

71 Yrs. 8 Mos. 3 ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer).

Farmer

9. BIRTHPLACE

(State or Country) Iowa

10. NAME OF
FATHER

William McCumsey

11. BIRTHPLACE
OF FATHER

(State or Country)

12. MAIDEN NAME
OF MOTHER

Emmanta Kingie

13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Mar 31 1922 W M Brown

Local Registrar

16. DATE OF DEATH

Feb 12 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 1922 to Feb 8 1922
that I last saw him alive on Feb 8 1922
and that death occurred on the date stated above, at 10 AM.

The CAUSE OF DEATH was as follows:

Bright's Disease

(Duration) 2 Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) W. M. Brown M. D.

Feb 1922 (Address) Council, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Adams

DATE OF BURIAL

19

20. UNDERTAKER

E W Fisher

ADDRESS

Council

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 37421

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. _____
County of Adams Primary Registration District No. _____
City of Fruitvale (Nt. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Grace Marie Hamill

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female White

Married
(Write the word.)

6. DATE OF BIRTH.

June 19 1896
(Month) (Day) (Year)

7. AGE

25 Yrs. 8 Mos. 10 ds.

IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country)

Galax Carol Co Va

10. NAME OF FATHER

James W Stamey

11. BIRTHPLACE OF FATHER

(State or Country)

N. C.

12. MAIDEN NAME OF MOTHER

Ada May Brannock

13. BIRTHPLACE OF MOTHER

(State or Country)

Va

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

G. J. Hamill

(Address)

Fruitvale Idaho

Filed March 31 1922

Local Registrar

16. DATE OF DEATH

March 1 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1917 to Aug 1921.

that I last saw her alive on Sept- 1921 and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed)

M. D.

Mar 1922 (Address) Council

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cemetary March 3 1922

20. ADDRESS

Council

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Adams Registration District No. 1
City of Council Primary Registration District No. 1
(No. 1 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Emmett May Thorpe

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 37422

Registered No. 1845

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-OWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH

(Month) 1 (Day) 1 (Year) 1922

7. AGE

5-9 Yrs. 0 Mos. 0 ds.

IF LESS than 1 day
how many 0 hrs.
or 0 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

housewife

9. BIRTHPLACE

(State or Country)

Oregon

10. NAME OF FATHER

Thomas M. May

11. BIRTHPLACE OF FATHER

(State or Country)

Pennsylvania

12. MAIDEN NAME OF MOTHER

Martha Dodson

13. BIRTHPLACE OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. E. Thorpe

(Address)

Council Bluffs

15.

March 31 1922

W. M. Brown

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

January 18 11 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Or 1922 to Jan 17 1922
that I last saw her alive on Jan 17 1922
and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Peptic Ulcer - Hemorrhage

(Duration) 0 Yrs. 0 mos. 0 ds.

Contributory
(Secondary)

(Duration) 0 yrs. 0 mos. 0 ds.

(Signed) H. M. Brown M. D.

Jan 19 1922 (Address) Council

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 0 yrs. 0 mos. 0 days. In the State 0 yrs. 0 mos. 0 days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Council Bluffs Idaho Jan 27 1922

DATE OF BURIAL

20. UNDERTAKER

Northman McCann Weiser, Idaho

ADDRESS

CERTIFICATE OF DEATH

37423

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No.)

(St.)

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY That I attended deceased from

that I last saw her alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Signed)

1922 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

37424

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Bannock*City of *Pocatello*Registration District No. *28*Primary Registration District No. *141*(No. *St.*)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Estella Matthews*File No. *H 8*Registered No. *3778*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

May 1895
(Month) (Day) (Year)

7. AGE

26 Yrs. *10* Mos. *ds.*IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

3/2 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 27th 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *Feb 22 1922* to *Feb 27 1922*that I last saw her alive on *Feb 27 1922* and that death occurred on the date stated above, at *8 AM*.

The CAUSE OF DEATH* was as follows:

General peritonitis from ruptured spleen(Duration) Yrs. mos. *10* ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) *W. L. Young* M. D.*Feb 27 1922* (Address) *Pocatello Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

New Cemetery 3/3 1922

20. UNDERTAKER

ADDRESS

H. H. Walker Pocatello

CERTIFICATE OF DEATH

37425
28
2161
State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
48
File No.
Registered No. 3779

1. PLACE OF DEATH

County of Bannock
City of Pocatello

Registration District No. _____
Primary Registration District No. _____
(No. 245 - No South St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William Heston Wardle

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Child
(Write the word.)

6. DATE OF BIRTH November 15 1922
(Month) (Day) (Year)

7. AGE 2 Yrs. 3 Mos. 14 ds. IF LESS than 1 day
how many _____ hrs.
or _____ min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Child

9. BIRTHPLACE

(State or Country) Pocatello Idaho

10. NAME OF FATHER

J. Melford Wardle

11. BIRTHPLACE OF FATHER

(State or Country) Utah

12. MAIDEN NAME OF MOTHER

Mahisa Shaw

13. BIRTHPLACE OF MOTHER

(State or Country) Lee Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. H. Wardle

(Address) Pocatello

15. Filed 3/2 1922

W. H. Wardle
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 1 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 21 1922 to March 1 1922
that I last saw him alive on 2-28 1922
and that death occurred on the date stated above, at 12:20 AM.

The CAUSE OF DEATH* was as follows:

Bronchial pneumonia

(Duration) Yrs. mos. 7 ds.
Contributory (Secondary) La Grippe

(Duration) Yrs. mos. 3 ds.
(Signed) D. C. Ray M. D.

3-2 1922 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Mountain View Bur

DATE OF BURIAL

Mar 3 1922

20. UNDERTAKER

Schumacher & Hall

ADDRESS

Pocatello

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bannock
 City of POCATELLO, IDAHO

If death occurs away from usual residence, give facts called for under special information.

Registration District No. _____

Primary Registration District No. _____

(No. General Hosp St.)

2. FULL NAME

William Russell Toston

37426

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 48Registered No. 3780

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

Yrs. 7 Mos. 7 ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address) POCATELLO, IDAHO

15.

Filed Mar 6 19 22

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 5 19 22
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

7/27 19 22 to 8/5 19 22

that I last saw him alive on 8/5 19 22and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Blue baby - Pneumonia(Duration) Yrs. 7 mos. 7 ds.

Contributory (Secondary)

(Duration) yrs. 7 mos. 7 ds.

(Signed)

3/6 19 22 (Address) POCATELLO, IDAHO

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. 7 mos. 7 days. In the State yrs. 7 mos. 7 days

Where was disease contracted if not at place of death

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mt View Cem. Mar 6 19 22

20. UNDERTAKER
H. L. McHAN

ADDRESS

POCATELLO, IDAHO

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of BannockCity of POCATELLO, IDAHO

If death occurs away from usual residence, give facts called for under special information.

Registration District No. _____

Primary Registration District No. _____

(No. 532 So. Johnson St.)State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 48Registered No. 3781

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

John William Brammon

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male white widower

6. DATE OF BIRTH

May 26 1849
(Month) (Day) (Year)

7. AGE

72 Yrs. 9 Mos. 10 ds.
IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

Farm Laborer

9. BIRTHPLACE

(State or Country)

Ind.

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

Ind.

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Ind.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles E. Brammon(Address) POCATELLO, IDAHO

15.

Filed 3/6 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 4 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 7 1921 to March 1922that I last saw him alive on Mar 3 1922and that death occurred on the date stated above, at 12:45 P.

The CAUSE OF DEATH* was as follows:

Chronic (Kidney) Nephritis
(Chronic) Asthma Cordis(Duration) Several years yrs. mos. ds.Contributory
(Secondary)(Duration) Several yrs. mos. ds.

(Signed)

3/6 1922 (Address) POCATELLO, IDAHO

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 1 yrs. 7 mos. days. In the State 1 yrs. 7 mos. days

Where was disease contracted if not at place of death?

Former or usual residence Canon City Colo.19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Canon City Colo. Mar 6 1922

20. UNDERTAKER

H. L. McHAN

ADDRESS

POCATELLO, IDAHO

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

37428

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

Bannock

Registration District No.

Primary Registration District No.

(No. 245- No Tenth

St.)

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Myrtle Mary Wardle

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 4 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 22 1922 to Mar 4 1922

that I last saw her alive on Mar 4 1922

and that death occurred on the date stated above, at 9⁰⁰ P. M.

The CAUSE OF DEATH* was as follows:

Influenza followed by pneumonia

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

M. D.

3/6 1922 (Address) Pocatello, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mountain View Bur Mar 6 1922

20. UNDERTAKER

ADDRESS

Schumacher & Hall Pocatello

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH *Primm* Registration District No. *28*
 County of *Blaine* Primary Registration District No. *2141*
 City of *Primm* (No. *Primm Bros Hospital* St.) Registered No. *3783*
 If death occurs away from usual residence, give facts called for under special information. *Alfred John Whiting* 37429
 2. FULL NAME *Alfred John Whiting* death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*
 (Write the word.)
 6. DATE OF BIRTH *March 6th 1922*
 (Month) (Day) (Year)
 7. AGE *2* IF LESS than 1 day
 Yrs. Mos. ds. how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work *None*
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) *Primm*

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country) *Springville Utah*

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country) *Idaho Falls Ida*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Alfred Reece Whiting*(Address) *Crystal*

15.

Filed *3/8* 19*22*Local Registrar *Alfred*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *March 8th 1922*
 (Month) (Day) (Year)

17. I HEREBY CERTIFY That I attended deceased from *March 6th 1922* to *March 8th 1922*
 that I last saw him alive on *March 8th 1922*
 and that death occurred on the date stated above, at *5:20 A.M.*

The CAUSE OF DEATH* was as follows:

Premature Birth(Duration) *—* Yrs. *—* mos. *—* ds.

Contributory (Secondary)

(Duration) *—* yrs. *—* mos. *—* ds.(Signed) *J. V. Brown* M. D.or *8* 19*22* (Address) *Primm*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death *—* yrs. *—* mos. *2* days. In the State *—* yrs. *—* mos. *—* days

Where was disease contracted if not at place of death? *Premature Birth*Former or usual residence *Crystal Ida*

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL *3/9* 19*22*

20. UNDERTAKER

ADDRESS *J. P. Waller Primm*

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bannock
 City of Pocatello

Registration District No. _____

Primary Registration District No. _____

(No. 429 N. Seventh St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Donald R. Frugoli

37430 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. _____

Registered No. 3784

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Dec 4th 1920
 (Month) (Day) (Year)

7. AGE

15 Yrs. 1 Mos. 3 ds.
 IF LESS than 1 day
 how many _____ hrs.
 or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work _____

(b) General nature of industry, business or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country) Fresno Cal

10. NAME OF FATHER

Dante Frugoli

11. BIRTHPLACE OF FATHER

(State or Country) Mont -

12. MAIDEN NAME OF MOTHER

Lulu Blue

13. BIRTHPLACE OF MOTHER

(State or Country) Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dante Frugoli(Address) 429 N 7th

15. Filed

3/8 1922Local Registrar J. H. Young

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 7th 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar 7th 1922 to Mar 7th 1922that I last saw him alive on March 7th 1922and that death occurred on the date stated above, at P. M.

The CAUSE OF DEATH* was as follows:

pneumonia(Duration) _____ Yrs. _____ mos. 19 ds.Contributory (Secondary) none

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Dr. Lynn M. D.Mar 8th 1922 (Address) Pocatello, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Mountain View

20. UNDERTAKER

Chunshu Hall

DATE OF BURIAL

Mar 9, 1922

ADDRESS

City

CERTIFICATE OF DEATH

37431

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Bannock*Registration District No. *28*City of *Castles*Primary Registration District No. *2141*(No. *General Hospital*)File No. *49*Registered No. *3785*

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Lillian L. Delate

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

*Female**White**Married*
(Write the word.)

6. DATE OF BIRTH

May 30th 1862
(Month) (Day) (Year)

7. AGE

59 Yrs. *9* Mos. *11* ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)*Retired*

9. BIRTHPLACE

(State or Country)

Texas

10. NAME OF FATHER

Albert Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Sidney Delate
738 1/2 N. Main

15.

Filed

*3/11 1922**W. H. Young*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 11 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *3-5 1922* to *3-11 1922*, that I last saw him alive on *3-11 1922* and that death occurred on the date stated above, at *M.* The CAUSE OF DEATH* was as follows:*Broncho-pneumonia*(Duration) Yrs. mos. *5* ds.

Contributory (Secondary)

Influenza(Duration) Yrs. mos. *2* ds.

(Signed)

W. H. Young M. D.*3/11 1922* (Address) *Castles, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

Wagon Wheel
Church of Jesus Christ
Castles, Idaho

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

28 37432 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
2141 File No.
Registered No. 3786

1. PLACE OF DEATH

County of Bannock
City of Pocatello

Registration District No.

Primary Registration District No.

(No. 116 1st W. Pocatello)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Alma Mathisen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED single
(Write the word.)

6. DATE OF BIRTH December 1877
(Month) (Day) (Year)

7. AGE 44 Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION Gard Foreman at Tie Plant.

9. BIRTHPLACE Quid Idaho
(State or Country)

10. NAME OF FATHER Michael Mathisen

11. BIRTHPLACE OF FATHER Norway
(State or Country)

12. MAIDEN NAME OF MOTHER Corsine Johnson

13. BIRTHPLACE OF MOTHER Norway
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Andy McDonald
(Address) Pocatello Idaho

15. Filed Mar 13 1922

J. H. Murphy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 11 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12 - 22 1921 to 3 - 11 1922
that I last saw him alive on 3 - 11 1922
and that death occurred on the date stated above, at 3300 M.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) Yrs. mos. ds.
Contributory (Secondary) Arteriosclerosis

(Duration) yrs. mos. ds.
(Signed) F. H. Wicks M. D.
3/11 1922 (Address) Pocatello, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 10 yrs. mos. days. In the State 10 yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence Quid Idaho

19. PLACE OF BURIAL OR REMOVAL Quid Idaho DATE OF BURIAL 3/15 1922

20. UNDERTAKER H. F. McMan ADDRESS Pocatello Idaho

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No.

Primary Registration District No.

(No.

201

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from March 5th 1922 to March 12th 1922 that I last saw her alive on March 12th 1922 and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

M. D.

mar 12 1922 (Address) Pocatello Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No.

Primary Registration District No.

(No.)

2164

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

Jan 1st 1919 to March 14th 1922
that I last saw her alive on March 14th 1922
and that death occurred on the date stated above, at 10:59 A.M.

The CAUSE OF DEATH* was as follows:

(Duration) Yrs. 6 mos. ds.

Contributory (Secondary)

(Duration) 3 yrs. mos. ds.

(Signed)

3/5 1922

(Address) Pocatello, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Bannock*City of *Pocatello*

If death occurs away from usual residence, give facts called for under special information.

Registration District No. _____

Primary Registration District No. _____

(No. _____)

General Hospital (St.)

2. FULL NAME

*Kate E. M. Gaffin*State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. _____

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 15 - 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 10 1922 to March 15 1922
that I last saw her alive on *March 15 1922*
and that death occurred on the date stated above, at *1130 am*

The CAUSE OF DEATH* was as follows:

*S. Peritonitis (Post Operation)
Shins of Abdominal Wall*

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Mar 16 22

(Address)

*Thos F. Muen M. D.
Pocatello, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bellevue Feb 19 1922

20. UNDERTAKER

ADDRESS

Schumacher 1400 City

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No.

St.)

2. FULL NAME

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

The CAUSE OF DEATH* was as follows:

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

M. D.

16 19 22 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Bannock*City of *Pocatello*

If death occurs away from usual residence, give facts called for under special information.

Registration District No. _____

Primary Registration District No. _____

(No. _____)

2. FULL NAME

Charles W. Donat

28 37437 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. _____
 Registered No. *3791*
 If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

Mar 12

(Month)

(Day)

(Year)

7. AGE

6

Yrs.

Mos.

ds.

IF LESS than 1 day

how many _____ hrs.

or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

3/18 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 18

(Month)

(Day)

19 *22* (Year)

17. I HEREBY CERTIFY, That I attended deceased from

*Mar 12 1922 to Mar 18 1922*that I last saw him alive on *Mar 18 1922*and that death occurred on the date stated above, at *7:30 PM*

The CAUSE OF DEATH* was as follows:

Septiphilia

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Magnum Union**Mar 19 1922*

20. UNDERTAKER

ADDRESS

*Chambers & Sons**City*

CERTIFICATE OF DEATH

37438 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 28

County of Bannock Primary Registration District No. 2141City of Pocatello (No. Sumo Idaho St.)

File No. 49

Registered No. 3792

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lillian Jenkins

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female white Single

6. DATE OF BIRTH

Oct 18 1919
(Month) (Day) (Year)

7. AGE

3 Yrs. 5 Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)none

9. BIRTHPLACE

(State or Country) Arbon, Ida.

10. NAME OF FATHER

William T. Jenkins

11. BIRTHPLACE OF FATHER

(State or Country) Malad, Ida.

12. MAIDEN NAME OF MOTHER

Lillian Sheriff

13. BIRTHPLACE OF MOTHER

(State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed Nov 18 1922 J. Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

3 18 22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar. 13 1922 to Mar 15 1922
that I last saw her alive on 3-13 1922
and that death occurred on the date stated above, at 8:08 M.

The CAUSE OF DEATH* was as follows:

Pneumonia(Duration) Yrs. mos. ds. 13 ds.

Contributory (Secondary)

Influenza(Duration) Yrs. mos. ds. 5 ds.

(Signed)

D. C. Ray M. D.
3-18 1922 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence Life in Idaho.

19. PLACE OF BURIAL OR REMOVAL

Sumo, Idaho

DATE OF BURIAL

Mar 19 1922

20. UNDERTAKER

McHaw and Co

ADDRESS

Pocatello.

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

37439
28
State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 49
Registered No. 3793

1. PLACE OF DEATH

County of Bannock
City of Pocatello

Registration District No. _____

Primary Registration District No. _____

(No. 1145 E. Clark St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Kenneth Russell Richards

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-OWED OR DIVORCED

Male white single

6. DATE OF BIRTH

Nov 17 1922
(Month) (Day) (Year)

7. AGE

1 Yrs. 3 Mos. 28 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

none

9. BIRTHPLACE

(State or Country)

Pocatello, Idaho

10. NAME OF FATHER

Linford Richards

11. BIRTHPLACE OF FATHER

(State or Country)

Missouri

12. MAIDEN NAME OF MOTHER

Edith Ball

13. BIRTHPLACE OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Linford Richards
1445 E. Clark St. Pocatello, Ida
(Address)

15.

Filed Nov 18 1922

J. Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 17 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

3/14 1922 to 3/17 1922
that I last saw him alive on 3/17 1922
and that death occurred on the date stated above, at 7 a.m.

The CAUSE OF DEATH* was as follows:

Sepsisemia

(Duration) Yrs. mos. ds.

Contributory (Secondary)

Streptococci infection of Pectoralis region

(Duration) yrs. mos. ds.

(Signed) J. Young M. D.

3/18/22 (Address) Pocatello, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death? Ida in Pocatello

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

MT View Cem.

3/20 1922

20. UNDERTAKER

ADDRESS

McNown Undertaking Co. Pocatello, Ida

CERTIFICATE OF DEATH

37440

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 28
County of *Bannock* Primary Registration District No. 2161
City of *Pocatello* 1.5 mile N. of town St.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Toy Long Jim*File No. 49
Registered No. 3794

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female Chinese Single

6. DATE OF BIRTH

Jan 21 1922
(Month) (Day) (Year)

7. AGE

1 Mos. 28 ds.
Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).*none*

9. BIRTHPLACE

(State or Country)

Pocatello, Ida.

10. NAME OF FATHER

Louie Jim

11. BIRTHPLACE OF FATHER

(State or Country)

China

12. MAIDEN NAME OF MOTHER

Hauie She

13. BIRTHPLACE OF MOTHER

(State or Country)

China

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Louie Jim*
(Address) *Pocatello, Idaho*

15.

Filed *Mar 18 1922**J. Young*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 18 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *3/18 1922* to *3/18 1922*that I last saw her alive on *3/18 1922*and that death occurred on the date stated above, at *5 a.m.*

The CAUSE OF DEATH* was as follows:

Pneumonia(Duration) Yrs. mos. *3* ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. Young M. D.
3/18 1922 (Address) *Pocatello, Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death *Life* In the State *Idaho* yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence *Life in Pocatello*

19. PLACE OF BURIAL OR REMOVAL

Mt. View Cem

DATE OF BURIAL

Mar 18 1922

20. UNDERTAKER

McTear and Co. Pocatello

ADDRESS

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bannock
City of Pocatello

Registration District No. _____

Primary Registration District No. _____

St. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Margaret Louise Green

State of Idaho
2837441
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 49
Registered No. 3793

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married

6. DATE OF BIRTH

Jan 31 1922
(Month) (Day) (Year)

7. AGE

4 Yrs. 1 Mos. 21 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

none

9. BIRTHPLACE

(State or Country) McCannan Ida.

10. NAME OF FATHER

Jared Green

11. BIRTHPLACE OF FATHER

(State or Country) Idaho.

12. MAIDEN NAME OF MOTHER

Hilda Thawn

13. BIRTHPLACE OF MOTHER

(State or Country) Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jared Green

(Address) McCannan Ida.

15.

Filed Mar 21 1922 J. Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 21 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar 29 1922 to Mar 21 1922

that I last saw him alive on Mar 20 1922

and that death occurred on the date stated above, at 5:10 M.

The CAUSE OF DEATH* was as follows:

Pneumonia Rt. Chest
Spinal meningitis
Influenza
(Duration) Yrs. mos. ds.

Contributory (Secondary) Spinal Meningitis

(Duration) Yrs. mos. ds.

(Signed) H. C. Green M. D.

3/21 1922 (Address) Pocatello, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. / days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence McCannan Ida.

19. PLACE OF BURIAL OR REMOVAL

McCannan Idaho

DATE OF BURIAL

Mar 29 1922

20. UNDERTAKER

McDonnell & Co. Pocatello, Ida.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM 1		RECEIVED		CERTIFICATE OF DEATH		State of Idaho BOARD OF HEALTH Bureau of Vital Statistics	
City of <u>Pocatello</u>		(No. <u>Lynn Hospital</u> St.)		Registered No. <u>3796</u>		If death occurred in a hospital, institution or camp, give its NAME instead of street and number.	
<p>If death occurs away from usual residence, give facts called for under special information.</p> <p>2. FULL NAME <u>Bertha Virginia Whiting</u></p>							
PERSONAL AND STATISTICAL PARTICULARS							
3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED <u>Married</u> (Write the word.)					
6. DATE OF BIRTH <u>February 21 1904</u> (Month) (Day) (Year)							
7. AGE <u>18 Yrs. - 29 ds.</u>		IF LESS than 1 day how many hrs. or min.?					
8. OCCUPATION (a) Trade, profession or particular kind of work <u>House wife</u> (b) General nature of industry, business or establishment in which employed (or employer) <u>-</u>							
9. BIRTHPLACE (State or Country) <u>Idaho Falls</u>							
10. NAME OF FATHER <u>J. W. Staley</u>							
11. BIRTHPLACE OF FATHER (State or Country) <u>Virginia</u>							
12. MAIDEN NAME OF MOTHER <u>Sarah Phoebe Adams</u>							
13. BIRTHPLACE OF MOTHER (State or Country) <u>Utah</u>							
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>A. R. Whiting</u> (Address) <u>Crystal</u>							
15. Filed <u>3/21 1922</u> Local Registrar <u>J. Young</u>							
MEDICAL CERTIFICATE OF DEATH							
16. DATE OF DEATH <u>March 20 1922</u> (Month) (Day) (Year)							
17. I HEREBY CERTIFY, That I attended deceased from <u>Mar 6 1922</u> to <u>Mar 19 1922</u> that I last saw her alive on <u>Mar 19 1922</u> and that death occurred on the date stated above, at <u>1:30 P.M.</u> The CAUSE OF DEATH* was as follows: <u>Influenza</u>							
(Duration) Yrs. mos. <u>14</u> ds.							
Contributory (Secondary) <u>Caupumint</u>							
(Duration) Yrs. mos. <u>7</u> ds.							
(Signed) <u>J. V. Lynn</u> M. D. <u>Mar 20 1922</u> (Address) <u>Pocatello 209</u>							
*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.							
18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) At place of death <u>14</u> yrs. <u>14</u> mos. <u>14</u> days. State <u>18</u> yrs. <u>29</u> mos. <u>29</u> days Where was disease contracted if not at place of death? <u>1045 No. Grant</u> Former or usual residence <u>Crystal Idaho</u>							
19. PLACE OF BURIAL OR REMOVAL <u>Blackfoot Id.</u>				DATE OF BURIAL <u>Mar 22 1922</u>			
20. UNDERTAKER <u>Schumacher & Hall</u>				ADDRESS <u>Pocatello</u>			

FORM V. S. No. 5-A-25 M. 1-19.

1. PLACE OF DEATH

County of Bannock
City of Cocatillo

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No. 2837443Primary Registration District No. 2161(No. General Hospital St.)State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 89Registered No. 3797

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

September 11 1893
(Month) (Day) (Year)

7. AGE

28 Yrs. 6 Mos. 7 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Cambridge Mass

10. NAME OF FATHER

James H. Hodgkins

11. BIRTHPLACE OF FATHER

(State or Country) Cambridge Mass

12. MAIDEN NAME OF MOTHER

Carrie E. Booker

13. BIRTHPLACE OF MOTHER

(State or Country) Cambridge Mass

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harry J. Titus(Address) 257 N. 10th

15.

Filed 3/23 1922Local Registrar J. P. Young

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 22 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

3/12/1922 to 3/22/1922
that I last saw her alive on 3/22/1922
and that death occurred on the date stated above, at 12:20 P.M.

The CAUSE OF DEATH* was as follows:

Operation 3/13/22

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory (Secondary) Following operation

(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed) H. C. Irving M. D.3/23 1922 (Address) Cocatillo Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Boston Mass

DATE OF BURIAL

March 1922

20. UNDERTAKER

Schumacher Hall

ADDRESS

Cocatillo



ARTHUR W. HALL
MORTUARY

229 South Garfield

TELEPHONE 226

POCATELLO, IDAHO

May 20, 1937

Pearl Dillingham
Department of Public Welfare
Boise, Idaho

Dear Madam:

Replying to your letter of the 15th.

According to our records, we find the correct date of death of Alice Edna Titus is March 20, 1922. Therefore, the date of March 20, 1922 as given on the death certificate is an error.

Yours very truly,

Arthur W. Hall

AWH:nn

CERTIFICATE OF DEATH

State of Idaho
28741 BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No.

Primary Registration District No.

(No.)

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many hrs.

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

15. Filed

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw her alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

387445

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Bannock*City of *Pocatello*

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
Registration District No. *21619*Place of Registration District No. *St. Anthony Hospital*File No. *49*Registered No. *3803*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME *Felix Sanchez*

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *Male*4. COLOR OR RACE *Mexican*5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*6. DATE OF BIRTH *about 1887*

(Month)

(Day)

(Year)

7. AGE *35*

LESS than 1 day

8. OCCUPATION *Laborer*

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE *Mexico*

(State or Country)

10. NAME OF FATHER *Unknown*11. BIRTHPLACE OF FATHER *Unknown*

(State or Country)

12. MAIDEN NAME OF MOTHER *Unknown*13. BIRTHPLACE OF MOTHER *Unknown*

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Chumacher & Hall*(Address) *Pocatello, Idaho*15. *3/29*Filed *1922*Local Registrar *J. Hanna*16. DATE OF DEATH *Mar 22nd*

(Month)

(Day)

19 *22* (Year)17. I HEREBY CERTIFY, That I attended deceased from *3-17-1922* to *3-22-1922*that I last saw him alive on *3-12-1922*and that death occurred on the date stated above, at *8:30* M.

The CAUSE OF DEATH* was as follows:

Influenza pneumonia(Duration) Yrs. mos. *5* ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) *A. M. Newton* M. D.*Mar 29 1922* (Address) *Pocatello, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Mountain View* DATE OF BURIAL *Mar 29 1922*20. UNDERTAKER *Chumacher & Hall*ADDRESS *City*

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Barnack
City of POCATELLO, IDAHO

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 28

Primary Registration District No. 2141

(No. Lynn Bros Hosp St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 49

Registered No. 3802

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Hilda Mae Meads Templeton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF
FATHER

11. BIRTHPLACE
OF FATHER

(State or Country)

12. MAIDEN NAME
OF MOTHER

13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw her alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:
ulcer of the stomach
operation

(Duration) 1 Yrs..... mos..... ds.

Contributory
(Secondary)

(Duration) 1 yrs..... mos..... ds.

(Signed) Dr. J. W. S. M. D.

(Address) POCATELLO, IDAHO

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death 14 yrs. 14 mos. 14 days. In the State 7 yrs. 14 mos. 14 days

Where was disease contracted
if not at place of death?

Former or usual residence Cash Junction Utah

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Salt Lake City Utah Mar 29 1922

20. UNDERTAKER

ADDRESS

H. L. McHAN

POCATELLO, IDAHO

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. _____

County of Blaine Primary Registration District No. _____City of Pocatello No. 657 St. 2161

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lo. N. Fick SrFile No. 49Registered No. 3801

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

March 6 1852
(Month) (Day) (Year)

7. AGE

70 Yrs. 22 Mos. 22 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

Contractor

9. BIRTHPLACE

(State or Country)

Can Sabley, Fort

10. NAME OF FATHER

Joseph Fick

11. BIRTHPLACE OF FATHER

(State or Country)

Canada

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Lo. N. Fick Sr
Pocatello

15.

Filed

3/28 1922J. Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 28 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar 28th 1922 to Mar 28 1922that I last saw him alive on Mar 28 1922and that death occurred on the date stated above, at 6:30 A.M.

The CAUSE OF DEATH* was as follows:

Coronary Sclerosis(Duration) 4 Yrs. _____ mos. _____ ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Dr. J. Young M. D.

19. _____

(Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. View Cemetery 3/28 1922

20. UNDERTAKER

ADDRESS

Dr. J. Young Pocatello

CERTIFICATE OF DEATH

287448 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 49
 Registered No. 3800

1. PLACE OF DEATH

County of Barnock
 City of POCATELLO, IDAHO

Registration District No.

Primary Registration District No. 2161(No. Pocatello General Hosp)

If death occurs away from
 usual residence, give facts
 called for under special in-
 formation.

2. FULL NAME

George Heddlie

If death occurred in a hos-
 pital, institution or camp,
 give its NAME instead of
 street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDwidower

6. DATE OF BIRTH

Not Known 1867
 (Month) (Day) (Year)

7. AGE

55 Yrs. Mos. ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or
 particular kind of work
 (b) General nature of in-
 dustry, business or estab-
 lishment in which employ-
 ed (or employer)

County Charge

9. BIRTHPLACE

(State or Country)

Poland10. NAME OF
FATHERNot Known11. BIRTHPLACE
OF FATHER

(State or Country)

" "12. MAIDEN NAME
OF MOTHER" "13. BIRTHPLACE
OF MOTHER

(State or Country)

" "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Pocatello Gen. Hospital(Address) POCATELLO, IDAHO

15.

Filed Mar. 27 1922

J. Young
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 27 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 15 1922 to Mar 26 1922
 that I last saw him alive on Mar 26 1922
 and that death occurred on the date stated above, at 12:25 a.m. M.

The CAUSE OF DEATH* was as follows:

Cancer of the stomach.(Duration) 1 Yrs. 6 mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Carl W. Clark M. D.3/27 1922 (Address) POCATELLO, IDAHO

*State the Disease Causing Death; or in deaths from Violent Causes, state
 (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. 12 days. In the State yrs. mos. 12 days

Where was disease contracted
 if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Mt View Cem.

DATE OF BURIAL

Mar 29 1922

20. UNDERTAKER

H. L. McHAN

ADDRESS

POCATELLO, IDAHO

CERTIFICATE OF DEATH

2837440 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 99
 Registered No. 3799

1. PLACE OF DEATH

County of Bannock
 City of POCATELLO, IDAHO

Registration District No.

Primary Registration District No.

(No. General Hospital)

If death occurs away from
 usual residence, give facts
 called for under special in-
 formation.

2. FULL NAME

Minnie Alma Kirkpatrick

If death occurred in a hos-
 pital, institution or camp,
 give its NAME instead of
 street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Female white Married

6. DATE OF BIRTH

December 11 1871
 (Month) (Day) (Year)

7. AGE

50 Yrs. 3 Mos. 16 ds.

IF LESS than 1 day
 how many..... hrs.
 or..... min.?

8. OCCUPATION

(a) Trade, profession or
 particular kind of work.
 (b) General nature of in-
 dustry, business or estab-
 lishment in which employ-
 ed (or employer).

House wife

9. BIRTHPLACE

(State or Country)

Minnesota10. NAME OF
FATHERPartridge11. BIRTHPLACE
OF FATHER

(State or Country)

not known12. MAIDEN NAME
OF MOTHERGertrude Freeman13. BIRTHPLACE
OF MOTHER

(State or Country)

Minnesota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Arthur C Kirkpatrick(Address) POCATELLO, IDAHO

15.

Filed

Nov 27 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 27 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
3-20 1922 to 3-27 1922

that I last saw her alive on 3-26 1922
 and that death occurred on the date stated above, at 2:40 A.M.

The CAUSE OF DEATH* was as follows:

Septic meningitis

(Duration) Yrs. 2 mos. 2 ds.
 Contributory abscess middle ear
 (Secondary)

(Duration) Yrs. 21 mos. 21 ds.
 (Signed) Dr. J. W. ... M. D.

(Address) Pocatello, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state
 (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death 12 yrs. ... mos. ... days. In the State 12 yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

Chicago, Ill.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Los Angeles, CalMar 28 1922

20. UNDERTAKER

ADDRESS

H. L. McHANPOCATELLO, IDAHO

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

RECEIVED
CERTIFICATE OF DEATH

1. PLACE OF DEATH.

Registration District No. 84

County of Bannock

Primary Registration District No. 84

City of Lava Hot Spgs

(No. 84 St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37450

Registered No. 37450

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Oliver Cromwell Garthwait

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

December 4 1899
(Month) (Day) (Year)

7. AGE

82 yrs. 8 mos. 18 ds.

IF LESS than 1 day
how many.....hrs. or
.....min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work.....
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

New York

10. NAME OF FATHER

Henry J. Garthwait

11. BIRTHPLACE OF FATHER

(State or Country)

do not know

12. MAIDEN NAME OF MOTHER

unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. M. Gittins

(Address)

Lava Hot Spgs. Ida.

15.

Filed

4-1

1912

Walter Back
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March 22 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

.....191....., to.....191.....

that I last saw h.....alive on.....191.....

and that death occurred on the date stated above, at 9:30 P.M.

The CAUSE OF DEATH* was as follows:

Influenza

..... (Duration)yrs.....mos.....ds.

Contributory
(Secondary)

..... (Duration)yrs.....mos.....ds.

(Signed) M. D.

.....19..... (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted,
If not at place of death?

Former or
usual residence.....

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Mar 24 1922

20. UNDERTAKER

ADDRESS

none

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics.

File No. 37451

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bannock District No. _____
City of Lava Hot Springs Registration District No. _____
(No. _____) St. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Pearl Avery

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.Female White Single
(Write the word.)

6. DATE OF BIRTH.

3 2 1922
(Month) (Day) (Year)

7. AGE

Yrs. 17 Mos. 17 ds. 17
IF LESS than 1 day how many hrs. or min. 17

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country) Bannock -

10. NAME OF FATHER

Jesse James Avery

11. BIRTHPLACE OF FATHER

(State or Country) Utah -

12. MAIDEN NAME OF MOTHER

Alma Delilah Avery

13. BIRTHPLACE OF MOTHER

(State or Country) Downey Idaho -

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address) Lava Hot Springs -

15.

Filed 4-1 1922W. B. Bach

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

3 19 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from 3/2 1922 to 3/19 1922,
that I last saw her alive on 3/19 1922,
and that death occurred on the date stated above, at 6:20 AM.

The CAUSE OF DEATH* was as follows:

Pneumonia(Duration) Yrs. 9 mos. 9 ds.Contributory (Secondary) Myocarditis(Duration) Yrs. 2 mos. 2 ds.(Signed) W. B. Bach M. D.3/19/1922 (Address) Lava Hot Springs -

*State the DISEASE CAUSING DEATH; or in death from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos. 19 days In the State.....yrs.....mos. 19 days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

191

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **37452**
Registered No.

1. PLACE OF DEATH

County of **Bannock**
City of **Bancroft**

Registration District No. **84**
Primary Registration District No. **2161**
(No., St.)

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME **J.C.F. Dillon**

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **M** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED **single**
(Write the word.)

6. DATE OF BIRTH

March 22 **848**
(Month) (Day) (Year)

7. AGE

62 Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min. ?

8. OCCUPATION

(a) Trade, profession or
particular kind of work. **Presbyterian Minister**
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country) **Chicago, Ill**

10. NAME OF FATHER

J.C. Dillon

11. BIRTHPLACE OF FATHER

(State or Country) **Ill**

12. MAIDEN NAME OF MOTHER

?

13. BIRTHPLACE OF MOTHER

(State or Country) **Ill**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed **April 1** 19 **23**

W. B. Bach
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 15 19 **22**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Febch 15 19 **22**, to **March 15** 19 **22**.

that I last saw him alive on **March 15** 19 **22**
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Malignancy bladder

(Duration) **8** Yrs. mos. ds.

Contributory **anemia**
(Secondary)

(Duration) yrs. mos. ds.

(Signed) **Walter S. Bach** M. D.

19..... (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Charlotter Mich

DATE OF BURIAL

3-17-23

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **37453**
Registered No. _____

1. PLACE OF DEATH

County of **Bannock**City of **Bancroft**Registration District No. **84**Primary Registration District No. **2161**

(No. _____, _____ St.)

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME **Laura McClellen**

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

white5. SINGLE, MARRIED, WID-
OWED OR DIVORCED
married

(Write the word.)

6. DATE OF BIRTH

March 18 **1903**
(Month) (Day) (Year)

7. AGE

18 Yrs. _____ Mos. _____ ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min. ?

8. OCCUPATION

(a) Trade, profession or
particular kind of work**housewife**(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country) **Idaho**10. NAME OF
FATHER**Ernest Thompson**11. BIRTHPLACE
OF FATHER(State or Country) **Utah**12. MAIDEN NAME
OF MOTHER**Laura Loveland**13. BIRTHPLACE
OF MOTHER(State or Country) **Utah**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed **April 1** **1922**

Walter S. Baal
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 30, 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 28 **1922**, to **19**

that I last saw h.er. alive on **March 28** **19**

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory **miscarraige**
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) **Walter S. Baal** M. D.

3-30-1922 (Address) **Bancroft**

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH.

37456

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 21

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Blaine Lake AP
City of Paris (No. 1 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary Athay

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married

(Write the word.)

6. DATE OF BIRTH.

June 26 1860
(Month) (Day) (Year)

7. AGE

61 Yrs. 8 Mos. 7 ds.IF LESS than 1 day
how many.....hrs. or
.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....Housewife

9. BIRTHPLACE

(State or Country)

Kaysville, Utah

10. NAME OF FATHER

William Lindsay

11. BIRTHPLACE OF FATHER

(State or Country)

do not know

12. MAIDEN NAME OF MOTHER

May Louise Lindsay

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Blair A. Maer
Paris, Idaho.

15.

Filed 3 11 1922Mrs. J. L. Skinner
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 7 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Mar 1 1922 to Mar 7 1922, that I last saw her alive on Mar 7 1922 and that death occurred on the date stated above, at 11:00 A.M.

The CAUSE OF DEATH* was as follows:

Influenza, complicated with
severe dilatation of heart

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) E. G. Moore M. D.3/8 1922 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Paris3-8 1922

20. UNDERTAKER

ADDRESS

Bishop Ezra Stucki Paris Ida.

CERTIFICATE OF DEATH. ✓

37457

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 53

County of Bear Lake

Primary Registration District No.

City of Paris

(No. 1)

St.)

File No. 23

Registered No.

If death occurs away from
usual residence, give facts
called for under special
information.

2. FULL NAME

Bernice Rich

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

Single

(Write the word.)

6. DATE OF BIRTH.

Jan

(Month)

12

(Day)

1922

(Year)

7. AGE

18

Yrs.

Mos.

ds.

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work...
(b) General nature of in-
dustry, business, or estab-
lishment in which employ-
ed (or employer)

Student

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF
FATHER

Walter P. Rich

11. BIRTHPLACE
OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME
OF MOTHER

Kate Price

13. BIRTHPLACE
OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) X

Mrs. L. Rich

(Address)

Paris Idaho

15.

Filed

3-27

1922

Mrs. J. Skinner
Local Registrar

16. DATE OF DEATH

Mar

(Month)

22

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from
Mar 7 1922 to Mar 22 1922
that I last saw h. l. r. alive on Mar 22 1922
and that death occurred on the date stated above, at 3:30 P.M.
The CAUSE OF DEATH* was as follows:
Relapse following Influenza
Complicated with Acute Dilatation
of the Heart (True Heart Failure).
(Duration) 36 hrs Yrs. mos. ds.
Contributory
(Secondary)
(Duration) Yrs. mos. ds.
(Signed) C. O. Moore M. D.
3/22/1922 (Address) Paris Idaho*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)At place of death... Yrs. mos. days In the
State... Yrs. mos. daysWhere was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Paris Idaho

3-25 1922

20. UNDERTAKER

ADDRESS

Bishop Stucki

Paris Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

37458

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 22

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bear Lake
City of Bloomington

Registration District No. 53

Primary Registration District No.

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Georgenia Osmond

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widowed

(Write the word.)

6. DATE OF BIRTH.

Mar 7 1836
(Month) (Day) (Year)

7. AGE

86 Yrs. 0 Mos. 7 ds.IF LESS than 1 day
how many.....hrs. or
.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....Housewife

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

Fred Huckvale

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Mary Shope

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Mrs. J. L. Osmond
Bloomington Idaho

15.

Filed

3-171922Mrs. J. L. Osmond
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 14 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar 11 1922 to Mar 14 1922that I last saw her alive on Mar 14 1922and that death occurred on the date stated above, at 12 P.M.

The CAUSE OF DEATH* was as follows:

General Debility

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) O. J. Moore M. D.3/16 1922 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bloomington3 18 1922

20. UNDERTAKER

ADDRESS

Bishop A. A. HartBloomington

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 37459

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bear Lake Registration District No. 5-5
City of St Charles Primary Registration District No. 5-5
(No. 102 St.)

If death occurs away from usual residence, give facts called for under special information.

BUREAU OF VITAL STATISTICS

2. FULL NAME

Gustave Andrew Nelson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-OWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH.

Dec. 21 - 1885 - 1
(Month) (Day) (Year)

7. AGE

36

IF LESS than 1 day
how many hrs. or
..... min. ?

Yrs. Mos. 2 ds. 16

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

Ranchman
Veteranian

9. BIRTHPLACE

(State or Country)

St Charles Ida.

10. NAME OF FATHER

Rasmus P. Nelson

11. BIRTHPLACE OF FATHER

(State or Country)

Denmark

12. MAIDEN NAME OF MOTHER

Wilhelmina Anderstedt

13. BIRTHPLACE OF MOTHER

(State or Country)

Seden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Min Hannah Nelson(Address) St Charles Ida.

15.

Filed March 5 1922 John Mattoon
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 9 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 4 - 2 30, to Mar 9 1922, that I last saw him alive on Mar 9, 1922, and that death occurred on the date stated above, at 2³⁰ PM.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) Yrs. mos. 7 ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) J. D. Nelson M. D.

3/9/22 (Address) Paris Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St Charles Ida March 12 1922

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. **RECEIVED**
Registration District No. _____
County of Bear Lake Primary Registration District No. 53
City of St. Charles (No. _____ St.)

File No. 37460
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarah Kerstene Hairup.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. widow
(Write the word.)

6. DATE OF BIRTH.

Nov. 16 1837
(Month) (Day) (Year)

7. AGE

84 Yrs. 4 Mos. 15 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

housewife

9. BIRTHPLACE

(State or Country)

Denmark

10. NAME OF FATHER

Peter Overen

11. BIRTHPLACE OF FATHER

(State or Country)

Denmark

12. MAIDEN NAME OF MOTHER

don't know

13. BIRTHPLACE OF MOTHER

(State or Country)

Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

S. P. Hairup
St. Charles, Idaho

15.

Filed March 5 1922

John Matteson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 1 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 191_____ to _____ 191_____,

that I last saw h. _____ alive on _____ 191_____,

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

died of old age
no ill in attendance

(Duration) _____ Yrs. _____ mos. 1 ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

19 _____ (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Charles Id.

March 3 1922

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 37462

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bear Lake
City of Fish Haven Id.RECEIVED
APR 2 1922
BUREAU OF VITAL STATISTICS

Registration District No. _____

Affirmatory Registration District No. 5-5

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Rosina Beyeler

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH.

November 5th 1852
(Month) (Day) (Year)

7. AGE

69 Yrs. 25 Mos. 25 ds.IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....House Wife

9. BIRTHPLACE

(State or Country)

Switzerland

10. NAME OF FATHER

Christian

11. BIRTHPLACE OF FATHER

(State or Country)

Switzerland

12. MAIDEN NAME OF MOTHER

Haldman

13. BIRTHPLACE OF MOTHER

(State or Country)

Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Fritz Beyeler

(Address)

Fish Haven Idaho

15.

Filed

Filed April 1922John Mattison
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 2nd 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan. 20 1922 to Mar. 2 1922
that I last saw her alive on Feb. 1922
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) Yrs. mos. ds.

Contributory, (Secondary) Myocarditis

(Duration) Yrs. mos. ds.

(Signed) J. D. Sullivan M. D.Mar. 2 1922 (Address) Paris

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Fish Haven Id.March 6th 1922

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bear Lake Registration District No. 02
 City of Wendover Primary Registration District No. 2136
 If death occurs away from usual residence, give facts called for under special information. STATISTICS St.)

2. FULL NAME

Barbara Schmitt

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 37463
 Registered No.
 If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widow
(Write the word.)

6. DATE OF BIRTH.

July 28 1922
 (Month) (Day) (Year)

7. AGE

80 Yrs. 7 Mos. 5 ds.

IF LESS than 1 day
 how many hrs. or
 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Luganburg

10. NAME OF FATHER

John B. Schmitt

11. BIRTHPLACE OF FATHER

(State or Country)

Luganburg

12. MAIDEN NAME OF MOTHER

(Not known)

13. BIRTHPLACE OF MOTHER

(State or Country)

Luganburg

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Betty Schmitt

(Address)

Montpelier, Idaho

15.

4-19-22

Filed

1922N H King

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 5 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191..... to 191.....

that I last saw h..... alive on 191.....

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Apoplexy (No doctor in attendance)

(Duration) 2 Yrs. mos. ds.

Contributory
 (Secondary)

Senility

(Duration) 1 Yrs. mos. ds.

(Signed)

N H King

3-7-1922 (Address) Montpelier, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted

if not at place of death?

Former or
 usual residence

19. PLACE OF BURIAL OR REMOVAL

Montpelier, Idaho

DATE OF BURIAL

Mar 9 1922

20. UNDERTAKER

F. M. Williams

ADDRESS

Montpelier Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH

County of Bear Lake Registration District No. 52
 City of Novan Primary Registration District No. 2136
 (No. 2136 St.)
 If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Chas. Bartschi

State of Idaho

BOARD OF HEALTH

Bureau of Vital Statistics

File No. 37464Registered No. 37464
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH.

Aug
(Month)4
(Day)1869
(Year)

7. AGE

52 Yrs. 7 Mos. 1 ds.IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)Farmer

9. BIRTHPLACE

(State or Country)

Switzerland

10. NAME OF FATHER

Fredrich Bartschi

11. BIRTHPLACE OF FATHER

(State or Country)

Switzerland

12. MAIDEN NAME OF MOTHER

Susan Stauffer

13. BIRTHPLACE OF MOTHER

(State or Country)

Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Chas. Bartschi

(Address)

Novan, Idaho

15.

Filed 4-19-1922H. H. King
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar
(Month)5
(Day)1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

February 1922 to Feb 1922that I last saw him alive on about Feb 2 1922and that death occurred on the date stated above, at 6:10 P.M.

The CAUSE OF DEATH* was as follows:

Organic Heart Lesionabout 1 Yrs. mos. ds.
(Duration)Contributory
(Secondary)Yrs. mos. ds.
(Duration)(Signed) Ellis Kachley M. D.19 (Address) 707 N. 1st St. Soda Springs

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days, In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Novan, Idaho

DATE OF BURIAL

Mar 9 1922

20. UNDERTAKER

J. M. Williams

ADDRESS

Novan, Idaho

should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. Exact statement of OCCUPATION is very important.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37465
Registered No. 37465
If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

1. PLACE OF DEATH

County of Bear Lake
City of Montpelier

Registration District No. 52Primary Registration District No. 2136

(Not for use by St.)

If death occurs away from
usual residence, give facts
called for under special
information.

2. FULL NAME

Edgar Murrie Lindsay

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.Married
(Write the word.)

6. DATE OF BIRTH.

Jan 17 1887
(Month) (Day) (Year)

7. AGE

65 Yrs. 1 Mos. 20 ds.

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work Farmer
(b) General nature of in-
dustry, business, or estab-
lishment in which em-
ployed (or employer)

9. BIRTHPLACE

(State or Country) Utah10. NAME OF
FATHERWm B. Lindsay11. BIRTHPLACE
OF FATHER(State or Country) Canada12. MAIDEN NAME
OF MOTHERJulia Park13. BIRTHPLACE
OF MOTHER(State or Country) New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed 4-19-22 1922

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 9 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 3 1922 to March 9 1922

that I last saw him alive on March 9 1922

and that death occurred on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:

"Flu"

(Duration) Yrs. mos. ds.

Contributory
(Secondary)"Pneumonia"

(Duration) Yrs. mos. ds.

(Signed)

Chas. E. Hinkley M. D.

3-9-22 (Address) Montpelier

*State the Disease Causing Death; or in deaths from Violent
Causes, state (1) Means of Injury; and (2) whether Accidental,
Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place In the
of death yrs. mos. days, State yrs. mos. days

Where was disease contracted

if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

Pocoman Lake

DATE OF BURIAL

Mar. 11. 1922

20. UNDERTAKER

F. M. Williams

ADDRESS

Montpelier, Idaho

should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement
of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH

County of *Beauregard*City of *Montpelier*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lucile Bishoff

RECEIVED

CERTIFICATE OF DEATH

Registration District No. *5*Registration District No. *2131*

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *37466*

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

(Write the word.)

6. DATE OF BIRTH

6
(Month)*1909*
(Day)*1909*
(Year)

7. AGE

13

Yrs.

Mos.

ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Student

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

U.S.

10. NAME OF FATHER

Alfred Bishoff

11. BIRTHPLACE OF FATHER

(State or Country)

U.S.

12. MAIDEN NAME OF MOTHER

Eliza Genschner

13. BIRTHPLACE OF MOTHER

(State or Country)

Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Alfred Bishoff

(Address)

Geneva - Idaho

15.

Filed

4-19

19

H. H. King

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

3
(Month)*17*
(Day)*1922*
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar 16 19 *22* to *Mar 17* 19 *22*that I last saw him alive on *Mar 16* 19 *22*and that death occurred on the date stated above, at *12:30* M.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

W. H. King

M. D.

3-17-22 (Address) *Geneva - Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

yrs.

mos.

days.

In the

State

yrs.

mos.

days

Where was disease contracted if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

Geneva Idaho

DATE OF BURIAL

Mar 19 19 *22*

20. UNDERTAKER

F. H. Bishoff

ADDRESS

Montpelier

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No.

Primary Registration District No.

BUREAU OF VITAL STATISTICS

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Infant
(Write the word.)

6. DATE OF BIRTH

3 17th 1922
(Month) (Day) (Year)

7. AGE

30 hours

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

U.S.

10. NAME OF FATHER

Albert Thompson

11. BIRTHPLACE OF FATHER

(State or Country)

U.S.

12. MAIDEN NAME OF MOTHER

Elfie Borg

13. BIRTHPLACE OF MOTHER

(State or Country)

U.S.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Albert Thompson
Montpelier, Ida.

15.

Filed

4-20

19

N. H. King

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 17 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 17 1922, to March 18 1922

that I last saw him alive on March 18 1922

and that death occurred on the date stated above, at 12 o'clock

The CAUSE OF DEATH* was as follows:

"Flu"

(Duration) Yrs. mos. 30 hrs.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) Elmer E. Hingley, M. D.

3/20, 1922, (Address) Montpelier, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Ovid Ida.

DATE OF BURIAL

March 18 1922

20. UNDERTAKER

J. H. Williams

ADDRESS

Montpelier

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 37468

1. PLACE OF DEATH

County of *Bear Lake*City of *Bonanza*Registration District No. *52*Primary Registration District No. *2136*BU No. *1101*

St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Andrew Lewis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Jan 15 1922
(Month) (Day) (Year)

7. AGE

15
Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Montpelier Ida

10. NAME OF FATHER

Thos G. Lewis

11. BIRTHPLACE OF FATHER

(State or Country)

Single Idaho

12. MAIDEN NAME OF MOTHER

Calla Booth

13. BIRTHPLACE OF MOTHER

(State or Country)

St Chas Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Geo S. Rogers
Montpelier Ida

15.

Filed *4-20* 19 *22*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 26 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 25 1922 to *March 26 1922*that I last saw him alive on *March 25 1922*and that death occurred on the date stated above, at *2 P* M.

The CAUSE OF DEATH* was as follows:

myocardia

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *Geo S. Rogers* M. D.*3-27 1922* (Address) *Montpelier*

State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Bonanza Ida

DATE OF BURIAL

3-28 1922

20. UNDERTAKER

J M Williams

ADDRESS

Montpelier

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **37469**

1. PLACE OF DEATH. Registration District No. **52**
County of **Bear Lake** Primary Registration District No. **2136**
City of **Hardboro, Ida.** (St.)

Registered No. _____
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME **Mrs Mirinda Demmick**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Widowed**
(Write the word.)

6. DATE OF BIRTH **12 11 1899**
(Month) (Day) (Year)

7. AGE **82 yrs. 4 mos. 17 ds.**
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work **None (Invalid)**
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) **England**

10. NAME OF FATHER **Not Known**

11. BIRTHPLACE OF FATHER
(State or Country) **England**

12. MAIDEN NAME OF MOTHER **Mary Ann Trausley**

13. BIRTHPLACE OF MOTHER
(State or Country) **England**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **F. R. Pirnick**
(Address) **Montpelier**

15. Filed **4-20-22** **St. Aug.**
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH **3 29th 1922**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **No Physician** 191... to 191...
that I last saw h — alive on 191...
and that death occurred on the date stated above, at M.
The CAUSE OF DEATH* was as follows:

Sciuitity
(Duration) yrs. mos. ds.
Contributory **Broken leg.**
(Secondary)
(Duration) **9** yrs. mos. ds.
(Signed) **E. F. Hinson** M. D.
3-29-1922 (Address) **Montpelier Ida**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.
Where was disease contracted if not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL **Hardboro Ida** DATE OF BURIAL **Apr 2nd 1922**

20. UNDERTAKER **F. M. Williams** ADDRESS **Montpelier Ida**

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Benedict
City of St. MariesRegistration District No. 32
Primary Registration District No. 2049
(No. _____ St.)File No. 37430
Registered No. 13

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Gust Johnson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH

893
(Month) (Day) (Year)

7. AGE

27 Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Laborer

9. BIRTHPLACE

(State or Country)

Greece

10. NAME OF FATHER

John Maglawson

11. BIRTHPLACE OF FATHER

(State or Country)

Greece

12. MAIDEN NAME OF MOTHER

Mary Glinitz

13. BIRTHPLACE OF MOTHER

(State or Country)

Greece

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. E. Gibson

(Address)

Bozill Idaho

15.

Filed March 29 1922H. E. Hunt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 28 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

3/28/1922 to 3/28/1922
that I last saw him alive on 3/28/1922
and that death occurred on the date stated above, at 6:48 A.M.

The CAUSE OF DEATH* was as follows:

Basal Skull Fracture
resulting from rock falling on head
accidental (Duration) Yrs. mos. ds.Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

J. E. Gibson

M. D.

3/28/1922 (Address) Bozill Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days In the State Yrs. mos. days

Where was disease contracted if not at place of death? New Rav, IdahoFormer or usual residence Rav, Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Spokane Wash. 1922

20. UNDERTAKER

ADDRESS

H. E. Hunt & Co St Maries

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Benevolence
City of St. MariesRegistration District No. 32Primary Registration District No. 2049

(No. _____) (St. _____)

File No. 37471Registered No. 14

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Marjorie Florence Powell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female White

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Dec. 19 1917
(Month) (Day) (Year)

7. AGE

4 Yrs. 3 Mos. 2 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Wash.

10. NAME OF FATHER

Archie C Powell

11. BIRTHPLACE OF FATHER

(State or Country)

Wash.

12. MAIDEN NAME OF MOTHER

Laura Siechelstead

13. BIRTHPLACE OF MOTHER

(State or Country)

Mont.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Archie C Powell

(Address)

St. Maries

15.

Filed March 22 1922H E Hunt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 21 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Mar 21 1922 to Mar 21 1922that I last saw him alive on Mar 21 1922, and that death occurred on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction(Duration) _____ Yrs. _____ mos. 2 ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Owen S Platt M. D.Mar 22 1922 (Address) St. Maries Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Woodlawn

DATE OF BURIAL

3-23-1922

20. UNDERTAKER

H E Hunt Co

ADDRESS

St. Maries

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Benewah
City of St. MariesRegistration District No. 33
Primary Registration District No. 2049
(No. _____ St.)File No. 37472
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Mrs Jennie Porter

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

widowed

(Write the word.)

6. DATE OF BIRTH

March 17th

(Month)

(Day)

1841

(Year)

7. AGE

80 Yrs. 11 Mos. 23 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

house keeper

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Pennsylvania

10. NAME OF FATHER

Jacob Gressley

11. BIRTHPLACE OF FATHER

(State or Country)

Pennsylvania

12. MAIDEN NAME OF MOTHER

Margaret Sindlinger

13. BIRTHPLACE OF MOTHER

(State or Country)

Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs Clara D.sey

(Address)

St Maries Ida.

15.

Filed March 18 1922C. E. Hunt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 12

(Month)

(Day)

1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 21 1922, to March 12 1922that I last saw him alive on March 12 1922and that death occurred on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Myocarditis(Duration) 2 Yrs. _____ mos. _____ ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

3/15 (Signed) Delomwall M. D.1922 (Address) St Maries Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Woodlawn Cem.

DATE OF BURIAL

3/16 1922

20. UNDERTAKER

C. E. Hunt 20

ADDRESS

St Maries

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37473
Registered No. 12

1. PLACE OF DEATH

County of Benevise
City of St. Maries

Registration District No. 32Primary Registration District No. 2049

(No. _____) (St. _____)

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Stelba Frances Warren

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDMarried
(Write the word.)

6. DATE OF BIRTH

Feb. 3 1883
(Month) (Day) (Year)

7. AGE

39 Yrs. 1 Mos. 5 ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of workHousewife(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country)

Wash.10. NAME OF
FATHERF. M. Gunn11. BIRTHPLACE
OF FATHER

(State or Country)

Mo.12. MAIDEN NAME
OF MOTHERCora Strange13. BIRTHPLACE
OF MOTHER

(State or Country)

Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. M. Warren

(Address)

St. Maries

15.

Filed March 8 1922H. E. Hunt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 8 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Mar 7 1922 to Mar 8 1922

that I last saw her alive on Mar 8 1922
and that death occurred on the date stated above, at 1:30 A.M.

The CAUSE OF DEATH* was as follows:

General Peritonitis
following partial abortion(Duration) Yrs. _____ mos. 2 ds.Contributory
(Secondary)Falling down steps(Duration) Yrs. _____ mos. 7 ds.

(Signed)

E. O. Plaut

M. D.

Mar 8 1922 (Address) St. Maries, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Rockdale Wash.

DATE OF BURIAL

3/11 1922

20. UNDERTAKER

H. E. Hunt Co.

ADDRESS

St. Maries

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

1. PLACE OF DEATH

County of *Benneh*
City of *Plummer*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jos. J. Handley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married.
(Write the word.)

6. DATE OF BIRTH

Day of birth not known.

Dec.

1893

(Month)

(Day)

(Year)

7. AGE

49

3

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs. or min.

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...

Labourer

9. BIRTHPLACE

(State or Country)

Ireland.

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

No further information available.

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

son lives at J. O. Handley, Hamilton, Mont.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

W. J. J. Plummer, Ida

15.

Filed

4/26

1922

W. J. J. Plummer
Local Registrar

CERTIFICATE OF DEATH.

Registration District No.

46

Primary Registration District No.

2173

(No.

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. *37475*

Registered No.

4

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

no one present when death occurred this thought stated.

16. DATE OF DEATH

Took place on

March 17

1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191

to

191

that I last saw h. alive on

191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows

See reverse side for particulars

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed) *H. W. Adams, Coroner*

3/19/22 (Address) *St. Morris, Ida*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death.....yrs.....mos.....days

In the

State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Plummer, Ida

DATE OF BURIAL

March 20 1922

20. UNDERTAKER

W. J. J. Plummer

ADDRESS

Plummer,

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

1. PLACE OF DEATH.

County of Benevolah
City of Benevolah

Registration District No. 31
Primary Registration District No. _____
(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Nancy Prosper

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 37476Registered No. 49

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

7.

4. COLOR OR RACE

Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH.

(Month) _____ (Day) _____ (Year) 1907

7. AGE

14 Yrs. 8 Mos. 14 ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

None

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Thomas Prosper

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Mary Joseph

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Nich Lijohn

(Address)

Benevolah Idaho

15.

Filed March 7 1922

J. L. Bikan
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 5 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 5 1921, to March 5 1922, that I last saw her alive on Feb 26 1922, and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. Barkman M. D.

19 (Address) Benevolah

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Benevolah Idaho

3/7 1922

20. UNDERTAKER

ADDRESS

J. Falev

Benevolah

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 31
County of Bennett Primary Registration District No. _____
City of Bennett (No. _____ St.)File No. 237477Registered No. 1If death occurs away from
usual residence, give facts
called for under special
information.

2. FULL NAME

Joseph Dunstan MorrellIf death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.M. Indian Infant
(Write the word.)

6. DATE OF BIRTH.

March 16 1922
(Month) (Day) (Year)

7. AGE

Yrs. 1 Mos. 11 ds.
IF LESS than 1 day
how many hrs. or
min. 2

8. OCCUPATION

(a) Trade, profession or
particular kind of work...
(b) General nature of in-
dustry, business, or estab-
lishment in which employ-
ed (or employer)...

9. BIRTHPLACE

(State or Country) Bennett, Ida10. NAME OF
FATHERJohn Morrell11. BIRTHPLACE
OF FATHER(State or Country) Wash.12. MAIDEN NAME
OF MOTHERAngelina Guinanose13. BIRTHPLACE
OF MOTHER(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Morrell
(Address) Bennett, Ida

15.

Filed 4/22 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 27 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

4/10 1922, to 4/16 1922that I last saw him alive on 4/16 1922and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia(Duration) Yrs. mos. 14 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Fred Barbeau M. D.4/22 1922 (Address) Bennett, Ida*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)At place In the
of death....yrs....mos....days State....yrs....mos....daysWhere was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bennett, Ida 4/22 1922

20. UNDERTAKER

ADDRESS

J. Falcon Bennett

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS
should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement
of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH Renewal, MAINE
County of Renewal Registration District No. 31
City of Landers Primary Registration District No. _____
(No. _____) St. _____

File No. 137478
Registered No. 50

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles Freemont Rhodes

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH.

March 28 1886
(Month) (Day) (Year)

7. AGE

66 Yrs. 23 Mos. _____ ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min. 2)

8. OCCUPATION

(a) Trade, profession or particular kind of work... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country) Ohio

10. NAME OF FATHER

John Rhodes

11. BIRTHPLACE OF FATHER

(State or Country) Penn.

12. MAIDEN NAME OF MOTHER

Mary Young

13. BIRTHPLACE OF MOTHER

(State or Country) Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. L. Schulerust

(Address) Tehwa Wash.

15.

Filed 4/22 1922

J. E. Bihan
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 20 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 191____ to _____ 191____, that I last saw h. _____ alive on _____ 191____, and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Heart failure

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

19 (Address) _____

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Tehwa

4/23 1922

20. UNDERTAKER

ADDRESS

E. L. Schulerust

Tehwa, Wash.

1. PLACE OF DEATH

County of Benevolence
City of Sumner

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED CERTIFICATE OF DEATH

Registration District No. 32
Primary Registration District No. 2049
BUREAU OF VITAL STATISTICSState of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37479
Registered No. 2

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)6. DATE OF BIRTH Sept 4 1886
(Month) (Day) (Year)7. AGE 37 Yrs. 8 Mos. 10 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)Logger

9. BIRTHPLACE

(State or Country)

Wis

10. NAME OF FATHER

Joseph Norton

11. BIRTHPLACE OF FATHER

(State or Country)

Mo.

12. MAIDEN NAME OF MOTHER

Idea Cross

13. BIRTHPLACE OF MOTHER

(State or Country)

Wis.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm J H Norton
(Address) St. Maries15. Filed April 15 1922 H E Hunt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 14 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19. to 19.
that I last saw him alive on April 14 1922
and that death occurred on the date stated above, at 1:40 PM,

The CAUSE OF DEATH* was as follows:

Was working on landing, breaking
Railway of logs, was struck with
log and killed instantly.
Statement of Washington B. White who was
working (duration) time 10 mos. ds.Contributory
(Secondary)(Duration) yrs. mos. ds.
(Signed) H. G. Alcorn, Coroner
Benevolence Co. Ida.4/15 1922 (Address) St. Maries, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Reshtigo Wis19

20. UNDERTAKER

ADDRESS

H E Hunt CoSt. Maries

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bear River
City of St. MariesRegistration District No. 32Registration District No. 2049(No. 32, St.)File No. 37480Registered No. 20

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Louella Laura Powell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female White

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Jan. 21 1920
(Month) (Day) (Year)

7. AGE

2 Yrs. 3 Mos. 18 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. X
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Archie C. Powell

11. BIRTHPLACE OF FATHER

(State or Country) Wash.

12. MAIDEN NAME OF MOTHER

Laura Sichelstead

13. BIRTHPLACE OF MOTHER

(State or Country) Mont.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Archie C. Powell(Address) St. Maries

15.

Filed April 11 1922H. E. Hunt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 10 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar 20 1922 to Apr 10 1922
that I last saw h. a alive on Apr 10 1922
and that death occurred on the date stated above, at 1 P M.

The CAUSE OF DEATH* was as follows:

Pneumonia(Duration) Yrs. 2 mos. 2 ds.Contributory
(Secondary)(Duration) Yrs. 12 mos. 12 ds.(Signed) A. S. Platt

M. D.

4/11 1922 (Address) St. Maries, Id.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. 2 mos. 2 days. In the State Yrs. 2 mos. 2 days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Woodlawn Ceme.

DATE OF BURIAL

4/11 1922

20. UNDERTAKER

H. E. Hunt Co

ADDRESS

St. Maries

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Benevolence
City of St. MariesRegistration District No. 39Primary Registration District No. 2049(No. St. Maries Hospital St.)File No. 37481Registered No. 19

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William Beresford

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

6. DATE OF BIRTH

April (Month) 24 (Day) 1904 (Year)

7. AGE

17 Yrs. 11 Mos. 14 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Bank messenger

(b) General nature of industry, business or establishment in which employed (or employer).

Bestingway on P.P. at time of death

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

G.W. Beresford

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Ada Sadler

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

C.A. Robins M.D.
St. Maries, Ida

(Address)

15.

Filed Apr 10 1922 H.E. Hunt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April (Month) 9 (Day) 1922 (Year)17. I HEREBY CERTIFY, That I attended deceased from April 9, 1922 to April 9, 1922 that I last saw him alive on April 9, 1922 and that death occurred on the date stated above, at 12-20 A.M.
The CAUSE OF DEATH* was as follows:Run over by part of freight train which he had boarded - Accidental

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

C.A. Robins M.D.
4/10/22 (Address) St. Maries, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

Millicent - Alberta, Canada

19. PLACE OF BURIAL OR REMOVAL

Brooks, Alberta

DATE OF BURIAL

Apr 19, 22

20. UNDERTAKER

H.E. Hunt & Co

ADDRESS

St. Maries

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Benevolence
City of St. MariesRegistration District No. 32Primary Registration District No. 2049File No. 37482Registered No. 8

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Sidney Stork

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male whitesingle
(Write the word.)

6. DATE OF BIRTH

Feb 6 1922
(Month) (Day) (Year)

7. AGE

10 Yrs. 2 Mos. 2 ds.IF LESS than 1 day
how many.....hrs.
or.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Schoolboy

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Fred Stork

11. BIRTHPLACE OF FATHER

(State or Country)

Kansas

12. MAIDEN NAME OF MOTHER

Prudence Smith

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Fred Stork

(Address)

St. Maries

15.

Filed April 8 1922HE Hunt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 8 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Apr 8 1922 to Apr 8 1922that I last saw him alive on Apr 8 1922and that death occurred on the date stated above, at 6:15 A.M.

The CAUSE OF DEATH* was as follows:

Acute nephritis(Duration) Yrs. mos. 5 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

C.B. Smith

M. D.

Apr 8 1922 (Address) St. Maries, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Woodlawn

DATE OF BURIAL

4/9 1922

20. UNDERTAKER

HE Hunt Co

ADDRESS

St. Maries

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bennett
City of St. MariesRegistration District No. 32Primary Registration District No. 2049File No. 37483Registered No. 17

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Evelyn May Gaskill

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

6. DATE OF BIRTH

June (Month) 15 (Day) 1913 (Year)

7. AGE

8 Yrs. 9 Mos. 22 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country)

St. Maries Idaho

10. NAME OF FATHER

Francis A Gaskill

11. BIRTHPLACE OF FATHER

(State or Country)

Indiana

12. MAIDEN NAME OF MOTHER

Elizabeth Surope

13. BIRTHPLACE OF MOTHER

(State or Country)

Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Francis A Gaskill

(Address)

St. Maries

15.

Filed

April 8 1922 H. E. Hunt

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April (Month) 7 (Day) 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar 28 1922 to Apr 7 1922that I last saw him alive on Apr 6 1922and that death occurred on the date stated above, at 1:30 am

The CAUSE OF DEATH* was as follows:

Endocarditis(Duration) Yrs. mos. one ds.
Contributory (Secondary) Scarlet fever(Duration) yrs. mos. 1 mos. 24 ds.(Signed) O. W. Platt M. D.Apr 1922 (Address) St. Maries, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Woodlawn

DATE OF BURIAL

Apr 9 1922

20. UNDERTAKER

O. H. M. Wagon

ADDRESS

RECEIVED CERTIFICATE OF DEATH

1. PLACE OF DEATH
 County of Bennett Registration District No. 32
 City of St. Maries Primary Registration District No. 2049 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Luke Lova

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 37484
 Registered No. 16

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED unmarried
 (Write the word.)

6. DATE OF BIRTH

Jan. 7 1858
 (Month) (Day) (Year)

7. AGE

72 Yrs. 2 Mos. 27 ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Mich.

10. NAME OF FATHER

John Lova

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Harriet Johnson

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Harry Lova
Calgar

15.

Filed

April 8 1922

H. E. Hunt
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 6 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended, deceased from Apr. 6 1922, to Apr 6 1922
 that I last saw him alive on Apr 6 1922
 and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

General Senility

(Duration) 3 Yrs. 3 mos. 3 ds.
 Contributory (Secondary) Cerebral Sclerosis

(Duration) 3 yrs. 3 mos. 3 ds.
 (Signed) C. E. Hunt M. D.

Apr 7 1922 (Address) St. Maries, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Woodlawn

4/9 1922

20. UNDERTAKER

ADDRESS

H. E. Hunt Co

St. Maries

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of SchoshoneCity of Arroyo

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Albert B. Soder

CERTIFICATE OF DEATH

Registration District No. 3Primary Registration District No. 2041(No. 2)

(St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 37485Registered No. 22

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

35 Yrs. apparent Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Gen Laborer

(b) General nature of industry, business or establishment in which employed (or employer).

Cm & St P. & R.

9. BIRTHPLACE

(State or Country)

New York State

10. NAME OF FATHER

Charles G. Soder

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Lusia Stattemeyer

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Joseph C. Soder

(Address)

822 Jackson St. Seattle, Wn

15.

Filed

April 18, 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Apr 13 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Apr 13 1922 to Apr 13 1922that I last saw him alive on 19and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Rock slide on Eagle Id. striking deceased on back causing internal hemorrhage also legs by broken

(Duration) Yrs. mos. ds.

Contributory
(Secondary)Loss of blood.

(Duration) Yrs. mos. ds.

X (Signed) A. G. Braden, J.P. M. D.4/18 1922 (Address) Arroyo, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Peterson Ave.19

20. UNDERTAKER

ADDRESS

Winters & Winters

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

37486

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Registration District No.

Registration District No.

St.)

File No.

Registered No.

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many hrs.

or 20 min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF
FATHER11. BIRTHPLACE
OF FATHER

(State or Country)

12. MAIDEN NAME
OF MOTHER13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw h alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

RECEIVED

APR 21 1922

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37487

1. PLACE OF DEATH *Bright* Registration District No. *116*
County of *Bright* Primary Registration District No. *2150*
City of *Aberdeen* (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Peter Junk

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WID-OWED OR DIVORCED *Married*
(Write the word.)

6. DATE OF BIRTH *Dec 8 1850*
(Month) (Day) (Year)

7. AGE *71* Yrs. *3* Mos. *13* ds. IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Farmer

9. BIRTHPLACE

(State or Country)

Russia

10. NAME OF FATHER

Jacob Junk

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown March 22 1922

12. MAIDEN NAME OF MOTHER

Anna Classen

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

H. C. N. ike

(Address)

Aberdeen, Idaho

15.

Filed *March 22 1922* *Wm. C. N. ike*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 21 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *March 20 1922* to *March 21 1922* that I last saw him alive on *March 21 1922* and that death occurred on the date stated above, at *4:45 P.M.*

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) Yrs. _____ mos. *4* ds.
Contributory (Secondary) *Acute nephritis*

(Duration) Yrs. _____ mos. *1* ds.

(Signed) *M. C. N. ike* M. D.(Address) *Aberdeen, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Memorial Cemetery Aberdeen, Idaho *March 24 1922*

20. UNDERTAKER ADDRESS

H. C. N. ike *Aberdeen, Idaho*

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 37488
Registered No. 37

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH Blackfoot Registration District No. 121
County of Bingham Primary Registration District No. 2194
City of Blackfoot (No. Idaho, Isaac Boyle St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hattie Gardner

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE Caucasian 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH

April 28 1879
(Month) (Day) (Year)

7. AGE

42 Yrs. 11 Mos. ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Housewife

9. BIRTHPLACE

(State or Country)

Indiana

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) By - Martha E. High - Blackfoot
(Address) Blackfoot Idaho15. Filed 3-29-22 Mr. Walter E. P. P.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 27 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Nov. 30 1921 to March 27 1922, that I last saw her alive on March 27 1922, and that death occurred on the date stated above, at 1 P. M. The CAUSE OF DEATH* was as follows:
Paresis(Duration) Yrs. 5 mos. ds.
Contributory (Secondary) Specific(Duration) Yrs. 7 mos. ds.
(Signed) W. J. Brown M. D.3/28 1922 (Address) Blackfoot

*State the Disease Causing Death; or in deaths from violent causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. 3 mos. 27 days. In the State 2 yrs. mos. daysWhere was disease contracted if not at place of death? UnknownFormer or usual residence Arco, Idaho

19. PLACE OF BURIAL OR REMOVAL

Arco Idaho

20. UNDERTAKER

Exp. Bur. Blackfoot Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH

County of Bingham
City of Blackfoot

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED

CERTIFICATE OF DEATH

APR 1922

Registration District No. 121Primary Registration District No. 2194

STATISTICS

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 37489Registered No. 37489

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

Caucasian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

March
(Month)26
(Day)1892
(Year)

7. AGE

29 Yrs.11 Mos.18 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Actress

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

None given

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Asylum Records
By Martha E. High - Bookkeeper
(Address) Blackfoot, Idaho

15.

Filed March 19 1922 Mrs Thelen E. Falcus

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March
(Month)18
(Day)1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 6 1919 to March 18 1922that I last saw her alive on March 18 1922and that death occurred on the date stated above, at 2 A.M.

The CAUSE OF DEATH* was as follows:

Exhaustion of Paresis(Duration) 7 Yrs. 19 mos. _____ ds.Contributory
(Secondary)(Duration) 3 yrs. _____ mos. _____ ds.(Signed) C. J. Cooney, D.3.18.1922 (Address) Blackfoot, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 2 yrs. 11 mos. 18 days. In the State 6 yrs. _____ mos. _____ daysWhere was disease contracted if not at place of death? Don't knowFormer or usual residence None given

19. PLACE OF BURIAL OR REMOVAL

Asylum Cemetery

DATE OF BURIAL

Mar. 19 1922

20. UNDERTAKER

J. T. Griffith

ADDRESS

Blackfoot, Ida

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **37490**
Registered No. **41**

1. PLACE OF DEATH

County of **Bingham** Registration District No. **121**
City of **Blackfoot** Primary Registration District No. **2194** St.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Roe Harris

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **Caucasian** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Married**
(Write the word.)

6. DATE OF BIRTH

877
(Month) (Day) (Year)

7. AGE

48 Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Unknown

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Martha E. High - from Asylum Records**
(Address) **Blackfoot, Idaho**

15.

Filed **March 3 1922** **Mr. Walter E. Pate**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 1 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Mar. 13 1919** to **Mar. 1 1922**, that I last saw her alive on **Feb. 28 1922**, and that death occurred on the date stated above, at **4:30 A.M.**

The CAUSE OF DEATH* was as follows:

Exhaustion of Incubation

(Duration) Yrs. mos. ds.

Contributory (Secondary) **Psychosis Depressive Chronic Schizophrenia**

(Duration) Yrs. mos. ds.

(Signed) **W. E. Pate** M.D.

3-1-22 (Address) **Blackfoot, Idaho**

*State the Disease Causing Death; or in deaths from Violence, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death **24** yrs. **1** mos. **4** days. In the State **24** yrs. **1** mos. **4** days

Where was disease contracted if not at place of death?

Former or usual residence **Victor, Idaho**

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Asylum Cemetery

Mar. 3 1922

20. UNDERTAKER

ADDRESS

J. A. Griffith

Blackfoot, Idaho

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

RECEIVED CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

No. 12125

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

2-15-1922 19 to Mar 3 1922

that I last saw him alive on Mar 3 1922

and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Coronary thrombosis

Contributory

(Duration) Yrs. mos. ds.

(Duration) yrs. mos. ds.

(Signed) J. B. Davis M. D.

1922 (Address) Bluffton Id.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bingham
City of ShelleyRegistration District No. 121Primary Registration District No. 2117

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary Marinda HansenFile No. 37492Registered No. 43

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Female

4. COLOR OR RACE

Cauc

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

Aug. 15 1894
(Month) (Day) (Year)

7. AGE

27 Yrs. 6 Mos. 16 ds.
IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Home wife
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Wah.

10. NAME OF FATHER

Fred Johnson

11. BIRTHPLACE OF FATHER

(State or Country) Dennmark

12. MAIDEN NAME OF MOTHER

Martha Andersen

13. BIRTHPLACE OF MOTHER

(State or Country) Wah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Estlin Hansen(Address) Shelley, Idaho,15. Filed March 6 1922 Mrs. Helen E. Pattee

Local Registrar

16. DATE OF DEATH

March 3 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Feb 26 1922 to March 3 1922that I last saw him alive on March 2 1922
and that death occurred on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH* was as follows:

Pertussis(Duration) Yrs. mos. 0 ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) F. J. Phelan M. D.1922 (Address) Shelley, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Shelley Cemetery

DATE OF BURIAL

March 6 1922

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 121
County of Bingham Primary Registration District No. 2144
City of Moskelland St.)File No. 37493Registered No. 44

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William Christensen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

MaleWhiteSingle

(Write the word.)

6. DATE OF BIRTH

March41922

(Month)

(Day)

(Year)

7. AGE

Yrs.

Mos.

ds.

IF LESS than 1 day

how many hrs.

30 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

William H. Christensen

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Elsie Richardson

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

C. H. Leavitt

(Address)

Moskelland

15.

Filed March 4 1922 Mrs. Helen E. Farnham

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March41922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 4 1922, to March 4 1922that I last saw him alive on March 4 1922and that death occurred on the date stated above, at 4:59 A.M.

The CAUSE OF DEATH* was as follows:

Premature birth
7th month

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

W. W. Beck M. D.3/4 1922 (Address) Blackfoot, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Moskelland Cem.

19.....

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bingham
City of MorelandRegistration District No. 121
Primary Registration District No. 2194
(No. 121 St.)File No. 37494
Registered No. 48

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

VITAL
STATISTICSElsie Christensen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female WhiteMarried
(Write the word.)

6. DATE OF BIRTH

April 29 1888
(Month) (Day) (Year)

7. AGE

10
33 Yrs. 23 Mos. 6 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Housewife

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Thomas G Richardson

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Sarah Luella Dalton

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

T G Richardson
Homer Ida

(Address)

15.

Filed March 7 1922 at Moreland, Idaho
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 6 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from April 28 1922 to March 6 1922 that I last saw her alive on March 6 1922 and that death occurred on the date stated above, at 10:30 A.M.
The CAUSE OF DEATH* was as follows:Pneumonia(Duration) Yrs. mos. 3 ds.Contributory (Secondary) Influenza + miasma(Duration) yrs. mos. 6 ds.(Signed) W W Beck M. D.3/7 1922 (Address) Blackfoot, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Moreland, Id.

19

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 37496
Registered No. 47

1. PLACE OF DEATH

County of Bingham
City of MorelandRegistration District No. 121Primary Registration District No. 2194
(No. 108 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Melissa Lowe

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Married
(Write the word.)6. DATE OF BIRTH February 23 888
(Month) (Day) (Year)7. AGE 34 Yrs. 0 Mos. 16 ds.
IF LESS than 1 day
how many..... hrs.
or..... min.?8. OCCUPATION Housewife

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE Collinston, Utah
(State or Country)10. NAME OF FATHER Calvin wheeler11. BIRTHPLACE OF FATHER Maine
(State or Country)12. MAIDEN NAME OF MOTHER Marion Hutchinson13. BIRTHPLACE OF MOTHER Spanish Fork, Utah
(State or Country)14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) JW Lowe
(Address) Moreland15. March 11 1922 Mr Walter E. Paton
Filed Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 9th 22
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Mar 3 1922 to Mar 9 1922
that I last saw her alive on Mar 9 1922
and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia(Duration) Yrs. mos. 4 ds.
Contributory (Secondary) Influenza(Duration) yrs. mos. 7 ds.(Signed) Joseph B Davis M. D.3/11 1922 (Address) Blackfoot Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Moreland DATE OF BURIAL 3/12 192220. UNDERTAKER E. E. Gale ADDRESS Blackfoot.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of BinghamCity of BeyfordRegistration District No. 121Primary Registration District No. 2194(No. Maria Antonia

St.)

File No. 37497Registered No. 48

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mrs. Maria Antonia

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

32

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Housewife

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Mexico

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

Mexico

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Mexico

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Blackfoot, Idaho

15.

Filed

Mar 10 1922Mrs. Helen E. Fisher
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 15
(Month) (Day)1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar 4 1922 to Mar 14 1922that I last saw her alive on Mar 14 1922and that death occurred on the date stated above, at 3 A.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia(Duration) Yrs. mos. 5 ds.Contributory
(Secondary)(Duration) yrs. mos. 10 ds.

(Signed)

Beyford

M. D.

1922 (Address)

Beyford, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Grove Cemetery1922

20. UNDERTAKER

ADDRESS

J. A. Archibald

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 37498
Registered No. 19

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

Registration District No. 121County of BinghamPrimary Registration District No. 2194City of Wapello

(No.)

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ezra C. Folkman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDMaleWhiteMarried (Write the word.)

6. DATE OF BIRTH

March11884

(Month)

(Day)

(Year)

7. AGE

38 Yrs.0 Mos.5 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Farmer

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho10. NAME OF
FATHERJeppa Folkman11. BIRTHPLACE
OF FATHER

(State or Country)

Denmark12. MAIDEN NAME
OF MOTHERAnna Serena Anderson13. BIRTHPLACE
OF MOTHER

(State or Country)

Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

March 17 1922Mr. Helen E. Folkman

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March16th22

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 11 1922 to March 16 1922that I last saw him alive on March 16 1922and that death occurred on the date stated above, at 9 a M.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration)

Yrs.

mos.

10 ds.Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

W. W. Beck M. D.3/17 1922(Address) Blackfoot, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

yrs.

mos.

In the

days

State

yrs.

mos.

days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Chaterfield, IdahoOn arrival

20. UNDERTAKER

ADDRESS

E. A. EgliBlackfoot, Idaho

CERTIFICATE OF DEATH

1. PLACE OF DEATH

Registration District No. 121
 County of Bingham Primary Registration District No. 2174
 City of Blackfoot BUREAU (No. STATISTICS) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

STATISTICS

Charles Braier

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 37499Registered No. 5

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED

Male negro Single
 (Write the word.)

6. DATE OF BIRTH

1842
 (Month) (Day) (Year)

7. AGE

80 Yrs. Mos. ds.
 IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

Laborer

9. BIRTHPLACE

(State or Country) S. Carolina

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

according to Weyburn Ricard
 (Informant) Martha C. High

(Address) Blackfoot, Idaho

15. March 17 1922 Mrs. Walter E. Pat.
 Filed Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 16 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar 2, 1922, to March 16 1922,

that I last saw him alive on March 16 1922,

and that death occurred on the date stated above, at 4:20 P.M.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Congestion

(Duration) Yrs. mos. ds.
 Contributory Arteriosclerosis
 (Secondary)

(Duration) Yrs. mos. ds.
 (Signed) Carl H. Brown M.D.

3-16-1922 (Address) Blackfoot, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. 14 days. In the State 3 yrs. mos. days

Where was disease contracted if not at place of death? Unknown

Former or usual residence Weiser, Idaho

19. PLACE OF BURIAL OR REMOVAL

Asylum Cemetery Bft. Mar. 17 1922

20. UNDERTAKER

J. A. Griffith Blackfoot, Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bingham
City of Blackfoot, IdaRegistration District No. 121
Primary Registration District No. 2194
(No. St.)File No. 37500
Registered No. 52

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William Leon Young

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male White Single (Write the word.)

6. DATE OF BIRTH

August 5 1921
(Month) (Day) (Year)

7. AGE

7 Yrs. 18 Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).None

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

William Leon Young

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Idanah Jones

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Kathleen Jones

(Address)

Moreland Idaho

15.

Filed

March 23, 22 Moreland E. Paton
19 22 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 23 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar 10 1922, to March 23 1922
that I last saw him alive on March 13 1922
and that death occurred on the date stated above, at 8:30 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia(Duration) Yrs. mos. 17 ds.Contributory
(Secondary)Influenza

(Duration) yrs. mos. ds.

(Signed)

W. W. Beck M. D.3/23 1922 (Address) Blackfoot, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Moreland - Cem 3 23 1922

20. UNDERTAKER

ADDRESS

E. H. Egli Blackfoot

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of CinghamCity of Blackfoot

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No. 151Primary Registration District No. 2194(No. 151 St.)State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 37591Registered No. 37591

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

May 31 1921
(Month) (Day) (Year)

7. AGE

9 Yrs. 15 Mos. 25 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

None

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

William H. Horton

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Hattie B. Black

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. H. Horton

(Address)

Pringle Idaho

15.

Filed

March 26 1922 W. H. Horton E. P. Palmer

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 25 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 23 1922 to March 25 1922
that I last saw h. _____ alive on March 23 1922
and that death occurred on the date stated above, at 2 A.M.
The CAUSE OF DEATH* was as follows:Influenza(Duration) _____ Yrs. _____ mos. 3 ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W. W. Beck M. D.3/25 1922 (Address) Blackfoot, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Summit Cemetery Mar 27 1922

20. UNDERTAKER ADDRESS

Ext. Beck Blackfoot

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37502
Registered No. 34

1. PLACE OF DEATH

County of Bingham
City of Blackfoot

Registration District No. 121Primary Registration District No. 2194(No. Casylum St.)

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Ebbie Elliott

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

Caucasian

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

married
(Write the word.)

6. DATE OF BIRTH

January 23 1894
(Month) (Day) (Year)

7. AGE

28 Yrs. 2 Mos. 1 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work

(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Heath, Idaho

10. NAME OF
FATHER

James Ruit

11. BIRTHPLACE
OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME
OF MOTHER

Unknown

13. BIRTHPLACE
OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Martha E. High - Bookkeeper

(Address) Blackfoot, Idaho

15.

Filed 3-27 1922 Miss Helen C. Pater

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 24 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec. 23 1920, to March 24 1922,

that I last saw him alive on March 24 1922,

and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Oedema of lungs

(Duration) Yrs. mos. 1 1/2 ds.

Contributory (Secondary) Valvular lesion of heart

(Duration) Yrs. mos. 1 1/2 ds.

(Signed) C. J. Cooper M. D.

3-25-22 (Address) Blackfoot, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death 1 yrs. 3 mos. 1 days. In the State 28 yrs. 2 mos. 1 days

Where was disease contracted if not at place of death? Unknown

Former or usual residence Heath, Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Casylum Cemetery Mar. 27 1922

20. UNDERTAKER

ADDRESS

J. A. Griffith Blackfoot, Ida.

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH *Blackfoot* 21 1922
 County of *Bingham* Registration District No. *121*
 City of *Blackfoot* (No. *R. H. 203* St.)
 Primary Registration District No. *2194*

File No. *37503*
 Registered No. *58*

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Sarah Lucile Scott

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED

Female white Single
 (Write the word.)

6. DATE OF BIRTH

march 25 1922
 (Month) (Day) (Year)

7. AGE

Yrs. *2* Mos. ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

Infant

9. BIRTHPLACE

(State or Country) *Idaho*

10. NAME OF FATHER

David M. Scott

11. BIRTHPLACE OF FATHER

(State or Country) *Utah*

12. MAIDEN NAME OF MOTHER

Vilale Hugovne

13. BIRTHPLACE OF MOTHER

(State or Country) *Utah*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

D and M. Scott

(Address)

Blackfoot R. 7 D. 3

15. Filed

*March 27 1922**M. H. C. Paine*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

mch 27 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

mch 25 1922 to *mch 27 1922*
 that I last saw him alive on *mch 27 1922*

and that death occurred on the date stated above, at *10 P.M.*

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

H. J. Simmons

3/28 1922 (Address) *Blackfoot Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Samuel cemetery *3/29 1922*

20. UNDERTAKER

ADDRESS

Ed Park *Blackfoot*

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of BinghamCity of Blackfoot

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No. 121Primary Registration District No. 3194State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 37504Registered No. 584

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

Caucasian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

about-

(Month)

(Day)

1866
(Year)

7. AGE

about56 Yrs.

Mos.

ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Farmer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Techi, Utah

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

according to testimony of records

(Address)

Martha E. High - BlackfootBlackfoot, Idaho

15.

Filed

March 28, 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 27

(Month)

(Day)

1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

January 3, 1920, to March 27, 1922that I last saw him alive on March 27, 1922and that death occurred on the date stated above, at 8:30 P.M.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Congestion

(Duration)

Yrs.

mos.

ds.

Contributory

(Secondary)

Valvular Heart Trouble

(Duration)

Yrs.

mos.

ds.

(Signed)

Carl Hoover

M. D.

3:27 1922 (Address) Blackfoot, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 2 yrs. 2 mos. 24 days. In the State 40 yrs. mos. days

Where was disease contracted if not at place of death?

Unknown

Former or usual residence

Moore, Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Coylum CemeteryMar. 28, 1922

20. UNDERTAKER

ADDRESS

J. A. GriffithsBlackfoot, Idaho

1. PLACE OF DEATH

County of *Bern & Lyon*City of *Blackfoot*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED CERTIFICATE OF DEATH

Registered District No. *121*Primary Registration District No. *2194*(No. *3108* St.)State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *37505*Registered No. *58*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED*Male white Single*
(Write the word.)

6. DATE OF BIRTH

March 29 1922
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or *30* min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).*Farmer*

9. BIRTHPLACE

(State or Country)

Blackfoot Idaho

10. NAME OF FATHER

M. V. Van Seters

11. BIRTHPLACE OF FATHER

(State or Country)

Hullond

12. MAIDEN NAME OF MOTHER

Eva Adler

13. BIRTHPLACE OF MOTHER

(State or Country)

Hullond

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

*M. V. Van Seters
Groveland*

15.

Filed

Mar 30 1922 Mrs. Thales E. Futer

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 29 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 29 1922 to *March 29 1922*that I last saw *him* alive on *March 29 1922*and that death occurred on the date stated above, at *12* M.

The CAUSE OF DEATH* was as follows:

Peritonitis lunch 6 1/2 mo

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

*F. W. M. D.**3/29 1922* (Address) *Blackfoot Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Harland Ida**Mar 30 1922*

20. UNDERTAKER

ADDRESS

M. V. Van Seters

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Blaine
City of Hailey
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 57
Primary Registration District No. 2022
(8022) St.)

File No. 37506
Registered No. 15

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Samuel Hamilton Allen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH Dec 12 1852
(Month) (Day) (Year)

7. AGE 69 Yrs. 3 Mos. 11 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Mine Supt & Owner
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE Maine
(State or Country)

10. NAME OF FATHER Jas. Allen

11. BIRTHPLACE OF FATHER Ireland
(State or Country)

12. MAIDEN NAME OF MOTHER Margaret Hamilton

13. BIRTHPLACE OF MOTHER Ireland
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. H. Allen
(Address) Hailey, Idaho

15. Filled 4-1 1922 R. H. Wright
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Wright
March 23 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 9 1922 to Mar-23 1922
that I last saw him alive on Mar-22 1922
and that death occurred on the date stated above, at 8 P M.

The CAUSE OF DEATH* was as follows:
Chronic Articular Rheumatism

(Duration) 3 Yrs. mos. ds.
Contributory (Secondary) Edema of lungs
(Duration) yrs. mos. ds. 10
(Signed) Robert H. Wright M. D.
3/24 1922 (Address) Hailey, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Hailey, Ida DATE OF BURIAL 3/25 1922
20. UNDERTAKER R. D. Harris ADDRESS Hailey

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Blaine
City of HaileyRegistration District No. 57
Primary Registration District No. 2022
(No. 57 St.)State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37507
Registered No. 96

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Henry Richard Plughoff

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married

(Write the word.)

6. DATE OF BIRTH

Feb 16 1851
(Month) (Day) (Year)

7. AGE

66Yrs. 1 Mos. 8 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Merchant

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Maryland

10. NAME OF FATHER

William Plughoff

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Sarah E. Voss

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Frank R. Plughoff

(Address)

Hailey, Ida

15.

Filed 4-1 1922 R. H. Wright

Local Registrar

MEDICAL CERTIFICATE OF DEATH

Brook

16. DATE OF DEATH

March 23 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 25 1922, to March 23 1922,
that I last saw him alive on March 23 1922,
and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency
Cardiac Dilatation of left
Ventricle

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

L. E. Brock

M. D.

3/26 1922 (Address) Hailey, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Hailey, Ida

DATE OF BURIAL

3-26 1922

20. UNDERTAKER

R. D. Harris

ADDRESS

Hailey

CERTIFICATE OF DEATH

1. PLACE OF DEATH ✓

County of BlaineCity of Hailey

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 57Primary Registration District No. 2022(No. 102)

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 37508Registered No. 77

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Bennett

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

(Year)

7. AGE

61

Yrs.

Mos.

ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Miner

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Jack Harper
Hailey, Ida.

15.

Filed

4-11922R. H. Wright
Local Registrar

MEDICAL CERTIFICATE OF DEATH

Brook

16. DATE OF DEATH

March 24
(Month) (Day)1922
(Year)17. I HEREBY CERTIFY, That I attended deceased from Feb 25 1922, to March 24 1922, that I last saw him alive on March 24 1922, and that death occurred on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis of the lungs

(Duration) Yrs. mos. ds.

Contributory
(Secondary)Bronchitis

(Duration) yrs. mos. ds.

(Signed)

L. F. Brook M. D.3/25, 1922 (Address) Hailey, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Hailey, Ida

DATE OF BURIAL

3-26 1922

20. UNDERTAKER

R. D. Harris

ADDRESS

Hailey

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

Registration District No. 57
 County of Blaine Primary Registration District No. 2022
 City of Hailey (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ide May Smith

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 37509Registered No. 10

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single

(Write the word.)

6. DATE OF BIRTH

Jan. 6 1911
 (Month) (Day) (Year)

7. AGE

11 Yrs. Mos. ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Abner Smith

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Annie Bardon

13. BIRTHPLACE OF MOTHER

(State or Country)

New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Mrs. Annie Coop.
Hailey, Id.

15.

Filed 4-1 1922 R. H. Wright

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 3 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan-5 1922 to Mar-3 1922
 that I last saw her alive on Mar-2 1922
 and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Duration) 2 Yrs. mos. ds.

Contributory (Secondary)

Influenza

(Duration) yrs. mos. 4 ds.

(Signed)

Robert H. Wright M. D.
3/4 1922 (Address) Hailey, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Hailey, Ida

DATE OF BURIAL

Mar-5 1922

20. UNDERTAKER

Stottan

ADDRESS

Hailey

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Blaine Registration District No. 57
 City of Hailey (No. 2022) St. Idaho

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

J. B. Schaub

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 37510

Registered No. 9

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

single
(Write the word.)

6. DATE OF BIRTH

about 1857
(Month) (Day) (Year)

7. AGE

65 Yrs. about Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

Miner

9. BIRTHPLACE

(State or Country)

Wisconsin

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

L. E. Quigg
Hailey Idaho

(Address)

15.

Filed 4-1 19 22 R. H. Wright
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

about
March 2 19 22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19
that I last saw him alive on 19
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH was as follows:

Coronary Arteriosclerosis
Senile

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Robert E. Lyle M. D.
Hailey Idaho (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Honey Creek, Wis

DATE OF BURIAL

19

20. UNDERTAKER

R. D. Harris

ADDRESS

Hailey, Id

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Blaine
City of BellevueRegistration District No. 57Primary Registration District No. 2022(No. 1026 St.)File No. 37511Registered No. 11

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Joseph D. Bergin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDMarried

(Write the word.)

6. DATE OF BIRTH

January 6 1842
(Month) (Day) (Year)

7. AGE

80 Yrs. 1 Mos. 29 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Farmer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ireland

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Mrs. M. M. Bergin

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Alphonsus J. Bergin

(Address)

Bellevue, Id.

15.

Filed

3 - 30 1922R. H. Wright

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

No M. S.
March 5 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19....., to 19.....that I last saw h..... alive on.....19.....

and that death occurred on the date stated above, at.....M.

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Signed).....M. D.

19..... (Address).....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Bellevue

DATE OF BURIAL

Mar. 7 1922

20. UNDERTAKER

R. H. Wright

ADDRESS

Hailey

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Blaine*City of *Belleme*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No. *57*Primary Registration District No. *2022*

(No. 1000)

St.

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *37512*Registered No. *12*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

Jan 30 1895
(Month) (Day) (Year)

7. AGE

47 Yrs. *1* Mos. *15* ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

Farmer

9. BIRTHPLACE

(State or Country)

Nevada

10. NAME OF FATHER

Sam Wray Sr.

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Ester Isadora

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Rupert, Ida

15.

Filed *4-1**1922**R. H. Wright*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 8 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

*Mar 4 1922 to Mar 8 1922*that I last saw him alive on *Mar 8 1922*and that death occurred on the date stated above, at *7 P M*

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia(Duration) Yrs. mos. *5* ds.

Contributory (Secondary)

Influenza(Duration) yrs. mos. *8* ds.

(Signed)

*Robert H. Wright M. D.**3-9-22* (Address) *Hailey, Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental/Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Belleme, Ida

DATE OF BURIAL

Mar 12 1922

20. UNDERTAKER

R. D. Harris

ADDRESS

Hailey

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Blaine
City of BellemeRegistration District No. 57
Primary Registration District No. 2022
(No. _____) (St. _____)File No. 37513
Registered No. 13

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Fred. Bryden

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH

Oct. 29 1922
(Month) (Day) (Year)

7. AGE

17 Yrs. 17 Mos. _____ ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Warren Bryden

11. BIRTHPLACE OF FATHER

(State or Country) Nevada

12. MAIDEN NAME OF MOTHER

Elsie Grenfell

13. BIRTHPLACE OF MOTHER

(State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Elsie Martin(Address) Belleme, Ida

15.

Filed 4-1 1922 R. H. Wright
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Brook
Mar. 16 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from March 14 1922, to March 19 1922, that I last saw him alive on March 17 1922, and that death occurred on the date stated above, at 11 P.M. The CAUSE OF DEATH* was as follows:Lobar Pneumonia(Duration) _____ Yrs. _____ mos. 5 ds.Contributory Pulmonary Hemorrhage
(Secondary)(Duration) _____ yrs. _____ mos. 2 ds.(Signed) L. J. Brook M. D.3/18 1922 (Address) Hailey, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Belleme, Ida

DATE OF BURIAL

3/18 1922

20. UNDERTAKER

R. D. Harris

ADDRESS

Hailey

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Blaine Registration District No. 57
City of Lame Primary Registration District No. 2022
(No. Odell R. Murphy St.)File No. 37514
Registered No. 14

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Odell R. Murphy
Hainsworth (Baby)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)6. DATE OF BIRTH Dec 22 1921
(Month) (Day) (Year)7. AGE 2 Yrs. 27 Mos. 27 ds. IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)9. BIRTHPLACE
(State or Country) Gannett10. NAME OF FATHER G. R. Murphy11. BIRTHPLACE OF FATHER
(State or Country) Idaho12. MAIDEN NAME OF MOTHER Pearl Hainsworth13. BIRTHPLACE OF MOTHER
(State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H. Hainsworth
(Address) Gannett, Ida15. 4-1 19 22 R. H. Wright
Filed Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 21 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
.....19..... to19.....
that I last saw h..... alive on.....19.....
and that death occurred on the date stated above, at.....M.
The CAUSE OF DEATH* was as follows:(Duration)Yrs.....mos.....ds.
Contributory
(Secondary)(Duration)yrs.....mos.....ds.
B (Signed) E. S. B M. D.
2/19/22 (Address) Hailey, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Gannett, Ida DATE OF BURIAL 3/22/2220. UNDERTAKER R. D. Harris ADDRESS Hailey

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
APR 21 1922
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No.

Registration District No.

City of

2. FULL NAME

37515

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

M.

White

married
(Write the word.)

6. DATE OF BIRTH

7. AGE

68 Yrs 4 Mos 28 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

Printer

9. BIRTHPLACE

(State or Country)

Ind.

10. NAME OF FATHER

David Goss

11. BIRTHPLACE OF FATHER

(State or Country)

Ind.

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Mrs. Calvin Goss
Clarksfork, Ida.

15.

Filed

March 4 1922

John Larson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb.

15

1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY That I attended deceased from

Did not attend

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

NATURAL CAUSE.

Did not believe in physicians
Nephritis cause of death
(Diagnosis from symptoms)Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Floyd W. Wernicke, M. D.

3-1-1922 (Address) Sandpoint, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Clarksfork, Ida.

7/18 1922

20. UNDERTAKER

ADDRESS

B. H. Pugh, Sandpoint, Ida.

CERTIFICATE OF DEATH

37516

State of Idaho
BOARD OF HEALTH

Bureau of Vital Statistics

File No. 1

Registered No. 24

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

1. PLACE OF DEATH

County of Bonner

City of Hope

If death occurs away from
usual residence, give facts
called for under special
information.RECEIVED
APR 2 1922BUREAU OF VITAL
STATISTICS

2. FULL NAME

Laura Elaine Holliday

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

Single

6. DATE OF BIRTH

Jan 3 1922
(Month) (Day) (Year)

7. AGE

Yrs. Mos. 3 ds.

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of in-
dustry, business, or estab-
lishment in which em-
ployed (or employer)

Infant

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF
FATHER

Paul Holliday

11. BIRTHPLACE
OF FATHER

(State or Country)

Brookings, S. D.

12. MAIDEN NAME
OF MOTHER

Madge Morris

13. BIRTHPLACE
OF MOTHER

(State or Country)

Harris, Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Filed March 4 1922 John Larson
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 14 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Did not attend

that I last saw h..... alive on 191.....

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Pneumonia (Diagnosis
from report of nurse

(Duration) Yrs. mos. ds.

Contributory

(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

Floyd Wendell M. D.

3-1-1922 (Address) Sandpoint, Id.

*State the Disease Causing Death; in deaths from Violent
Causes, state (1) Means of Injury; and (2) whether Accidental,
Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place

In the

of death yrs. mos. days, State yrs. mos. days

Where was disease contracted

if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

Hope Cemetery
M. E. Gable

DATE OF BURIAL

1-16-22

20. UNDERTAKER

ADDRESS

Hope, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH

County of Bonner Registration District No. 80.
 City of Clarksfork Registration District No. 2107
Ranch near Clarksfork, Id.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Winsey Carr

CERTIFICATE OF DEATH

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 737517Registered No. 23

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
 (Write the word.)

6. DATE OF BIRTH Dec. 20 1847
 (Month) (Day) (Year)

7. AGE 74 Yrs. 1 Mos. 8 ds. IF LESS than 1 day how many..... hrs. or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

Woodman

9. BIRTHPLACE

(State or Country)

Penn

10. NAME OF FATHER

Carr

11. BIRTHPLACE OF FATHER

(State or Country)

Penn

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) M. H. Miller
 (Address) Clarksfork, Idaho.

15. Feb. 19 22 John Larson
 Filed Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan. 28 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1-2-1922 to 1922

that I last saw him alive on 1-2 1922

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis
Senile Debility

(Duration)..... Yrs..... mos..... ds.

Contributory
 (Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed) Hayden Wanda D.

2-1-22 (Address) Sandpoint, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Hope, Idaho. 1/31 1922

20. UNDERTAKER

B. H. Pugh, Sandpoint, Ida.

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFAADING INK — THIS IS A PERMANENT RECORD
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH

County of Bonner Registration District No. 78
 City of Sandpoint Primary Registration District No. 2155
Idaho (State) Idaho (County) Idaho (City) Idaho (State)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Rosella Sawyer

CERTIFICATE OF DEATH

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 37518
 Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F. 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
 (Write the word.)

6. DATE OF BIRTH Nov. 20 1
 (Month) (Day) (Year)

7. AGE 77 Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Canada

10. NAME OF FATHER

Phillip Sullivan

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Mary O'Brien

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Cora B. Sawyer
Sawyer, Idaho.

15. Filed Mch 9 1922 J. W. Didier
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 7 19 22
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Neuro-Christian Scientist 19 1921
 that I last saw her alive on June 14 19 1921
 and that death occurred on the date stated above, at 7:30 P.M.
 The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. W. Didier M. D.

3/8 1922 (Address) Laclede, Idaho

*State, the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Laclede, Idaho. 3/9 19 22

20. UNDERTAKER

ADDRESS

B. H. Pugh, Sandpoint, Ida

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bonner
City of LacledeRegistration District No. 87Primary Registration District No. 2/15-5(No. Laclede, Ida. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Abner N. KnightState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 5 37519Registered No. 29

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M. White

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED
Married
(Write the word.)

6. DATE OF BIRTH

June 15 1892
(Month) (Day) (Year)

7. AGE

71 Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

Carpenter

9. BIRTHPLACE

(State or Country)

Ida.

10. NAME OF FATHER

Night

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

"

13. BIRTHPLACE OF MOTHER

(State or Country)

"

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

His own role took

(Address)

15.

Filed 19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 30 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 1 1922 to March 30 1922that I last saw him alive on March 30 1922and that death occurred on the date stated above, at 5:00 A.M.

The CAUSE OF DEATH* was as follows:

cerebral apoplexy(Duration) 2 Yrs. 2 mos. 1 ds.Contributory arteriosclerosis
(Secondary)(Duration) 10 yrs. 2 mos. 2 ds.(Signed) Theodidien M. D.4/3 1922 (Address) Laclede, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 10 yrs. 2 mos. 2 days. In the State 10 yrs. 2 mos. 2 days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Laclede, Idaho.

DATE OF BURIAL

4/5 1922

20. UNDERTAKER

B. H. Pugh, Sandpoint, Ida.

ADDRESS

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bonner
 City of Sandpoint

Registration District No. 78
 Primary Registration District No. 2155
 (No. Elmira Ida St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Joe C. Grant

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 37520

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED

M. | white

Single
 (Write the word.)

6. DATE OF BIRTH

Unknown 1 842
 (Month) (Day) (Year)

7. AGE

80 Yrs. Mos. ds.

IF LESS than 1 day
 how many hrs.
 or min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

Merchant

9. BIRTHPLACE

(State or Country)

Scotland

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

"

12. MAIDEN NAME OF MOTHER

"

13. BIRTHPLACE OF MOTHER

(State or Country)

"

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Chas. Lang
Elmira, Idaho

(Address)

15.

Filed April 6 1922

Floyd Wendle
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb. 10 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

.....19..... to19.....
 that I last saw him alive on19.....
 and that death occurred on the date stated above, atM.

The CAUSE OF DEATH* was as follows:

Chronic heart disease
scinty

(Duration) Yrs. mos. ds.

Contributory
 (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. R. Waller M. D.

3-20 1922 (Address) Sandpoint, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sandpoint, Ida Feb. 14 1922

20. UNDERTAKER

ADDRESS

B. H. Pugh, Sandpoint, Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bonner
City of SandpointRegistration District No. 78Primary Registration District No. 2155(No. 815-Superior & Florence)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Alvin O. HalversonState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 37521

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Dec. 2 1891
(Month) (Day) (Year)

7. AGE

31 Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Woodman

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Nebr.

10. NAME OF FATHER

Alf Halverson

11. BIRTHPLACE OF FATHER

(State or Country)

Nisc.

12. MAIDEN NAME OF MOTHER

Ida Barney

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Ida Ryan

(Address)

Sandpoint, Idaho.

15.

Filed March 22 1922Floyd Weadle
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 1 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan. 28 1922 to Feb. 27 1922that I last saw him alive on Feb. 28 1922,
and that death occurred on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis of lungs and bowels.Approximately (Duration) 3 Yrs. mos. ds.Contributory Flu
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Dr. R. E. St. G.Mar. 20 1922 (Address) Sandpoint, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Sandpoint, Ida.

DATE OF BURIAL

Mar. 3 1922

20. UNDERTAKER

B. H. Pugh, Sandpoint, Ida.

ADDRESS

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bonner
City of SandpointRegistration District No. 78Primary Registration District No. 2155(No. Bernad Hotel St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

D. Crawford SmithFile No. 37522

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH

Unknown 1899
(Month) (Day) (Year)

7. AGE

23 Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Ireland

10. NAME OF FATHER

Crawford Smith

11. BIRTHPLACE OF FATHER

(State or Country) Unknown

12. MAIDEN NAME OF MOTHER

"

13. BIRTHPLACE OF MOTHER

(State or Country) "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dr. C. P. Stackhouse
(Address) Sandpoint, Idaho.

15.

Filed April 6 1922 Floyd Wendt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 1 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Feb 7 - 1922, to March 1 1922, that I last saw him alive on March 1 1922, and that death occurred on the date stated above, at 10.30 P.M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia with Infuenza
began a week following tonsillotomy.
Tuberculosis - lungs - developed
after being gassed in France
(Duration) Yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) C. P. Stackhouse M. D.4-1 1922 (Address) Sandpoint, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Sandpoint Ida

DATE OF BURIAL

3/7 1922

20. UNDERTAKER

B. H. Pugh, Sandpoint, Ida.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 37523

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Bonner Registration District No. 78
City of Sandpoint Primary Registration District No. 2155
(No. Kootenai, Ida St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

James H. Shipman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

M. WhiteMarried
(Write the word.)

6. DATE OF BIRTH

Nov. 12 1855
(Month) (Day) (Year)

7. AGE

71 Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Woodman

9. BIRTHPLACE

(State or Country)

New York

10. NAME OF FATHER

Shipman

11. BIRTHPLACE OF FATHER

(State or Country)

New York

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

11

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Carlton Shipman
Kootenai, Idaho.

(Address)

15.

Filed April 6 1922Floyd Wandle
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 8 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from July 4 1919, to Sept 1919
that I last saw him alive on Sept 1919,
and that death occurred on the date stated above, at 8:30 A. M.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis(Duration) many yrs. mos. ds.Contributory
(Secondary)(Duration) many yrs. mos. ds.

(Signed)

A. H. Jones M. D.
Sandpoint, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Sandpoint, Ida 3 12 1922

20. UNDERTAKER

ADDRESS

B. H. Pugh, Sandpoint, Ida

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bonner
City of SandpointRegistration District No. 78
Primary Registration District No. 2155
(No. 334 South Boyer St.)File No. 37524

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Edward August Schwartz

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widowed
(Write the word.)

6. DATE OF BIRTH

Mar. 2 1844
(Month) (Day) (Year)

7. AGE

78 Yrs. 78 Mos. _____ ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Merchant

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

Casper Schwartz

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

"

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

H. H. Schwartz

(Address)

Sandpoint Idaho.

15.

Filed

April 6 1922Floyd Wendle

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 2 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

JAN - 1922 to MAY - 2 1922that I last saw him alive on MAY - 1 - 1922

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis(Duration) Several yrs mos. _____ ds.Contributory
(Secondary)Senility

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Floyd Wendle

M. D.

March 30 1922 (Address) Sandpoint, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Sandpoint, Ida

DATE OF BURIAL

3/6 1922

20. UNDERTAKER

B. H. Pugh, Sandpoint, Ida.

ADDRESS

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bonner
City of SandpointRegistration District No. 78Primary Registration District No. 2155(No. Ch Ranch, near Sandpoint)File No. 37525

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary A. Jones

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

3. F. 4. White 5. married
(Write the word.)

6. DATE OF BIRTH

Oct. 7 1849
(Month) (Day) (Year)

7. AGE

72 Yrs. 4 Mos. 23 ds.IF LESS than 1 day
how many..... hrs.
or..... min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Housewife

9. BIRTHPLACE

(State or Country)

N. C.

10. NAME OF FATHER

Eng. Bunker

11. BIRTHPLACE OF FATHER

(State or Country)

Asia

12. MAIDEN NAME OF MOTHER

Adelaide Yates

13. BIRTHPLACE OF MOTHER

(State or Country)

N. C.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Hattie E. Buck

(Address)

Sandpoint, Ida.

15.

Filed

April 6 1922Floyd Wendle
Local Registrar

16. DATE OF DEATH

March 2 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb. 1 1922 to Mar. 2 1922that I last saw h. er alive on Feb. 22 1922

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Tuberculosis
Intestinal(Duration) 2 Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

Floyd Wendle M. D.3-30 1922 (Address) Sandpoint, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sandpoint, Idaho 3/3 1922

20. UNDERTAKER

ADDRESS

B. H. Pugh, Sandpoint, Ida.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37526

1. PLACE OF DEATH

County of Bonner
City of Landsburg

Registration District No. 78Primary Registration District No. 2155(No. City Hospital St.)

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Lloyd A Soab

Registered No. _____

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDSingle
(Write the word.)

6. DATE OF BIRTH

Sept. 22. 1921
(Month) (Day) (Year)

7. AGE

1 Yrs. 5 Mos. 10 ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.

At Home

(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer).....

9. BIRTHPLACE

(State or Country)

Nebr.10. NAME OF
FATHERAdolph Soab11. BIRTHPLACE
OF FATHER

(State or Country)

Nebr.12. MAIDEN NAME
OF MOTHEREdna Westerman13. BIRTHPLACE
OF MOTHER

(State or Country)

Nebr.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Adolph Soab

(Address)

Landsburg, Idaho.

15.

Filed

April 6 1922Floyd Wendle
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 8 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Feb-1 1922 to MAR-9 1922

that I last saw him alive on MAR-9 1922,
and that death occurred on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia(Duration) Yrs. mos. 7 ds.Contributory
(Secondary)Auto Toxinia(Duration) yrs. 2 mos. ds.

(Signed)

Floyd Wendle M. D.3-9-22 1922(Address) Landsburg, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted
if not at place of death?.....

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Colburn, Ida.

DATE OF BURIAL

3/5/22 1922

20. UNDERTAKER

B. H. Pugh, Landsburg, Ida.

ADDRESS

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Bonner*City of *Sandpoint*

If death occurs away from usual residence, give facts called for under special information.

Registration District No. *78*Primary Registration District No. *2155*(No. *On Ranch near Cocolalla, Ida.*)File No. *37527*

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

August Wiess

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widowed
(Write the word.)

6. DATE OF BIRTH

Apr. 14 1922
(Month) (Day) (Year)

7. AGE

80

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

Raucher

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

*L. C. Clary
Cocolalla, Idaho*

15.

Filed

*April 6 1922**Floyd Wendle*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar. 5 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *No. - 1920* to *Mar - 5 1922*that I last saw him alive on *Mar - 1 1922*

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Influenza.(Duration) Yrs. mos. *14* ds.Contributory
(Secondary)*Senility*

(Duration) yrs. mos. ds.

(Signed)

Floyd Wendle

M. D.

3-3-22 1922 (Address) *Sandpoint, Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sprague, Wash

19

20. UNDERTAKER

ADDRESS

B. H. Pugh, Sandpoint, Ida.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

10
2

6

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bonner
City of SandpointRegistration District No. 78
Primary Registration District No. 2/55
(No. Kootenai Idaho St.)File No. 37528

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarah Sigmundson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F. 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED married
(Write the word.)6. DATE OF BIRTH Sept. 25 1872
(Month) (Day) (Year)7. AGE 49 Yrs. Mos. ds. IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Housewife

9. BIRTHPLACE

(State or Country)

Iceland

10. NAME OF FATHER

Arv Gudmundson

11. BIRTHPLACE OF FATHER

(State or Country)

Iceland

12. MAIDEN NAME OF MOTHER

Gudrun

13. BIRTHPLACE OF MOTHER

(State or Country)

Iceland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) S. H. Sigmundson
(Address) Kootenai, Idaho.15. Filed April 6 1922 Floyd Wendle
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 10 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from MAR-1 1922 to MAR-10 1922
that I last saw her alive on MAR-8 1922
and that death occurred on the date stated above, at 8:30 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia(Duration) Yrs. mos. 8 ds.Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) Floyd Wendle M. D.3-30-22 (Address) Sandpoint, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Sandpoint, Idaho. Mar 11 1922

20. UNDERTAKER

ADDRESS

B. H. Pugh, Sandpoint, Ida.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of BonnerCity of Sandpoint

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 78Primary Registration District No. 2155(No. 991 Poplar St.)

2. FULL NAME

John BuskeState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 37529

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

single
(Write the word.)

6. DATE OF BIRTH

Jan. 19 1922
(Month) (Day) (Year)

7. AGE

Yrs. 1 Mos. 21 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho.

10. NAME OF FATHER

John Buske

11. BIRTHPLACE OF FATHER

(State or Country) Mich

12. MAIDEN NAME OF MOTHER

Ara Demers

13. BIRTHPLACE OF MOTHER

(State or Country) Nic.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ing Buske
(Address) Sandpoint Ida.

15.

Filed April 6 1922 Floyd Wendt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 11 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 4 1922, to March 11 1922
that I last saw him alive on March 11 1922
and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Stomach neoplasia.
Mother died 2 hrs after birth of child
of tuberculosis. Lung completed
last day of babies life. unsatisfactory
(Duration) _____ yrs. _____ mos. _____ ds.
Pneumonia or hepatic origin
Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) C. P. Stackhouse M. D.4-1-1922 (Address) Sandpoint, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Sandpoint, Ida.

DATE OF BURIAL

3/13 1922

20. UNDERTAKER

B. H. Pugh, Sandpoint, Ida.

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bonner
City of Sandpoint

Registration District No. 78
Primary Registration District No. 2155
(No. 328 South Bayert St.)

File No. 37530
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Howard Francis Brown

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH

Nov. 17 1910
(Month) (Day) (Year)

7. AGE

11 Yrs. 3 Mos. 26 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

School boy

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Harry E. Brown

11. BIRTHPLACE OF FATHER

(State or Country)

Minn.

12. MAIDEN NAME OF MOTHER

Laura Davis

13. BIRTHPLACE OF MOTHER

(State or Country)

Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Harry E. Brown

(Address)

Sandpoint, Idaho.

15.

Filed April 6 1922

Floyd Wendle

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 13 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 10 1922, to Mar 13 1922, that I last saw him alive on Mar 12 1922 and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Diabetes

(Duration) 2 Yrs. mos. ds.

Contributory (Secondary)

Influenza

(Duration) yrs. mos. 7 ds.

(Signed)

M. R. Wallace M. D.

B-29-22 (Address) Sandpoint, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sandpoint, Ida 3/15 1922

20. UNDERTAKER

ADDRESS

B. H. Cough, Sandpoint, Idaho.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37531
Registered No. _____

1. PLACE OF DEATH

County of Bonner Registration District No. 78
City of Sandpoint (No. 40 N. H. Ch St.)
Primary Registration District No. 2155

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Frank A. Jarvis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED widower
(Write the word.)

6. DATE OF BIRTH

Jan. 18 1851
(Month) (Day) (Year)

7. AGE

71 Yrs. 1 Mos. 26 ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Laborer

9. BIRTHPLACE

(State or Country)

Mass.

10. NAME OF FATHER

Jarvis

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. B. Gardner
(Address) Sandpoint, Ida.

15.

Filed April 6 1922

Floyd Wendle
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 16 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan. 19 1922 to March 16 1922
that I last saw him alive on 3-16-22
and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Cancer Stomach

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

J. B. Gardner M. D.
3-19-22 (Address) Sandpoint, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Sandpoint, Ida. 3/19 1922

20. UNDERTAKER

ADDRESS

B. N. Bugh, Sandpoint, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bonner
City of Sandpoint

Registration District No. 78
Primary Registration District No. 2155
(No. 23 Larch St.)

File No. 37532
Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anna Lindgreen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F. 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH Apr. 17 1871
(Month) (Day) (Year)

7. AGE 50 Yrs. 11 Mos. .. ds. IF LESS than 1 day how many .. hrs. or .. min. ?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE Sweden
(State or Country)

10. NAME OF FATHER Andrew Davidson

11. BIRTHPLACE OF FATHER Sweden
(State or Country)

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER Sweden
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Johan Lindgreen
(Address) Sandpoint, Idaho

15. Filed April 6 1922 Floyd Wendle
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 16 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 1 1922 to Mar. 16 1922 that I last saw her alive on Mar. 16 1922, and that death occurred on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH* was as follows:

Wickets

(Duration) Yrs. .. mos. .. ds.
Contributory (Secondary) Influenza

(Duration) yrs. 5 mos. .. ds.

(Signed) M. R. Waller M. D.
3-20-22 (Address) Sandpoint, Ida.

*State the Disease Causing Death; or in death from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. .. mos. .. days. In the State yrs. .. mos. .. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Sandpoint, Ida. DATE OF BURIAL 3/18 1922

20. UNDERTAKER B. H. Pugh, Sandpoint, Ida. ADDRESS

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

37533

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of BonnerCity of Priest River,Registration District No. 85Primary Registration District No. 2185

(No. _____ St.)

File No. 2Registered No. 87

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lindley Carroll Olson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

(Write the word.)

6. DATE OF BIRTH

March 9 1922
(Month) (Day) (Year)

7. AGE

— Yrs. — Mos. — ds.IF LESS than 1 day
how many 12 hrs.
or — min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

None

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho.

10. NAME OF FATHER

Carroll Olson

11. BIRTHPLACE OF FATHER

(State or Country)

Mo.

12. MAIDEN NAME OF MOTHER

Florence Callihan

13. BIRTHPLACE OF MOTHER

(State or Country)

Wash.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Carroll Olson
Priest River, Ida.

15.

Filed

Apr 1 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 9 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 8 1922 to March 9 1922that I last saw him alive on March 9 1922 19 and that death occurred on the date stated above, at 11 A. M.

The CAUSE OF DEATH* was as follows:

Premature birth at 6 Mo of pregnancy.

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

C. F. Getz

M. D.

Mar 10 1922 (Address) Priest River,

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Priest River, Ida.

DATE OF BURIAL

Mar 9 1922

20. UNDERLYING father

Carroll Olson

ADDRESS

Priest River

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

37534

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of **Bonner**City of **Priest River**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Norine Ann BryantRegistration, District No. **85**Primary Registration District No. **2085**

City No.

St.)

File No. **2**Registered No. **37**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCED
Single

(Write the word.)

6. DATE OF BIRTH

Feb. 18

(Month)

1922

(Day)

(Year)

7. AGE

14 ds.

Yrs.

Mos.

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

None

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho.

10. NAME OF FATHER

James Bryant

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Rosella Murray

13. BIRTHPLACE OF MOTHER

(State or Country)

S.D.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Priest River, Ida.

15.

Filed

19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar

(Month)

3

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 18

1922, to

Mar 3

1922,

that I last saw ^{pr} alive on **March 3** 1922,and that death occurred on the date stated above, at **3P.** A.M.

The CAUSE OF DEATH* was as follows:

Proncho Pneumonia

(Duration)

Yrs.

mos.

2 ds.Contributory
(Secondary)**Cardiac Weakness**

(Duration)

Yrs.

mos.

ds.

(Signed)

M. D.

Mar 4 1922

(Address)

Priest River,

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

May 4 1922

20. UNDERTAKER

ADDRESS

James Bryant**Priest River**

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37535
Registered No. _____

1. PLACE OF DEATH Bonneville
County of Bonneville Registration District No. _____
City of Laclede Idaho St. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Sarah Starr

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH _____

(Month) (Day) (Year)

7. AGE 34 Yrs. ____ Mos. ____ ds.
IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Elkport, Iowa

10. NAME OF FATHER

Jacob M. Walters

11. BIRTHPLACE OF FATHER

(State or Country)

not known

12. MAIDEN NAME OF MOTHER

Bora M. Woolridge

13. BIRTHPLACE OF MOTHER

(State or Country)

not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. Starr
Laclede, Idaho

15. Filed Apr 30 1922 F. W. Didier
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Apr. 26 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 22 1922 to Apr 26 1922 that I last saw her alive on Apr 25 1922 and that death occurred on the date stated above, at 5⁰⁰ A.M.

The CAUSE OF DEATH was as follows:

Diphtheria

____ (Duration) ____ Yrs. ____ mos. ____ ds.

Contributory (Secondary)

Cardiac Hypertrophy

____ (Duration) ____ Yrs. ____ mos. ____ ds.

4-30 (Signed) F. W. Didier M. D.
1922 (Address) Laclede, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Laclede, Idaho 4/26 1922

20. UNDERTAKER

ADDRESS

B. H. Pugh, Sandpoint, Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 37536

Registered No. 40

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH *Boonville*
 County of *Bonner*
 City of *Laclede* *Laclede, Idaho* St.
 Registration District No. _____
 Primary Registration District No. _____
 If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Florence Fuller*

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *F.* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*
 (Write the word.)

6. DATE OF BIRTH *Dec. 27* 19*21*
 (Month) (Day) (Year)

7. AGE *3* Yrs. *25* Mos. *5* ds.
 IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) *Idaho*

10. NAME OF FATHER

John F. Fuller

11. BIRTHPLACE OF FATHER

(State or Country) *Ill.*

12. MAIDEN NAME OF MOTHER

Johanna Lee

13. BIRTHPLACE OF MOTHER

(State or Country) *Maryland*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John F. Fuller
Laclede, Idaho

15.

Filed *Apr 30* 19*22* *F.W. Didier*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 22 19*22*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Apr 22* 19*22* to *Apr 22* 19*22*
 that I last saw her alive on *Apr 22* 19*22*
 and that death occurred on the date stated above, at _____ M.
 The CAUSE OF DEATH* was as follows:

* (Duration) * Yrs. * mos. *4* ds.Contributory (Secondary) *Pertussis** (Duration) * yrs. * mos. *20* ds.

4/22 (Signed) *F.W. Didier* M. D.
 19*22* (Address) *Laclede, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Columbia Falls, Mont. *4/* 19*22*

20. UNDERTAKER

ADDRESS

B. H. Pugh, Sandpoint, Idaho

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of BonnerCity of Sandpoint

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No. 78Primary Registration District No. 2155(No. City Hospital St.)Mabel YoochState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 37537

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F.

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDSingle
(Write the word.)

6. DATE OF BIRTH

March 1

(Month)

(Day)

1905
(Year)

7. AGE

17 Yrs.1 Mos.26 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

At Home

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

David Yooch

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Elnora Horn

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

David Yooch

(Address)

Sandpoint, Idaho

15.

Filed

May 41922Viola Allen

Dept Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 27

(Month)

(Day)

1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Apr 24 1922 to Apr 27 1922that I last saw her alive on Apr 27 1922and that death occurred on the date stated above, at 4:15 M.

The CAUSE OF DEATH* was as follows:

Eclampsia(Duration) Yrs. mos. 9 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

R. R. Hooten M. D.5-2 1922 (Address) Sandpoint, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sandpoint Idaho4/28 1922

20. UNDERTAKER

ADDRESS

B. N. Lusk, Sandpoint, Ida.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

BUREAU OF STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

(Duration)..... Yrs..... mos..... ds.

Contributory (Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed)..... M. D.

4/21/1922 (Address).....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH
 County of Bonner
 City of Sandpoint, Idaho
 If death occurs away from usual residence, give facts called for under special information.

RECEIVED
 MAY 9 1922

CERTIFICATE OF DEATH

Registration District No. 78
 Primary Registration District No. 2155
 (St.) Kootenai, Idaho

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 37539
 Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs. Emeli Oak

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F. 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widowed
 (Write the word.)

6. DATE OF BIRTH March 16 1849
 (Month) (Day) (Year)

7. AGE 73 Yrs. _____ Mos. _____ ds. IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION Housewife
 (a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE Sweden
 (State or Country)

10. NAME OF FATHER Bergquist

11. BIRTHPLACE OF FATHER Sweden
 (State or Country)

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER Sweden
 (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) P. H. Oak
 (Address) Kootenai, Idaho.

15. Filed May 4 1922 Viola Allen
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 7 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased once in 1921 to _____
 that I last saw her alive on 1921 _____
 and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:
Valvular Heart Disorder

(Duration) 4 Yrs. _____ mos. _____ ds.
 Contributory (Secondary) _____

(Signed) Floyd Wendt D.
73 22 (Address) Sandpoint, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.
 Where was disease contracted if not at place of death?
 Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Sandpoint, Ida. DATE OF BURIAL 4/10 1922.

20. UNDERTAKER B. H. Pugh ADDRESS Sandpoint, Ida.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bonner
City of SandpointRegistration District No. 78Primary Registration District No. 3155(No. Sunnyside, Idaho St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Robert G. DownsState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 37540

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

m.

4. COLOR OR RACE

white5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDsingle
(Write the word.)

6. DATE OF BIRTH

842
(Month) (Day) (Year)

7. AGE

80 Yrs.

Mos.

ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

Rancher (Retired)

9. BIRTHPLACE

(State or Country)

New York

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

C. C. Chandler
(Address) Sandpoint, Idaho

15.

Filed May 4 1922Viola Allen
Deputy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 31 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from June 1920 to Mar-31 1922 that I last saw him alive on Mar-26 1922 and that death occurred on the date stated above, at 3A M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis(Duration) 3 Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

Floyd C. Woodruff M. D.May 2 1922 (Address) Sandpoint, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Kathlamet, Ida.4/7 1922

20. UNDERTAKER

ADDRESS

B. N. Tugh, Sandpoint, Ida.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 37541
Registered No.

1. PLACE OF DEATH

County of Bonner Registration District No. 78
City of Sandpoint Primary Registration District No. 2155
(No. Central Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Sarah Vera Lloyd

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH

Dec. 31 1879
(Month) (Day) (Year)

7. AGE

42 Yrs. 3 Mos. 28 ds.IF LESS than 1 day
how many hrs.
or min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Housewife

9. BIRTHPLACE

(State or Country)

Minn

10. NAME OF FATHER

A. O. Richardson

11. BIRTHPLACE OF FATHER

(State or Country)

Minn

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

M. J. Lloyd
Cabinet Idaho

15.

Filed

May 4 1922Viola Allen
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Apr. 28 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
April 21 1922, to April 28 1922
that I last saw her alive on 19.....
and that death occurred on the date stated above, at 3:25 A.M.

The CAUSE OF DEATH* was as follows:

Surgical shock following perforation of bowel

(Duration) Yrs. mos. ds.

Contributory
(Secondary)Tumor(Duration) 4 yrs. mos. ds.

(Signed)

E. Anderson

M. D.

1922 (Address) Sandpoint, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Spokane, Wash5/1 1922

20. UNDERTAKER

ADDRESS

B. H. Pugh, Sandpoint, Idaho

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of BonnerCity of Glenary

If death occurs away from usual residence, give facts called for under special information.

RECEIVED

Registration District No. 78Primary Registration District No. 2155

(No. _____)

(St. _____)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 37543

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Mahala Dillman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widow
(Write the word.)

6. DATE OF BIRTH

March 30, 1875
(Month) (Day) (Year)

7. AGE

77

Yrs. _____ Mos. _____ ds. _____

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

Gilbert B. Severe

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Ed Melvin
Glenary, Ida

15.

Filed Mar 4 1922Ida Allen
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 28, 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept. 1920 to April 29, 1922that I last saw him alive on April 20, 1922

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Senile paralysis(Duration) 3 Yrs. _____ mos. _____ ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) N R Wallentin M. D.5/3 1922 (Address) Sanpoint Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Newman Cemetery Apr 30, 1922

20. UNDERTAKER

ADDRESS

Morrison and Dale Sanpoint Ida

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

BUREAU
STAT

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Dept.

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw her alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH *Walla Walla*
Registration District No. *78*
County of *Bonner*
Primary Registration District No. *2155*
City of *Sandpoint* (No. *On Ranch, near Sandpoint*)

File No. *37545*
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME *John Jacobson*

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M.* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *married*
(Write the word.)

6. DATE OF BIRTH *Nov. 1 1869*
(Month) (Day) (Year)

7. AGE *62* Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION *Raucher*
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE *Finland*
(State or Country)

10. NAME OF FATHER *Jacob Busar*

11. BIRTHPLACE OF FATHER *Finland*
(State or Country)

12. MAIDEN NAME OF MOTHER *Unknown*

13. BIRTHPLACE OF MOTHER *Finland*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *Mrs. John Jacobson*
(Address) *Sandpoint, Idaho.*

15. Filed *April 14 1922* *Viola Allen*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *April 9 1922*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Feb-12 1922*, to *April 9- 1922*, that I last saw him alive on *April 1 1922* and that death occurred on the date stated above, at *11:15 A.M.*

The CAUSE OF DEATH* was as follows:
gastric carcinoma

(Duration) Yrs. *6* mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) *W. H. Wallentin M. D.*
April 13 1922 (Address) *Sandpoint, Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Sandpoint, Ida.* DATE OF BURIAL *4/14 1922*

20. UNDERTAKER *B. H. Pugh, Sandpoint, Ida.* ADDRESS

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bonner Registration District No. 78
 City of Sandpoint Primary Registration District No. 2155
612 Superior St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Elsie Morris

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 37546

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F. 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
 (Write the word.)

6. DATE OF BIRTH Dec 5 1891
 (Month) (Day) (Year)

7. AGE 30 Yrs. 4 Mos. 10 ds. IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Mo.

10. NAME OF FATHER

Fred Wallace

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Clara Baker

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

E. Morris
Hope Idaho.

15. Filed May 4 1922 Viola Allen
Wpt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Apr. 15 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 16 1922, to Apr. 14 1922, that I last saw her alive on Apr. 14 1922, and that death occurred on the date stated above, at 1:25 P.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(Duration) 1 Yrs. 6 mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

J. P. E. S. O.

4/24 1922 (Address) Sandpoint, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Sakota

Former or usual residence

Hope Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sandpoint, Idaho 4/18 1922

20. UNDERTAKER

ADDRESS

B. H. Pugh, Sandpoint

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of **Bonner**City of **Priest River**

If death occurs away from usual residence, give facts called for under special information.

Registration District No. **85**Primary Registration District No. **2185**

(No. _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **37547**

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

BUREAU

2. FULL NAME **Tessie Landerdahl**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F.

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Single word.)

6. DATE OF BIRTH

April 22 1922
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

None

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho.

10. NAME OF FATHER

Walter Landerdahl

11. BIRTHPLACE OF FATHER

(State or Country)

S.D.

12. MAIDEN NAME OF MOTHER

Celia Neilson

13. BIRTHPLACE OF MOTHER

(State or Country)

S.D.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Walter Landerdahl**(Address) **Priest River, Ida.**

15.

Filed **May 1 1922** **C. F. Getz**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 24 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
April 22 1922 to April 24 1922that I last saw her alive on **Apr. 24 1922**and that death occurred on the date stated above, at **5.30** M.

The CAUSE OF DEATH* was as follows:

Intestinal Hemorrhage(Duration) Yrs. mos. **2** ds.Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) **C. F. Getz** M. D.**Apr. 25 1922** (address) **Priest River, Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL
Priest River,DATE OF BURIAL
Apr. 25, 2220. UNDERTAKER **Father Walter Landerdahl**ADDRESS
Priest River,

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

37548

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 85

County of Bonner

Primary Registration District No. 2185

File No. 2

Registered No. 39

City of Priest River, Idaho (No.) St.)

If death occurs away from usual residence, give facts called for under special information.

BUREAU OF VITAL STATISTICS

2. FULL NAME Morillo D. Lathrop

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widowed

(Write the word.)

6. DATE OF BIRTH

July 15 1848
(Month) (Day) (Year)

7. AGE

73 Yrs. 9 Mos. 12 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Miller

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

N.Y.

10. NAME OF FATHER

Daniel Lathrop,

11. BIRTHPLACE OF FATHER

(State or Country)

N.Y.

12. MAIDEN NAME OF MOTHER

Falena Dow

13. BIRTHPLACE OF MOTHER

(State or Country)

Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Vernon C. Lathrop

(Address) Priest River, Ida.

15.

Filed May 1 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 27 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 15 1922 to April 27 1922 that I last saw him alive on April 26 1922 and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis.

(Duration) 2 Yrs. mos. ds.

Contributory
(Secondary)

(Duration) mos. ds.

(Signed)

C. P. Gifford

M. D.

Apr 27 1922 Address) Priest River, Ida,

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Priest River, Ida.

Apr. 30 1922

20. UNDERTAKER

ADDRESS

Wm Davis

Newport.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

37549

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bonneville
City of Idaho FallsRegistration District No. 13
Primary Registration District No. 21 N. 2
(No. 460 No. 7 Water Ave)File No. _____
Registered No. 32

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Vivian Mable Chambulain

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH

April 28 1922
(Month) (Day) (Year)

7. AGE

25 Yrs. 10 Mos. 10 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)at Home

9. BIRTHPLACE

(State or Country)

Washington

10. NAME OF FATHER

Fred Raymire

11. BIRTHPLACE OF FATHER

(State or Country)

Oregon

12. MAIDEN NAME OF MOTHER

Anna Louise Palmer

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Idaho Falls

15.

Filed

Mar 11 1922 W. M. M. M.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 10 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 1 1921 to March 10 1922
that I last saw h. l. l. alive on March 10 1922
and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus(Duration) 100 Yrs. _____ mos. _____ ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

3/11/22

(Address)

Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Blackfoot, Ida

DATE OF BURIAL

3/12/22

20. UNDERTAKER

E. J. M. M.

ADDRESS

Idaho Falls

CERTIFICATE OF DEATH

37550

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 73
County of Barnesville Primary Registration District No. 215-0
City of Idaho Falls (No. Al St.)

File No.

Registered No. 97

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Theodore H. Jasline

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

married
(Write the word.)

6. DATE OF BIRTH

Feb 22 1847
(Month) (Day) (Year)

7. AGE

75 Yrs. 0 Mos. 7 ds.

IF LESS than 1 day

how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

Farming

9. BIRTHPLACE

(State or Country)

Ill.
New York

10. NAME OF FATHER

Joseph Jasline

11. BIRTHPLACE OF FATHER

(State or Country)

N. S.

12. MAIDEN NAME OF MOTHER

Philinda Frary

13. BIRTHPLACE OF MOTHER

(State or Country)

N. S.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

T. H. Jasline
Idaho Falls

15.

Filed

Mar 10 1922
W. H. H. H.

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 1 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb - 10 1922 to Mar 1 1922that I last saw him alive on Mar 7 1922and that death occurred on the date stated above, at 10 AM.

The CAUSE OF DEATH* was as follows:

Cystitis(Duration) Yrs. 3 mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

H. H. Spencer M. D.Mar 9 1922 (Address) Idaho Falls Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Idaho Falls

DATE OF BURIAL

3/4 1922

20. UNDERTAKER

B. B. Woodward

ADDRESS

Idaho Falls

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Banner
City of Idaho FallsRegistration District No. 73
Primary Registration District No. 214-0
St. Idaho

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John GeatzState of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37551
Registered No. 36

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White5. SINGLE, MARRIED, WIDOWED OR DIVORCED
married
(Write the word.)

6. DATE OF BIRTH

Apr 17 1866
(Month) (Day) (Year)

7. AGE

55 Yrs. 8 Mos. 27 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Butcher

9. BIRTHPLACE

(State or Country)

Canada

10. NAME OF FATHER

John Geatz

11. BIRTHPLACE OF FATHER

(State or Country)

Canada

12. MAIDEN NAME OF MOTHER

Laurie Allen

13. BIRTHPLACE OF MOTHER

(State or Country)

Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs J Geatz
(Address) City

15.

Filed Mar 9 1922 W Turner
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 13 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Dec 27 1921, to 10 1922
that I last saw him alive on 10th Feb 1922
and that death occurred on the date stated above, at 110 M.

The CAUSE OF DEATH* was as follows:

Heart Disease
Heart(Duration) Yrs. 1 mos. 1 ds.Contributory (Secondary) Myocarditis(Duration) Yrs. 1 mos. 1 ds.(Signed) H. D. Smith M. D.7/6 1922 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. 1 mos. 1 ds. In the State Yrs. 1 mos. 1 ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Idaho Falls

DATE OF BURIAL

2/16 1922

20. UNDERTAKER

Edmund Woodley

ADDRESS

Idaho Falls

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bonneville
City of Idaho Falls

Registration District No. 73Primary Registration District No. 2150

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lars P. C. Nielsen

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 37552Registered No. 317

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

married
(Write the word.)

6. DATE OF BIRTH

Feb
(Month)9
(Day)1855
(Year)

7. AGE

67 Yrs.11 Mos.16 ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Farmer

9. BIRTHPLACE

(State or Country)

Denmark

10. NAME OF FATHER

Ole Nielsen

11. BIRTHPLACE OF FATHER

(State or Country)

Denmark

12. MAIDEN NAME OF MOTHER

Sidse Nielsen

13. BIRTHPLACE OF MOTHER

(State or Country)

Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

L. P. Nielsen

(Address)

Idaho Falls

15.

Filed

Mar 919 22W. H. Wood
Local Registrar

16. DATE OF DEATH

Jan
(Month)25
(Day)1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 19, 1922 to Jan 25, 1922
that I last saw him alive on Jan 25, 1922
and that death occurred on the date stated above, at 4 P. M.
The CAUSE OF DEATH* was as follows:

Chronic Intestinal rephitis(Duration) 5 Yrs. mos. ds.

Contributory (Secondary)

Injury to back(Duration) four years ago yrs. mos. ds.

(Signed)

J. H. Wood M. D.1/26/22 (Address) Idaho Falls, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Ammon, Ida

DATE OF BURIAL

1-27-1922

20. UNDERTAKER

B. B. Wood

ADDRESS

Idaho FallsW. H. Wood

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 37553

Registered No. 34

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

1. PLACE OF DEATH

County of Bonneville
City of Idaho FallsRegistration District No. 73Primary Registration District No. 214-0

(No. St.)

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Eliza Butler

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female White

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED
Married
(Write the word.)

6. DATE OF BIRTH

Apr 19 1858
(Month) (Day) (Year)

7. AGE

62 Yrs. 10 Mos. 4 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)at Home

9. BIRTHPLACE

(State or Country)

10. NAME OF
FATHERWm A Gibson11. BIRTHPLACE
OF FATHER

(State or Country)

12. MAIDEN NAME
OF MOTHEREliza O Strander13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Mar 9 1922 Wm A Gibson

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 23 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19..... to 19.....

that I last saw h..... alive on..... 19.....

and that death occurred on the date stated above, at 5 a M.

The CAUSE OF DEATH* was as follows:

Carcinoma Ovary(Duration) 1 Yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Wm A Gibson M. D.7/25 1922 (Address).....*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)At place of death..... yrs. mos. days. In the
State..... yrs. mos. daysWhere was disease contracted
if not at place of death?.....Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Mecon, Ida

DATE OF BURIAL

7/26 1922

20. UNDERTAKER

B E Deenwoodley

ADDRESS

Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37554
Registered No. 33

1. PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 13
Primary Registration District No. 21V-0
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ada Grace Taylor

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH May 17 1870
(Month) (Day) (Year)

7. AGE 51 Yrs. 8 Mos. 26 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION at home
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE Utah
(State or Country)

10. NAME OF FATHER Jm I McEntire

11. BIRTHPLACE OF FATHER Va
(State or Country)

12. MAIDEN NAME OF MOTHER Sarah B Pritchett

13. BIRTHPLACE OF MOTHER Va
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ed McEntire
(Address) Rexburg, Ida

15. Filed Mar 9 1922
Local Registrar

16. DATE OF DEATH Feb 18 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 19 to 19 that I last saw him alive on 19 and that death occurred on the date stated above, at 9 A.M. The CAUSE OF DEATH* was as follows:

Exhaustion
(Duration) 3 Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) C. C. C. M. D.
1922 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Grant, Ida
DATE OF BURIAL 7/17 1922

20. UNDERTAKER E. H. Woodward
ADDRESS Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH ✓
County of Bannock
City of Idaho Falls

Registration District No. 13
Primary Registration District No. 2150
(No. 103 St.)

File No. 37555
Registered No. 32

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Vergie Campbell

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Infant
(Write the word.)

6. DATE OF BIRTH July 14 1922
(Month) (Day) (Year)

7. AGE 0 Yrs. 0 Mos. 21 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE Idaho
(State or Country)

10. NAME OF FATHER A. E. Campbell

11. BIRTHPLACE OF FATHER Utah
(State or Country)

12. MAIDEN NAME OF MOTHER Ada E. Owen

13. BIRTHPLACE OF MOTHER Idaho
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. E. Campbell
(Address) R. D. 3, Carey

15. Filed Mar 9 19 22 W. J. McNeill
Local Registrar

16. DATE OF DEATH Feb 3 19 22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 14 1922 to Feb 3 1922
that I last saw her alive on Jan 28 1922
and that death occurred on the date stated above, at 89 M.
The CAUSE OF DEATH* was as follows:

Influenza Pneumonia

(Duration) 8 Yrs. 8 mos. 8 ds.
Contributory (Secondary) Congenital weakness

(Duration) 8 yrs. 8 mos. 8 ds.
(Signed) W. J. McNeill M. D.
Idaho Falls Idaho
(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Ammon, Ida DATE OF BURIAL 2-4 1922

20. UNDERTAKER B. E. Edmundo ADDRESS Idaho Falls

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of BonnevilleRegistration District No. 73Primary Registration District No. 215-0City of Idaho FallsState No. 10

St.)

File No. 37556Registered No. 31

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Twila Miskin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Infant
(Write the word.)

6. DATE OF BIRTH

January 15 1922
(Month) (Day) (Year)

7. AGE

0 Yrs. 1 Mos. 13 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Arthur R Miskin

11. BIRTHPLACE OF FATHER

(State or Country)

Kansas

12. MAIDEN NAME OF MOTHER

Livina Belnap

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Arthur R. Miskin(Address) Idaho Falls, Ida

15.

Filed Mar 9 19 22 Unimpaired

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 28 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Feb 23 1922 to Feb 28 1922that I last saw her alive on Feb 26 1922and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Influenza Pneumonia(Duration) Yrs. mos. 6 ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed)

W. H. St. M. D.
Feb 28 1922 (Address) Idaho Falls, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Idaho Falls

DATE OF BURIAL

3/29/22

20. UNDERTAKER

Edwin W. W. W.

ADDRESS

Idaho Falls

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **37558**
Registered No. **37558**

1. PLACE OF DEATH

County of **Bonneville**City of **Idaho Falls**

Registration District No. _____

Primary Registration District No. **2100**

(Nov. 1911)

St.)

Registered No. **37558**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Stanley Marlow McMullen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCED**Single**
(Write the word.)

6. DATE OF BIRTH

June

(Month)

(Day)

1908
(Year)

7. AGE

13

Yrs.

Mos.

ds.

IF LESS than 1 day

how many _____ hrs.

or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

at Home

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

W.E. McMullen

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Myrtle Johnson

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W.E. McMullen

(Address)

Lincoln R.D. 1 City

15.

Filed

Mar 7**1922****Wm. D. Upm...**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb

(Month)

23

(Day)

1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

2/21**1922****19**that I last saw him alive on **2/22** **1922**and that death occurred on the date stated above, at **9:11** M.

The CAUSE OF DEATH* was as follows:

**Endocarditis following
Inf. Rheumatism had
been attended by Osteopath.**

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)**Inflammatory
by history**

(Duration)

Yrs.

mos.

ds.

(Signed)

7/25

(Address)

Idaho Falls

M. D.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Idaho, Ida

DATE OF BURIAL

2/26/22

20. UNDERTAKER

B. B. Woodward

ADDRESS

Idaho Falls

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25.M. 1-19.

CERTIFICATE OF DEATH

 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

1. PLACE OF DEATH

 County of Bannock Registration District No. 73
 City of Idaho Falls Primary Registration District No. 2150
 St.
File No. 37559Registered No. 22

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ardella Hansen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

June 10 1909
 (Month) (Day) (Year)

7. AGE

12 8 20
 Yrs. Mos. ds.

 IF LESS than 1 day
 how many..... hrs.
 or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

at home

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Hans C Hansen

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Allie Keller

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Allie K Hansen

(Address)

Idaho Falls

15.

Filed

Mar 7 1922 Idaho Falls
 Local Registrar

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 2 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 15 1920 Mar 14 1922
 that I last saw him alive on Mar 1 1922
 and that death occurred on the date stated above, at 4 A.M.
 The CAUSE OF DEATH* was as follows:
Chronic Valvular Endocarditis

The CAUSE OF DEATH* was as follows:

Chronic Valvular Endocarditis(Duration) 2 Yrs. 4 mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

3/4 1922 Idaho Falls
 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Idaho Falls

DATE OF BURIAL

3/5 1922

20. UNDERTAKER

Edmund Woodley

ADDRESS

Idaho Falls

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 37560

Registered No. 27

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Bannock Registration District No. 21
City of Idaho Falls Primary Registration District No. 21-5
St. Idaho

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Boby Messerli

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDSingle
(Write the word.)

6. DATE OF BIRTH

Mar 5 1922
(Month) (Day) (Year)

7. AGE

0 Yrs. 0 Mos. 0 ds.IF LESS than 1 day
how many _____ hrs.
or 30 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Idaho Falls

10. NAME OF FATHER

Jacob Messerli

11. BIRTHPLACE OF FATHER

(State or Country) Switz.

12. MAIDEN NAME OF MOTHER

Eliza Slater

13. BIRTHPLACE OF MOTHER

(State or Country) Switz.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address) Idaho Falls, Ida

15.

Filed Mar 9 1922Local Registrar L. K. Hatch

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 5 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 5 1922 to Mar 5 1922
that I last saw him alive on Mar 5 1922and that death occurred on the date stated above, at Idaho Falls.

The CAUSE OF DEATH* was as follows:

Died 30 minutes after birth.

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) H. Ray Hatch

M. D.

3/7 1922 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Idaho Falls

DATE OF BURIAL

3/7 1922

20. UNDERTAKER

B. G. Woodward

ADDRESS

Idaho Falls

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-2 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bannock Registration District No. 21
City of Idaho Falls St. Idaho

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Barleen Ulrich

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37561
Registered No. 26

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Infant
(Write the word.)

6. DATE OF BIRTH Feb 5 1922
(Month) (Day) (Year)

7. AGE 0 Yrs. 0 Mos. 21 ds. IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION:

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE Idaho
(State or Country)

10. NAME OF FATHER Fred Ulrich

11. BIRTHPLACE OF FATHER Germany
(State or Country)

12. MAIDEN NAME OF MOTHER Lone Baker

13. BIRTHPLACE OF MOTHER Idaho
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fred Ulrich
(Address) Idaho Falls

15. Filed Mar 9 1922 William
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 26 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 5 1922 to Feb 25 1922
that I last saw her alive on Feb 25 1922
and that death occurred on the date stated above, at M.
The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) Yrs. 5 mos. 5 ds.
Contributory (Secondary) Intermittent

(Duration) Yrs. 2 mos. 2 ds.
(Signed) J. H. Ray M. D.
7-8 1922 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. 5 mos. 5 days. In the State Yrs. 5 mos. 5 days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Idaho Falls DATE OF BURIAL 3/7/22

20. UNDERTAKER B. B. Woodward ADDRESS Idaho Falls

Dr. Hatch

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No.

Primary Registration District No.

(NCS)

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

19.22

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb.

25

19.22

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 22 19.22

to Feb 25 19.22

19.22

that I last saw her alive on Feb 25 19.22

and that death occurred on the date stated above, at 6:30 AM

The CAUSE OF DEATH* was as follows:

Influenza Pneumonia

(Duration)

Yrs.

mos.

3 ds.

Contributory
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

3/8 19.22

(Address)

Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

Yrs.

mos.

In the

days

State

8

Yrs.

mos.

days

Where was disease contracted if not at place of death?

Home Idaho Falls

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rise Hill

Feb. 28 19.22

20. UNDERTAKER

ADDRESS

C. H. Hayes

Idaho Falls

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bannock
City of Idaho FallsRegistration District No. 73
Primary Registration District No. 21V-6
(No. 73 St.)State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37563
Registered No. 24

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Geo. C. Nielsen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH

Dec 11 1857
(Month) (Day) (Year)

7. AGE

64 Yrs. 2 Mos. 21 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Farming

9. BIRTHPLACE

(State or Country)

Denmark

10. NAME OF FATHER

Wm C Nielsen

11. BIRTHPLACE OF FATHER

(State or Country)

Denmark

12. MAIDEN NAME OF MOTHER

?

13. BIRTHPLACE OF MOTHER

(State or Country)

Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Geo W Nielsen
RD 3 - Idaho Falls

15.

Filed

Mar 7 1922 Wm C Nielsen
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 4 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

3-1-1922 to 3-4-1922
that I last saw him alive on 3-1-1922
and that death occurred on the date stated above, at 10 AM.
The CAUSE OF DEATH* was as follows:Influenza.

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

W C Hallister, M. D.Mar 7 1922 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

Ship

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho Falls, Utah 3/8 1922

20. UNDERTAKER

ADDRESS

E C Shumway Idaho Falls

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37564
Registered No. 23

1. PLACE OF DEATH

County of Laramieville Registration District No. 73
City of Idaho Falls Primary Registration District No. 210-0
(No. _____) (St. _____)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Herrick

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Infant
(Write the word.)

6. DATE OF BIRTH

Feb. 15 1922
(Month) (Day) (Year)

7. AGE

0 Yrs. 0 Mos. 2 ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho Falls

10. NAME OF FATHER

R. P. Herrick

11. BIRTHPLACE OF FATHER

(State or Country)

Ogden, ut

12. MAIDEN NAME OF MOTHER

Afton Stringham

13. BIRTHPLACE OF MOTHER

(State or Country)

Ogden, ut

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Idaho Falls

15.

Filed Mar 7 1922 C. M. Clive

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb. 17 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-15 1922, to 2-17-22

that I last saw him alive on 2-17-22 1922

and that death occurred on the date stated above, at 79 M.

The CAUSE OF DEATH* was as follows:

Measles

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) C. M. Clive M. D.

7-17-22 (Address) Idaho Falls, Idy

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Ogden, Utah

DATE OF BURIAL

2-18-22

20. UNDERTAKER

B. B. Linwood

ADDRESS

Idaho Falls

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bannock
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 21V-0
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lola May Caughie

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37565
Registered No. 22

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH

Oct 14 1921
(Month) (Day) (Year)

7. AGE

7 Yrs. 7 Mos. 27 ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Idaho Falls

10. NAME OF FATHER

Leroy Caughie

11. BIRTHPLACE OF FATHER

(State or Country) Idaho

12. MAIDEN NAME OF MOTHER

Eileen Richardson

13. BIRTHPLACE OF MOTHER

(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Leroy Caughie

(Address) Idaho Falls

15.

Filed Nov 22 19 22

Local Registrar A. A. Aupert

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 11 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 10 1922, to Jan 11 1922, that I last saw her alive on Jan 11 1922 and that death occurred on the date stated above, at 59 A.M.

The CAUSE OF DEATH* was as follows:

Brucellosis

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) A. A. Aupert M.D.

1922

(Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Idaho Falls

DATE OF BURIAL

1-12-1922

20. UNDERTAKER

B. E. Hinwood

ADDRESS

Idaho Falls

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37566
Registered No. 21

1. PLACE OF DEATH

County of BONNEVILLECity of IDAHO FALLSRegistration District No. 73Primary Registration District No. 2100

(No.)

(St.)

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME LOUIE A. HALEY

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

MALE

4. COLOR OR RACE

WHITE5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDMARRIED

(Write the word.)

6. DATE OF BIRTH

JUNE141867

(Month)

(Day)

(Year)

7. AGE

54Yrs. 10Mos. 3

ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of workSALESMAN(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country)

NORTHVILLE, MICH.10. NAME OF
FATHERSAMUEL HALEY11. BIRTHPLACE
OF FATHER

(State or Country)

CANADA12. MAIDEN NAME
OF MOTHERELECTALockwood13. BIRTHPLACE
OF MOTHER

(State or Country)

NEW YORK

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Louie A. Haley
Idaho Falls, Ida.

15.

Filed

Apr. 171922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 17/1921
JUNE 14 1867

(Month)

(Day)

19.....
(Year)

17. I HEREBY CERTIFY, That I attended deceased from
FEB. 23' 1922, to 4/17/22 19.....

that I last saw him alive on 4/16/22 19.....
and that death occurred on the date stated above, at 5.30 M. A

The CAUSE OF DEATH* was as follows:

ADDISON'S DISEASE

(Duration)

UNKNOWN

Yrs.

mos.

ds.

Contributory
(Secondary)INFLUENZA

(Duration)

Yrs.

mos.

ds.

(Signed)

F. J. ERNEST

M. D.

4/17/1922

(Address)

SMITH BUILDING

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death.....Yrs.....mos.....days. In the State.....Yrs.....mos.....days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

MOLINE ILL

DATE OF BURIAL

4/21 1922

20. UNDERTAKER

CLIFF HAYES

ADDRESS

IDAHO FALLS I.

✓
CERTIFICATE OF DEATHState of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bonneville
City of Idaho FallsRegistration District No. 73
Primary Registration District No. 218-2
(No. St.)File No. 37567
Registered No. 20

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Eli D. Mikesell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Married
(Write the word.)

6. DATE OF BIRTH

Month 2 1876
(Month) (Day) (Year)

7. AGE

46 Yrs. 1 Mos. 3 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

John Mikesell

11. BIRTHPLACE OF FATHER

(State or Country)

Ind.

12. MAIDEN NAME OF MOTHER

Sarah Skinner

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Eli D. Mikesell
(Address) Idaho Falls, Id.

15.

Filed Apr 11 19 22 Wm. D. Mikesell
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 5 19 22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

..... 19..... to 19.....
that I last saw him..... alive on 19.....
and that death occurred on the date stated above, at 2 P. M.
The CAUSE OF DEATH* was as follows:Accidental Drowning

..... (Duration) Yrs. mos. ds.

Contributory
(Secondary)

..... (Duration) yrs. mos. ds.

(Signed)

4/9/22 19 22 E. E. Hinwoodey
(Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Idaho Falls, Ida

DATE OF BURIAL

4-8-1922

20. UNDERTAKER

E. E. Hinwoodey

ADDRESS

Idaho Falls

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37568

1. PLACE OF DEATH

County of BoundaryCity of Bonners Ferry

If death occurs away from
usual residence, give facts
called for under special in-
formation.

Registration District No. 79Primary Registration District No. 2156

(No. _____ St.)

Registered No. _____

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

2. FULL NAME Walter Oscar Super

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

May 4 1882
(Month) (Day) (Year)

7. AGE

38 Yrs. 10 Mos. 9 ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.

Section-hand

(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer).

S. J. Ry.

9. BIRTHPLACE

(State or Country)

Illinois10. NAME OF
FATHERJohn J. Super11. BIRTHPLACE
OF FATHER

(State or Country)

Bunker Hill Ill.12. MAIDEN NAME
OF MOTHEROline Moore13. BIRTHPLACE
OF MOTHER

(State or Country)

Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John Theodor Super

(Address)

15.

Filed 3/6/1922Local Registrar ESR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 4 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb. 26 1922 to May 4 1922

that I last saw him alive on May 4 1922and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia(Duration) Yrs. _____ mos. 2 ds.Contributory
(Secondary)Influenza(Duration) Yrs. _____ mos. 4 ds.

(Signed)

3/6/1922

(Address)

Bonners Ferry, Id.

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Bonners Ferry Id.

DATE OF BURIAL

May 6 1922

20. UNDERTAKER

DR Shook

ADDRESS

Bonners Ferry

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37569
Registered No. _____

1. PLACE OF DEATH

County of BoundaryCity of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 29Primary Registration District No. 5156

(No. _____ St.)

2. FULL NAME

Wong Born

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE Yellow 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE About70 Yrs. Mos. ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Cook

9. BIRTHPLACE

(State or Country)

China

10. NAME OF FATHER

Wong Hun

11. BIRTHPLACE OF FATHER

(State or Country)

China

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

China

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Wong Born
Spokane Wash.

15.

Filed

3/12/22 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 9 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec. 12 1921 to Mar. 9 1922that I last saw him alive on Mar. 9 1922and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver
(Primary Carcinoma of
adipose tissue)

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

3/11/22(Address) Bonner Ferry Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bonner Ferry Ida March 11, 1922

20. UNDERTAKER

ADDRESS

Restocky Bonner Ferry

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37570

1. PLACE OF DEATH

County of Bonanza
City of Bonanza Ferry

Registration District No. 29
Primary Registration District No. 2156
(No. _____ St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lawrence Irving Monhouse

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Infant
(Write the word.)

6. DATE OF BIRTH

Feb 12 1922
(Month) (Day) (Year)

7. AGE

25 Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Cyrus A. Monhouse

11. BIRTHPLACE OF FATHER

(State or Country) Missouri

12. MAIDEN NAME OF MOTHER

Maudie E. New

13. BIRTHPLACE OF MOTHER

(State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Cyrus A. Monhouse
(Address) _____

15. Mar. 9/1922
Filed 55th

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 9 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 24 1922, to Mar. 9 1922
that I last saw him alive on Mar. 8 1922
and that death occurred on the date stated above, at 4 P. M.
The CAUSE OF DEATH* was as follows:
Bronchopneumonia

(Duration) Yrs. mos. 13 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) R. B. Bowall M. D.

3-9-1922 (Address) Bonanza Ferry Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Bonanza Ferry Idaho

DATE OF BURIAL

Mar. 10. 1922

20. UNDERTAKER

Dr. Shook

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of BoundaryCity of Bonners Ferry

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 79Primary Registration District No. 5152

(No. _____)

St.)

File No. 37571

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Arthur J. States

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WID-OWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

June

(Month)

4

(Day)

1884

(Year)

7. AGE

37

Yrs.

9

Mos.

23

ds.

IF LESS than 1 day

how many _____ hrs.

or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Laborer

(b) General nature of industry, business or establishment in which employed (or employer)

By Road

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

Wm States

11. BIRTHPLACE OF FATHER

(State or Country)

unknown

12. MAIDEN NAME OF MOTHER

Julia Long

13. BIRTHPLACE OF MOTHER

(State or Country)

unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. J. Jones

(Address)

Bonners Ferry

15.

Filed

3/28/22

19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar.

(Month)

27

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19____, to

19____

that I last saw h_____ alive on_____ 19____

and that death occurred on the date stated above, at_____ M.

The CAUSE OF DEATH* was as follows:

Crushed by falling rock

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

E. E. Saunders

M. D.

Carson

19____

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

yrs.

mos.

days.

In the

State

yrs.

mos.

days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Crosby. N. D.

DATE OF BURIAL

3/291922

20. UNDERTAKER

Dr. Storky

ADDRESS

Bonners Ferry

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37572
Registered No.

1. PLACE OF DEATH

County of Boundary
City of Bonners Ferry

Registration District No. 79
Primary Registration District No. 2156
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Dorville Oscar Walter

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

M

W

Married
(Write the word.)

6. DATE OF BIRTH

Apr 14 1874
(Month) (Day) (Year)

7. AGE

47 Yrs. 11 Mos. 13 ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Laborer

(b) General nature of industry, business or establishment in which employed (or employer).

M. H. Ry

9. BIRTHPLACE

(State or Country)

Minn.

10. NAME OF FATHER

J. M. Walter

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Mary Castle

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

John Silatony

15.

Filed

3/28/1922

S. E. Fry
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 27 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

..... 19....., to 19.....
that I last saw h..... alive on..... 19.....
and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Crushed by falling rock

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

E. E. Saunders M. D.

3/28 1922

(Address)

Carman

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Bonners Ferry Ida

DATE OF BURIAL

Mar. 29. 1922

20. UNDERTAKER

Ed Tooley

ADDRESS

Bonners Ferry

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37573

1. PLACE OF DEATH

County of Bonner
City of Bonner Ferry

Registration District No. 79
Primary Registration District No. 2156
(No. _____ St.)

Registered No. _____

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

William J. Clark

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH Mar 10 1857
(Month) (Day) (Year)

7. AGE 65 Yrs. 17 Mos. da.
IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

Labour
S. N. Ry Co.

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

William Clark

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

May Jane Mills

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

H. L. Clark
Bonner Ferry, Ida.

15.

Filed

3/28/22 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 27 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____ 19____, to _____ 19____
that I last saw h_____ alive on _____ 19____
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Crushed by falling rock

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

3/28/22 1922

(Address)

E. E. Saunders M. D.
Canon

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bonner Ferry, Ida.

Mar 28 1922

20. UNDERTAKER

ADDRESS

Edw. L. Loney

Bonner Ferry, Ida.

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 37574

Registered No. _____

1. PLACE OF DEATH.

County of Butte Registration District No. 59
City of Moore Registration District No. 2129
St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mildred E. Mackay

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

W

Single

6. DATE OF BIRTH.

Mar. 6 1919
(Month) (Day) (Year)

7. AGE

3 Yrs. 7 Mos. 7 ds.

IF LESS than 1 day
how many hrs. or min. 2

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE

(State or Country)

Sugar City, Ida

10. NAME OF FATHER

Graham Mackay

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Fannie Stoddard

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Graham Mackay
Moore

15.

Filed 191

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar. 13 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-11-1922 to 3-12-1922 that I last saw her alive on 3-12-1922 and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) Yrs. mos. 2 ds.

Contributor (Secondary)

(Duration) Yrs. mos. ds.

(Signed)

3/13/22 J. M. Cannon M. D.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death... yrs... mos... days In the State... yrs... mos... days

Where was disease contracted if not at place of death?...

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Moore, Ida 3/15/22

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH

County of CanyonCity of Hamlet

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED

CERTIFICATE OF DEATH

Registration District No. 2006Primary Registration District No. 2006(No. 2006)

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 37575Registered No. 37575

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed April 15 1922 Pearl Soda
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

1922 (Year)17. I HEREBY CERTIFY, That I attended deceased from Oct 22 1921 to Feb 1 1922that I last saw him alive on Feb 1 1922
and that death occurred on the date stated above, at 7:00 A.M.

The CAUSE OF DEATH* was as follows:

Acute dilatation heart(Duration) 4 Yrs. 2 mos. 2 ds.Contributory (Secondary) Myocarditis (Rubeola)(Duration) 4 yrs. 2 mos. 2 ds.(Signed) Grace P. Belknap M. D.Mar 22 1922 (Address) Hamlet Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 4 yrs. 2 mos. 2 days. In the State 4 yrs. 2 mos. 2 days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Kohlertown Cem2/3 1922

20. UNDERTAKER

ADDRESS

Fred K. RobinsonHamlet Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Canyon
City of Hamlet

Registration District No. 7
Registration District No. 2006
(No. of Certificate) 37576

File No. 37576
Registered No. 37576

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wayne Morrison

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

16. DATE OF DEATH Feb 7 1922
(Month) (Day) (Year)

6. DATE OF BIRTH Oct 1903
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 26 1921, to Feb 7 1922
that I last saw him alive on Feb 6 1922
and that death occurred on the date stated above, at M.

7. AGE 18 Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

The CAUSE OF DEATH* was as follows:
Appendicitis - General peritonitis - Obstruction of bowels (Three operations - 1st one Dec 26)
(Duration) Yrs. 7 mos. 12 ds.

8. OCCUPATION Farmer
(a) Trade, profession particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Contributory (Secondary) None
(Duration) yrs. mos. ds.
(Signed) Geo. R. Proctor M. D.
Mar. 1922 (Address) Nampa, Ida

9. BIRTHPLACE Idaho
(State or Country)

10. NAME OF FATHER Lith Morrison

11. BIRTHPLACE OF FATHER New York
(State or Country)

12. MAIDEN NAME OF MOTHER Kate Lamb

13. BIRTHPLACE OF MOTHER Colo
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Raymond Morrison
(Address) Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.
Where was disease contracted if not at place of death?
Former or usual residence

15. Filed March 14 1922 Pearle Dodd
Local Registrar

19. PLACE OF BURIAL OR REMOVAL Kohlerman Cem DATE OF BURIAL Feb 9 1922

20. UNDERTAKER And H. Robinson ADDRESS Nampa

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

County of Canyon
City of NampaRECEIVED
APR 23 1922Registration District No. 7Primary Registration District No. 2606

(No. _____)

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Edward FrankState of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

37578

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

male

4. COLOR OR RACE

white5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.Single
(Write the word.)

6. DATE OF BIRTH.

Aug
(Month)10
(Day)1908
(Year)

7. AGE

13

Yrs.

Mos.

ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work....

none

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country)

Washington

10. NAME OF FATHER

John Frank

11. BIRTHPLACE OF FATHER

(State or Country)

unknown

12. MAIDEN NAME OF MOTHER

unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Dr. B. B. Boyner

(Address)

Nampa, Idaho

15.

Filed

April 10 1922Pearle Dodds

Local Registrar

16. DATE OF DEATH

Apr
(Month)6
(Day)1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 31 1921 to Apr 6 1922that I last saw him alive on Apr 6 1922and that death occurred on the date stated above, at 3:00 M.

The CAUSE OF DEATH was as follows:

Broncho Pneumonia

(Duration)

Yrs.

mos.

3 ds.Contributory
(Secondary)Influenza

(Duration)

Yrs.

mos.

3 ds.

(Signed)

Dr. B. B. Boyner

M. D.

4/6-1922 (Address) Nampa, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death.....

yrs.

mos.

days

In the

State.....

yrs.

mos.

days

Where was disease contracted if not at place of death?.....

Former or usual residence

South Point, Idaho

19. PLACE OF BURIAL OR REMOVAL

Nampa, Cen

DATE OF BURIAL

4/8 1922

20. UNDERTAKER

W. K. Robinson

ADDRESS

Nampa

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 7

County of Canyon

Primary Registration District No. 2606

City of Nampa

(No. St.)

File No. 37579

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Lillian Williams

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

Female White

Single

(Write the word.)

6. DATE OF BIRTH.

(Month) (Day) (Year)

7. AGE

26 Yrs. Mos. ds.

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...

home

9. BIRTHPLACE

(State or Country)

Illinois

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Donny Williams
Nampa Idaho

15.

Filed April 10 1922

Pearl Dadds
Local Registrar

16. DATE OF DEATH

4 4 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 9th 1918 to April 4th 1922.

that I last saw her alive on April 4th 1922.

and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Glandular Tuberculosis

(Duration) 1 Yrs. mos. ds.

Contributory (Secondary) Influenza

(Duration) Yrs. mos. ds.

(Signed) Donny Williams M. D.

4/4 1922 (Address) Nampa Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 7 yrs. 10 mos. 7 days In the State yrs. mos. days

Where was disease contracted if not at place of death? Blackfoot Idaho

Former or usual residence Regby Idaho

19. PLACE OF BURIAL OR REMOVAL

Regby Idaho

20. UNDERTAKER

June R Robinson

DATE OF BURIAL

4 1 1922

ADDRESS

Nampa

Idaho

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **37580**
Registered No.

1. PLACE OF DEATH

County of **Benyon**
City of **Hampton**

Registration District No. **7**
Primary Registration District No. **2006**
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Silas C. Young

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Single**
(Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

58

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, Profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Permi

10. NAME OF FATHER

John Young

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Laving Owen

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. C. Young
J. Haman, Ida, R#4.

15.

Filed **April 10 1922** **Pearle Dodds**
Local Registrar

16. DATE OF DEATH

Apr - 2 - 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Apr - 1 - 1922** to **Apr - 2 - 1922**
that I last saw him alive on **Apr - 2 - 1922**
and that death occurred on the date stated above, at **4** M.
The CAUSE OF DEATH was as follows:
Pneumonia

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) **Thos E. Mangum, M.D.**

4-10-1922 (Address) **Hampton, Ida.**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hampton Idaho

Apr 3 1922

20. UNDERTAKER

ADDRESS

Fred K. Robinson

Hampton

Ida

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 37581

Registered No.

1. PLACE OF DEATH

County of Ada

Registration District No.

Primary Registration District No. 2366

City of

(No.

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Gerald Wm Schmidt

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

Mar

31

22

(Month)

(Day)

(Year)

7. AGE

Yrs.

Mos.

ds.

IF LESS than 1 day
how many $2\frac{1}{2}$ hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Wm Schmidt

11. BIRTHPLACE OF FATHER

(State or Country)

Nebr

12. MAIDEN NAME OF MOTHER

Anna K Jolin

13. BIRTHPLACE OF MOTHER

(State or Country)

Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wm Schmidt

(Address)

Nampa #4

15.

Filed

Mar 10 1922

Pearl

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 31

(Month)

(Day)

1922
(Year)17. I HEREBY CERTIFY, That I attended deceased from
Mar 31 1922 to Mar 31 1922that I last saw him alive on Mar 31 1922
and that death occurred on the date stated above, at 4 M.

The CAUSE OF DEATH* was as follows:

Congenital weakness
and dystocia

(Duration)

Yrs.

mos.

3 hours
ds.Contributory
(Secondary)

Convulsions

(Duration)

Yrs.

mos.

ds.

(Signed)

Geo R Proctor

M. D.

Mar 5 1922 (Address) Nampa 2nd

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Kuhlmann Cem

DATE OF BURIAL

4-1922

20. UNDERTAKER

Bud K Proctor

ADDRESS

Nampa

MARGIN REQUIRED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH

County of Canyon
City of Hamlet

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Sarah E. Troxler

CERTIFICATE OF DEATH

Registration District No. 7
Primary Registration District No. 144
No. 37582

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 37582
Registered No. 37582

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widow
(Write the word.)

6. DATE OF BIRTH Jan 2 1848
(Month) (Day) (Year)

7. AGE 74 Yrs. 2 Mos. 7 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE Canada
(State or Country)

10. NAME OF FATHER James Eldridge

11. BIRTHPLACE OF FATHER Canada
(State or Country)

12. MAIDEN NAME OF MOTHER Sanders

13. BIRTHPLACE OF MOTHER Canada
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. Troxler
(Address) Hamlet, Idaho

15. Filed Mar 11 1922 Seamus Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 9 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 4 1922 to July 1922
that I last saw her alive on Mar 4 1922
and that death occurred on the date stated above, at 4:40 P.M.

The CAUSE OF DEATH* was as follows:
Senile gangrene
& Cardiac insufficiency
(Duration) Yrs. 3 mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) H. P. Ross M. D.
Apr 1 1922 (Address) Hamlet

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Kohlman Cem DATE OF BURIAL 3-11-1922

20. UNDERTAKER Frank Robinson ADDRESS Hamlet

1. PLACE OF DEATH

County of Canyon District No. 3
City of Nampa Primary Registration District No. 1
(No. (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Catherine Bell HuntlyState of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37583
Registered No. 37583

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

May 9 1919
(Month) (Day) (Year)

7. AGE

2 Yrs. 10 Mos. - 0 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed April 1 1922Sealed

Local Registrar

CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 10 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar 2 1922 to Mar 10 1922that I last saw her alive on Mar 9 1922and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia(Duration) Yrs. mos. 12 ds.

Contributory (Secondary)

Influenza

(Duration) yrs. mos. ds.

(Signed)

J. H. Murray M. D.
3/12 1922 (Address) Nampa, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Robb's Cemetery3-12-1922

20. UNDERTAKER

ADDRESS

Fred K. RobinsonNampa

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **37584**

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH **✓**County of **Canyon**
City of **Hammer**

Registration District No.

Primary Registration District No. **1006**

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

BUREAU
STAMP**Donald Word Reed**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.**male****wh.**

(Write the word.)

6. DATE OF BIRTH

Oct.**29****1921**

(Month)

(Day)

(Year)

7. AGE

5 Yrs. **0** Mos. **0** ds.IF LESS than 1 day
how many... hrs. or
D. min.

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
(b) General nature of in-
dustry, business, or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country)

Canyon Co Idaho10. NAME OF
FATHER**John W Reed**11. BIRTHPLACE
OF FATHER

(State or Country)

Utah12. MAIDEN NAME
OF MOTHER**Bentree Burinham**13. BIRTHPLACE
OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

M. J. Frink MD
Hammer Ida

15.

Filed **April 10** **1922****Pearle Dadds**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March**29****1922**

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from
March 6 **1922** to **March 28** **1922**
that I last saw him alive on **March 28** **1922**
and that death occurred on the date stated above, at **6 P** M.
The CAUSE OF DEATH* was as follows:**Broncho Pneumonia**

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)**Influenza**

(Duration)

Yrs.

mos.

ds.

(Signed)

M. J. Frink

M. D.

Mar 29 1922 (Address)

Hammer Ida*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place

In the

of death....yrs....mos....days State....yrs....mos....days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Kohlerstown Penn**3-31** **1922**

20. UNDERTAKER

ADDRESS

None

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ganyon Union District No. 7
City of Nampa Registration District No. 1006
(Not for use by Hospital St.)File No. 37585

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Edwence Jackson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Malewhitemarried

(Write the word.)

6. DATE OF BIRTH

9-16-1881

(Month)

(Day)

(Year)

7. AGE

40 Yrs. 6 Mos. 15 ds.

IF LESS than 1 day

how many _____ hrs.

or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

grocery man

9. BIRTHPLACE

(State or Country)

Oregon

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Carrie

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs Ella Jackson

(Address)

1219 - 2nd - north

15.

Filed April 10 1922Pearle Dadds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

3-31-1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19that I last saw h. _____ alive on 19

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Suicidal - Gun shot in left side.

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Paul L. Base M.D.4-1-1922 (Address) Coroner.
Bredwell Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Kohlerlawn Cem4-3 1922

20. UNDERTAKER

ADDRESS

Fred K RobinsonNampa Id

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MAINTAINED RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37586

1. PLACE OF DEATH

County of Canyon Registration District No. 1086
City of Nampa Primary Registration District No. 1086 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John R Simpson

Registered No. _____
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH May 5 1922
(Month) (Day) (Year)

7. AGE 60 Yrs. 11 Mos. 5 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION Contractor
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE Wis
(State or Country)

10. NAME OF FATHER Samuel Simpson

11. BIRTHPLACE OF FATHER Del.
(State or Country)

12. MAIDEN NAME OF MOTHER Sydney Citinerson

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. C. Simpson
(Address) Nampa Idaho

15. Filed Apr 16 1922 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr 31 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 11 1922 to Mar 31 1922 that I last saw him alive on Mar 31 1922 and that death occurred on the date stated above, at 8 P. M.
The CAUSE OF DEATH* was as follows:
Pneumonia Pectoris.

(Duration) 2 Yrs. 0 mos. 0 ds.
Contributory (Secondary) Influenza.
(Duration) 0 yrs. 0 mos. 21 ds.
(Signed) Geo. D. K. Keeler, M. D.
4-10-22 (Address) Nampa Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Nampa Idaho DATE OF BURIAL Apr 4 1922
20. UNDERTAKER J. K. Robinson ADDRESS Nampa Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon
City of NauphaRegistration District No. 7
Primary Registration District No. 1006
(No. Lake View Terrace St.)File No. 37587
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Ralph Charles Jones

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

Feb 14 1922
(Month) (Day) (Year)

7. AGE

— Yrs. 1 Mos. 15 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Geo H Jones

11. BIRTHPLACE OF FATHER

(State or Country)

Mo.

12. MAIDEN NAME OF MOTHER

Annie L. Shafer

13. BIRTHPLACE OF MOTHER

(State or Country)

S. Dak

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Geo H Jones

(Address)

Naupha Ida

15.

Filed April 10 1922 Pearle Dodds

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 2 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 1 1922 to April 2 1922
that I last saw him alive on April 2 1922and that death occurred on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Transition

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory (Secondary)

Premature birth

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

J H Murray M. D.4/14/1922 (Address) Naupha Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Rollulawee Cen

DATE OF BURIAL

4-7-1922

20. UNDERTAKER

Ed H Robinson

ADDRESS

Naupha

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Canyon
City of Middleton

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No. 3
Primary Registration District No. 2005
St. IdahoState of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37591
Registered No. 36

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-OWED OR DIVORCED married

6. DATE OF BIRTH

Feb 12 1856
(Month) (Day) (Year)

7. AGE

66 Yrs. 1 Mos. 12 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Rancher

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

Wm. Smith

11. BIRTHPLACE OF FATHER

(State or Country)

Don't know

12. MAIDEN NAME OF MOTHER

1111

13. BIRTHPLACE OF MOTHER

(State or Country)

1111

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Mary Smith
Middleton Ida

15.

Filed

Mar. 16 - 1922John H. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 14 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from 3-13 1922, to 3-14 1922 that I last saw him alive on 3-14 1922 and that death occurred on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Acute Indigestion(Duration) Yrs. mos. 2 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. H. Meyer M. D.3-14-1922 (Address) Middleton - Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Middleton

DATE OF BURIAL

3-17 1922

20. UNDERTAKER

C. V. Beckham

ADDRESS

Caldwell

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon Registration District No. 3
City of Notus Primary Registration District No. 2005
(No. 1000 St.)File No. 37593Registered No. 45

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William Eugene McLaughlin
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED
(Write the word.)

6. DATE OF BIRTH

July 24 1922
(Month) (Day) (Year)

7. AGE

8 Yrs. 11 Mos. 11 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)At home

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

M. W. McLaughlin
Idaho

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Eunice M. Leverton
Oklahoma

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

W. E. McLaughlin
Notus, Ida

15.

Filed April 7 1922John V. Meyer
Local Registrar

16. DATE OF DEATH

April 5 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 29 1922 to April 5 1922
that I last saw him alive on April 5 1922
and that death occurred on the date stated above, at 9:00 P.M.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia(Duration) Yrs. mos. 14 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

John V. Meyer M. D.
4/7 1922 (Address) Caldwell

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Buried in 4-7 1922

20. UNDERTAKER

ADDRESS

G. V. Beckham Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Canyon
City of CaldwellRegistration District No. 3
Primary Registration District No. 1005-
(No. 44 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ralph Lavene KleinState of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37594
Registered No. 44

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male white.

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

Dec 19 1919
(Month) (Day) (Year)

7. AGE

2 Yrs. 3 Mos. 17 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

At home

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

S. Ralph Klein

11. BIRTHPLACE OF FATHER

(State or Country)

Iowa

12. MAIDEN NAME OF MOTHER

Geneva W. McClary

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

S. Ralph Klein

(Address)

Caldwell, Ida

15.

Filed April 6 1922John H. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Apr 6 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Apr 24 1922 to April 6 1922that I last saw him alive on April 6 1922and that death occurred on the date stated above, at 11-22 M.

The CAUSE OF DEATH* was as follows:

Pneumonia and complications

(Duration) Yrs. mos. ds.

Contributory (Secondary)

Influenza

(Duration) yrs. mos. ds.

(Signed) Dora A. Heymonick D.O.4-6 1922 (Address) Caldwell

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Canyon Hill

DATE OF BURIAL

4-8 1922

20. UNDERTAKER

W. Beckham

ADDRESS

Caldwell

2. FULL NAME

MEDICAL CERTIFICATE OF DEATH

Local Registrar

20. UNDERTAKER	ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should be stated EXACTLY, OCCUPATION should be stated EXACTLY, in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of card.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED

Registration District No.

Primary Registration District No.

No.

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employment).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

(Duration) Yrs. mos. ds.
Contributory (Secondary)

(Duration) yrs. mos. ds.
(Signed) M. D.

19 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

1. PLACE OF DEATH

County of Canyon
City of CaldwellIf death occurs away from Sanitarium
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No. 3
Primary Registration District No. 2005
(No. 103 St.)State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37597
Registered No. 41If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED single

6. DATE OF BIRTH

Feb 11 1923
(Month) (Day) (Year)

7. AGE

19 Yrs. 1 Mos. 10 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work at home
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country) Colorado10. NAME OF
FATHERA. H. Raymond11. BIRTHPLACE
OF FATHER(State or Country) Kansas12. MAIDEN NAME
OF MOTHERMay William13. BIRTHPLACE
OF MOTHER(State or Country) Colorado

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. H. Raymond
Huston, Ida.

15.

Filed Mar. 23 - 1922John H. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 21 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
Mar. 21 1922 to Mar. 21 1922
that I last saw him alive on Mar. 21 1922
and that death occurred on the date stated above, at 5 P.M.
The CAUSE OF DEATH* was as follows:Influenza Pneumonia(Duration) _____ Yrs. _____ mos. 7 ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

3-22-22

(Address)

Caldwell, Idaho*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Pleasant Ridge

DATE OF BURIAL

3-24-22

20. UNDERTAKER

C. L. Beckham

ADDRESS

Caldwell

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of *Canyon*City of *Caldwell*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No. *3*Primary Registration District No. *1005*(No. *108*)

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *37598*Registered No. *40*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF
FATHER11. BIRTHPLACE
OF FATHER

(State or Country)

12. MAIDEN NAME
OF MOTHER13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Mar. 20 - 1922

Local Registrar

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

Sept 3 - 1920 to *March 18 - 1922*that I last saw her alive on *March 18 - 1922*and that death occurred on the date stated above, at *3:30* P. M.

The CAUSE OF DEATH* was as follows:

Uremic intoxication(Duration) Yrs. *7* mos. *7* ds.Contributory
(Secondary)(Duration) *2 +* yrs. *2* mos. *2* ds.

(Signed)

S. O. Duvalley M. D.

19

(Address) *Caldwell, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Canyon Hill**3-20-1922*

20. UNDERTAKER

ADDRESS

*C. V. Beckham**Caldwell*

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
1922
ITAL

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Cuyahoga Registration District No. 3
 City of Homestead (No. 2005 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Melvina Loin

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 37599Registered No. 38

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single

6. DATE OF BIRTH

1855
 (Month) (Day) (Year)

7. AGE

67 Yrs. Mos. ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

House

9. BIRTHPLACE

(State or Country)

Tennessee

10. NAME OF FATHER

B. F. Loin

11. BIRTHPLACE OF FATHER

(State or Country)

Tenn.

12. MAIDEN NAME OF MOTHER

Mary Lake

13. BIRTHPLACE OF MOTHER

(State or Country)

Tenn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Wm. Loin
Homestead, Pa.

15.

Filed Mar. 18 1922

John V. Meyer
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 16 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19

that I last saw h. er alive on Jan 20 1922

and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Paralysis

(Duration) 1 Yrs. mos. ds.

Contributory
 (Secondary)

(Duration) yrs. mos. ds.

(Signed)

Wm. Loin M. D.

Mar. 19 22 (Address) Wilden Eda.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Fargo cem. Mar 18 1922

20. UNDERTAKER

ADDRESS

W. Beckham Calderwell

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

Registration District No.

Primary Registration District No.

(No.)

St.)

File No.

Registered No.

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF
FATHER11. BIRTHPLACE
OF FATHER

(State or Country)

12. MAIDEN NAME
OF MOTHER13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at A.M.

The CAUSE OF DEATH* was as follows:

sidemaing lungs

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) M.D.

3/1/1922 (Address) Colchester, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state

(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of form.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Engel

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH

Feb 10 1852
(Month) (Day) (Year)

7. AGE

70 Yrs 1 Mos. 11 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Livery business
Retired

9. BIRTHPLACE

(State or Country)

Deer

10. NAME OF FATHER

Peter Engel

11. BIRTHPLACE OF FATHER

(State or Country)

France

12. MAIDEN NAME OF MOTHER

Barbara Nafziger

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Karl H. Mann

(Address) Emmett Idaho.

15. Filed Mar. 12 - 1922

John H. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 10 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 7 1922 to Mar 10 1922 that I last saw him alive on Mar 9 1922 and that death occurred on the date stated above, at 6 PM.

The CAUSE OF DEATH* was as follows:

Influenza Pneumonia

(Duration) Yrs. mos. 5 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

3-10-22 (Address) M. D.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Canyon Hill

DATE OF BURIAL

3-12-1922

20. UNDERTAKER

Paul L. base

ADDRESS

Baldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Mitchell

 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

 County of Canyon
City of _____
Registration District No. 3
 Primary Registration District No. 2007
(No. _____ St.)
File No. 37602Registered No. 9
 If death occurs away from
usual residence, give facts
called for under special
information.

2. FULL NAME

Jess Mahan
 If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

F

4. COLOR OR RACE

W5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH.

Nov
(Month)

7
(Day)

1921
(Year)

7. AGE

 Yrs. 15 Mos. 3 ds.

 IF LESS than 1 day
how many hrs. or
..... min. ?

8. OCCUPATION

 (a) Trade, profession or
particular kind of work.....
(b) General nature of in-
dustry, business, or estab-
lishment in which employ-
ed (or employer).....

9. BIRTHPLACE

(State or Country)

Canyon Co10. NAME OF
FATHERJess Mahan11. BIRTHPLACE
OF FATHER

(State or Country)

Idaho12. MAIDEN NAME
OF MOTHERMattie Drimmer13. BIRTHPLACE
OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Jess Mahan

(Address)

15.

Filed

Apr 101922Richard H. Halden

Local Registrar

16. DATE OF DEATH

Mar 10
(Month) (Day)

1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 25 1922 to Mar 10 1922

 that I last saw him alive on Mar 10 1922

 and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia
 (Duration) Yrs. mos. 13 ds.

 Contributory
(Secondary)

(Duration) yrs. mos. ds.

 (Signed) J. M. Mitchell M. D.

3/11 1922 (Address) Barren

 *State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.
18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)
 At place In the
of death yrs. mos. days State yrs. mos. days

 Where was disease contracted
if not at place of death?

 Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

RoswellMar 11 1922

20. UNDERTAKER

ADDRESS

Barren Fun CoBarren

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at P. M.

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Signed)

3-26-22

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

1. PLACE OF DEATH

County of CassiaCity of Burley

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Le Roy Bailey

CERTIFICATE OF DEATH

Registration District No. 117Primary Registration District No. 2196

State of Idaho

BOARD OF HEALTH

Bureau of Vital Statistics

File No. 37580Registered No. 581

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH.

Feb. 1921
(Month) (Day) (Year)

7. AGE

11 Yrs. 11 Mos. ds.IF LESS than 1 day
how many hrs. or
..... min.?"

8. OCCUPATION

(a) Trade, profession or particular kind of work

At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Burley Ida.

10. NAME OF FATHER

Leon Bailey

11. BIRTHPLACE OF FATHER

(State or Country)

Summit Co. W. Va.

12. MAIDEN NAME OF MOTHER

Lillie Smith

13. BIRTHPLACE OF MOTHER

(State or Country)

Pocatello Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

R. M. Bailey

(Address)

R. F. D. #4 Burley Ida.

15.

Filed March 25, 1922H. J. Patterson
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 24, 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from March 24, 1922 to March 24, 1922that I last saw her alive on March 24, 1922
and that death occurred on the date stated above, at 2:00 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia(Duration) Yrs. mos. 2 ds.Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) J. C. Patterson M. D.3-25-1922 (Address) Burley Ida.

*State the Disease Causing Death; or in Deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days, State yrs. mos. daysWhere was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Burley Ida.

DATE OF BURIAL

Mar. 25, 1922

20. UNDERTAKER

Bishop W. R. Waite

ADDRESS

Burley

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Cassia*
 City of *Burley*
 If death occurs away from
 usual residence, give facts
 called for under special
 information.

Registration District No. *117*
 Primary Registration District No. *2196*
 (No. *21* VITAL St.)

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. *37507*
 Registered No. *582*
 If death occurred in a hos-
 pital, institution or camp,
 give its NAME instead of
 street and number.

2. FULL NAME *George Arthur Chatburn*

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED. *Single* (Write the word.)

6. DATE OF BIRTH. *Jan. 9, 1887*
 (Month) (Day) (Year)

7. AGE *38* Yrs. *2* Mos. *6* ds. IF LESS than 1 day
 how many hrs. or
 min.?

8. OCCUPATION

(a) Trade, profession or
 particular kind of work *School Teacher*
 (b) General nature of in-
 dustry, business, or estab-
 lishment in which em-
 ployed (or employer)

9. BIRTHPLACE

(State or Country) *Shelby Co. Iowa*

10. NAME OF
FATHER

John Chatburn

11. BIRTHPLACE
OF FATHER

(State or Country) *England*

12. MAIDEN NAME
OF MOTHER

Margaret Chatburn

13. BIRTHPLACE
OF MOTHER

(State or Country) *Iowa*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *W. W. Chatburn*
 (Address) *Albion, Idaho*

15. *Apr. 6, 1922* *Dr. J. C. Patterson*
 Filed Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 15, 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to 191

that I last saw h... alive on 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Poisoning, Suicidal
 (Duration) Yrs. mos. ds.

Contributory
 (Secondary)

(Duration) Yrs. mos. ds.

(Signed) *L. B. Galloway (Coroner)* M.D.

3/15/22 (Address) *Burley, Idaho*

*State the Disease Causing Death; or in deaths from Violent
 Causes, state (1) Means of Injury; and (2) whether Accidental,
 Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place In the
 of death yrs. mos. days, State yrs. mos. days

Where was disease contracted
 if not at place of death?

Former or
 usual residence

19. PLACE OF BURIAL OR REMOVAL

Albion, Idaho

20. UNDERTAKER

L. B. Galloway

DATE OF BURIAL

Mar. 17, 1922

ADDRESS

Burley, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS
 should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement
 of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M, 6-15-17.

APR 21 1922

CERTIFICATE OF DEATH

37608 State of Idaho
BOARD OF HEALTH

1. PLACE OF DEATH

County of *Cassia*

Registration District No. *117*

City of *Burley*

Primary Registration District No. *2196*

If death occurs away from usual residence, give facts called for under special information.

(No., St.)

File No.

Registered No. *583*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME *Maurice Jensen (Geech)*

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single (Write the word.)

6. DATE OF BIRTH.

June 15 19*13*
(Month) (Day) (Year)

7. AGE

8 Yrs. *9* Mos. *5* ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

In School

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Provo Utah

10. NAME OF FATHER

Chris Jensen

11. BIRTHPLACE OF FATHER

(State or Country)

Denmark

12. MAIDEN NAME OF MOTHER

Mary Jensen

13. BIRTHPLACE OF MOTHER

(State or Country)

Provo Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mrs. Leon Gillelde*

(Address) *P.O. Box Burley Ida.*

Filed *Apr 6th* 19*22*

Dr. J. C. Patterson

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 20 19*22*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

..... 191..... to 191.....

that I last saw h..... alive on 191.....

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Fracture Of Skull & Neck

Auto Accident

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) *L. B. Gellagey* (Coroner) *M. D.*

3/21/1922, (Address) *Burley Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days, State yrs. mos. days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Burley Ida.

DATE OF BURIAL

3/22/1922

20. UNDERTAKER

L. B. Gellagey

ADDRESS

Burley Ida.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics1. PLACE OF DEATH *Idaho* RE *Idaho*
County of *Idaho* District No. *Idaho*
City of *Idaho* (No. *Idaho* St.)File No. *37609*
Registered No. *37609*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Sarah Penelope Nelson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Widowed*6. DATE OF BIRTH *1 5 1892*
(Month) (Day) (Year)7. AGE *70 Yrs. 2 Mos. 4 ds.* IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work *Housewife*
(b) General nature of industry, business or establishment in which employed (or employer)9. BIRTHPLACE *Idaho*
(State or Country)10. NAME OF FATHER *David Ruel*11. BIRTHPLACE OF FATHER *Idaho*
(State or Country)12. MAIDEN NAME OF MOTHER *Margaret Rutherford*13. BIRTHPLACE OF MOTHER *Idaho*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Margaret Stacy*
(Address) *Idaho*15. Filed *Mar 13 1922* *W. J. G. M. D.*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

3 10 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to *19*
that I last saw h. alive on *1922*and that death occurred on the date stated above, at *7 A.M.*

The CAUSE OF DEATH* was as follows:

old age -(Duration) Yrs. *6* mos. ds.Contributory (Secondary) *Bright's*

(Duration) Yrs. mos. ds.

(Signed) *Without Medical Attendant* M. D.*3/13 1922* (Address) *Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Idaho

DATE OF BURIAL

3/12 1922

20. UNDERTAKER

ADDRESS

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Clark
City of DuboisRegistration District No. 125Primary Registration District No. 2203(No. Dubois Ida St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Sarah A. FeiserState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 37611

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female White Widow
(Write the word.)

6. DATE OF BIRTH

July 1849
(Month) (Day) (Year)

7. AGE

72 Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Housewife
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Ind.

10. NAME OF FATHER

Robert Feiser

11. BIRTHPLACE OF FATHER

(State or Country) "

12. MAIDEN NAME OF MOTHER

"

13. BIRTHPLACE OF MOTHER

(State or Country) "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address) Dubois, Idaho

15.

Filed Mar 13 1922 W. J. Feiser
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 12 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar 5 1922, to Mar 12 1922,
that I last saw her alive on Mar 12 1922,
and that death occurred on the date stated above, at 11:00 a.m.

The CAUSE OF DEATH* was as follows:

Alm. Pneumonia(Duration) Yrs. mos. 7 ds.Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

3-13-1922 (Address) Dubois, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Hamilton Ind 19

20. UNDERTAKER ADDRESS

W. J. Feiser Dubois, Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of *Clearwater*

City of *Orufino*

Registration District No. *90*

Primary Registration District No. *2168*

(No. *9*)

St.)

File No. *37612*

Registered No. *9*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Unnamed*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male*

4. COLOR OR RACE *white*

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. *Infant*
(Write the word.)

6. DATE OF BIRTH *July 25 1922*

(Month)

(Day)

(Year)

7. AGE *7* yrs. *4* mos. *4* ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work *none*

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE *Idaho.*

(State or Country)

10. NAME OF FATHER *Egna Tallett*

11. BIRTHPLACE OF FATHER *Mo*

(State or Country)

12. MAIDEN NAME OF MOTHER *Lucy A. Another*

13. BIRTHPLACE OF MOTHER *Idaho.*

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Egna Tallett*

(Address) *Kenore Idy*

15.

Filed *3/1*

19*22*

Local Registrar *J. M. F. J. M. F.*

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH *March 1 1922*

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from *July 25 1922* to *March 1 1922*
that I last saw her alive on *March 1 1922*

and that death occurred on the date stated above, at *11⁰⁰ A.M.*

The CAUSE OF DEATH* was as follows:

Coaginital malformation

(Duration) *7* yrs. *4* mos. *4* ds.

Contributory (Secondary)

(Duration) *7* yrs. *4* mos. *4* ds.

(Signed) *J. M. F. J. M. F.*

3/1 1922 (Address) *Orufino Ida*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Ida*

DATE OF BURIAL *3/2 1922*

20. UNDERTAKER *Ida*

ADDRESS *Orufino Ida*

FORM V. S. No. 5-12 M. 6-15-17.

1. PLACE OF DEATH **Clairewater** Registration District No. **90**
 County of **Clairewater** Primary Registration District No. **2168**
 City of **Orfino** STATISTICS, St.)
 If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Israel Burr Brown**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WID-OWED OR DIVORCED. **Single**
(Write the word.)6. DATE OF BIRTH. **Aug 22 1875**
(Month) (Day) (Year)7. AGE **37** Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work **Miner**
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) **W. Va**

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **H. Smith**
(Address) **Orfino Ida**15. **Apr 1 1912**
Filed **J. M. Smith**
Local Registrar

CERTIFICATE OF DEATH

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. **37613**
 Registered No.
 If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **Nov 6 1912**
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from **1912** to **March 5 1912**
that I last saw him alive on **March 5 1912**
and that death occurred on the date stated above, at **12:20 AM**.

The CAUSE OF DEATH* was as follows:

Cancer stomach
(Duration) **1** Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.
(Signed) **E. H. Stewart** M. D.
3/6 1912 (Address) **Orfino Ida**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days, State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Clairewater Ida

DATE OF BURIAL

Mar 7 1912

20. UNDERTAKER

W. A. Shaw ADDRESS **Orfino Ida**

FORM V. S. No. 5-12 M. 6-15-17

RECEIVED
APR 21 1922
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37614
Registered No. 37614
If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

1. PLACE OF DEATH
County of Clearwater Registration District No. 90
City of Opfer Registration District No. 2168
(No. St.)
If death occurs away from
usual residence, give facts
called for under special
information.

2. FULL NAME Fredrika Johnson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH. Oct 20 1. 1855
(Month) (Day) (Year)

7. AGE 67 Yrs. 4 Mos. 15 ds. IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of in-
dustry, business, or estab-
lishment in which em-
ployed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Sweden

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William Johnson(Address) Opfer15. Med 27 1922 W. J. GaultFiled Med 27 1922 W. J. Gault
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar 7 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Apr 6 1921 to March 7 1922
that I last saw her alive on March 6 1922
and that death occurred on the date stated above, at 10:30 A.M.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease
(Duration) 3 Yrs. mos. ds.

Contributory
(Secondary)

(Duration) 3 Yrs. mos. ds.
(Signed) W. J. Gault M. D.
Opfer 1922 (Address) Opfer, Ida

*State the Disease Causing Death; or in deaths from Violent
Causes, state (1) Means of Injury; and (2) whether Accidental,
Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place In the
of death yrs. mos. days, State yrs. mos. days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

20. UNDERTAKER

DATE OF BURIAL

ADDRESS

Opfer, IdaMar 7 1922W. A. ShawOpfer, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. ... 37615 ...
Registered No. 12 ...
If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

1. PLACE OF DEATH
County of Clearwater ...
City of Orpio ...
If death occurs away from
usual residence, give facts
called for under special
information.
2. FULL NAME James L. Ferrer

RECEIVED
APR 21 1922
BUREAU OF VITAL

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.
(Write the word.)

6. DATE OF BIRTH.
Mar 21 1922
(Month) (Day) (Year)

7. AGE
82 Yrs. 11 Mos. 8 ds.
IF LESS than 1 day
how many ... hrs. or
... min.?

8. OCCUPATION
(a) Trade, profession or
particular kind of work
(b) General nature of in-
dustry, business, or estab-
lishment in which em-
ployed (or employer)

9. BIRTHPLACE
(State or Country) Ohio

10. NAME OF
FATHER

11. BIRTHPLACE
OF FATHER
(State or Country) ✓

12. MAIDEN NAME
OF MOTHER Mary J. Ferrer

13. BIRTHPLACE
OF MOTHER
(State or Country) ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. Ferrer

(Address) Idaho

15. Mar 15 1922
Filed J. M. Fairley
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Mar 9 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Feb 22 1922 to March 9 1922
that I last saw him live on March 9 1922
and that death occurred on the date stated above, at 6:30 P. M.

The CAUSE OF DEATH* was as follows:
Chronic Myocarditis

(Duration) 10 Yrs. ... mos. ... ds.
Contributory Enlarged prostate & bladder
(Secondary) infection
(Duration) 4 Yrs. ... mos. ... ds.
(Signed) E. J. Maxwell M. D.
Mar 1922 (Address) Orpio, Ida.

*State the Disease Causing Death; or in deaths from Violent
Causes, state (1) Means of Injury; and (2) whether Accidental,
Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place In the
of death ... yrs. ... mos. ... days, State ... yrs. ... mos. ... days

Where was disease contracted
if not at place of death? ...

Former or
usual residence ...

19. PLACE OF BURIAL OR REMOVAL
Orpio Ida

20. UNDERTAKER
W. A. Shaw

DATE OF BURIAL
3/11 1922
ADDRESS
Orpio

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

RECEIVED CERTIFICATE OF DEATH

13

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **37616**
Registered No. **13**

1. PLACE OF DEATH. **ADD 8-1-1922**
County of **Clearwater** Registration District No. **2168**
City of **Orofino** (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Charles Carr

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

male white married
(Write the word.)

6. DATE OF BIRTH **?** **?** **1**
(Month) (Day) (Year)

7. AGE **46** yrs. **?** mos. **?** ds. IF LESS than 1 day how many... hrs. or min?

8. OCCUPATION **?**
(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer).

9. BIRTHPLACE
(State or Country)

W. S.

10. NAME OF FATHER **?**

11. BIRTHPLACE OF FATHER
(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER **?**

13. BIRTHPLACE OF MOTHER
(State or Country)

Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. H. Otterberg
Orofino, Idaho

15.

Filed

March 21 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March 11 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Feb. 22 1922**, to **March 10 1922**

that I last saw him alive on **March 10 1922** and that death occurred on the date stated above, at **3:30 AM**.

The CAUSE OF DEATH* was as follows:

Melancholia

(Duration) **?** yrs. **?** mos. **?** ds.

Contributory (Secondary)

(Duration) **?** yrs. **?** mos. **?** ds.

(Signed)

John W. Sullivan M. D.

(Address) **Orofino, Idaho**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death... yrs. ... mos. **16** ds. State **4** yrs. **?** mos. **?** ds.

Where was disease contracted, If not at place of death? **I do not know**

Former or usual residence. **Post Falls, Idaho**

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Olympia Wash **191**

20. UNDERTAKER

ADDRESS

W. A. Spaul **Orofino**

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of

Clearwater

Registration District No. 40

City of

Crescent

BUREAU OF

STATISTICS

Primary Registration District No. 2168

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Alice Paisley

State of Idaho

BOARD OF HEALTH

Bureau of Vital Statistics

File No. 37617

Registered No. 1
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Mar 8

(Month)

8

(Day)

1855

(Year)

7. AGE

67

Yrs.

Mos.

6

ds.

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

James Boatright

11. BIRTHPLACE OF FATHER

(State or Country)

✓

12. MAIDEN NAME OF MOTHER

✓

13. BIRTHPLACE OF MOTHER

(State or Country)

Oklahoma

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Alice Paisley

(Address)

Crescent

15.

Filed

Apr 1 1922

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 14

(Month)

14

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from
March 10, 1922 to March 19, 1922

that I last saw him alive on 191...
and that death occurred on the date stated above, at 6:40 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary +
Chronic Myocarditis

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) E. L. Morrison M. D.

3/14/22 (Address) Crescent

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days, State yrs. mos. days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Leahon Ida

DATE OF BURIAL

3/17/22

20. UNDERTAKER

W. A. Shaw

ADDRESS

Crescent

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37618
Registered No. 79

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX ☐ MALE ☐ FEMALE

4. COLOR OR RACE ☐ WHITE ☐ BLACK ☐ OTHER

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED

Male	White	Married
		(Write the word.)

6. DATE OF BIRTH Jan 14 1946
(Month) (Day) (Year)

7. AGE 77 yrs. 1 mos. 27 ds. IF LESS than 1 day
how many.....hrs. or
.....min?

8. OCCUPATION

(a) Trade, profession or particular kind of work *Lamendryman*
(b) General nature of industry business or establishment in which employed (or employer) *?*

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

**11. BIRTHPLACE
OF FATHER**
(State or Country)

12. MAIDEN NAME
OF MOTHER

**13. BIRTHPLACE
OF MOTHER**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. W. Gleason
(Address) 675 Lind. Ave

15. *Mch 3 1955* *J. M. Gandy*
Filed _____ Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Mar. 14 1902
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 4 1921, to Mar. 11 1922

that I last saw h. alive on Mar 11 1942
and that death occurred on the date stated above, at 8³⁰ M.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

_____ 7 7 7

----- (Duration) 1 yrs. 1 mos. 1 ds.

Contributory (Secondary) Insanity

(Duration) 2 yrs. 3 mos. 4 ds.

(Signed) John W. Green M. D.

3/1/1954 (Address) *San Francisco*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos. 7 ds. In the State..... yrs..... mos..... ds.

Where was disease contracted,
If not at place of death? *Spain*

Former or usual residence *St. Maries, Idaho*

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL

A. hirsuta 191

20. UNDERTAKER	ADDRESS

FORM V. S. No. 5-12 M. 6-15-17.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

(No.)

St.)

State of Idaho
BOARD OF HEALTH

Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH.

7. AGE

IF LESS than 1 day
how many ... hrs. or
... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Mar 30 1922

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar - 15 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 3 1922 to March 15 1922

that I last saw him alive on March 15 1922

and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) 7 Yrs. 2 mos. 2 ds.

Contributory (Secondary) Influenza

(Duration) 7 Yrs. 2 mos. 2 ds.

(Signed) J. W. Shaw M. D.

3/15/22 (Address) Blanding, N.M.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death ... yrs. ... mos. ... days, State ... yrs. ... mos. ... daysWhere was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Blanding, N.M.

20. UNDERTAKER

W. A. Shaw

DATE OF BURIAL

Mar 16 1922

ADDRESS

Blanding

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37620
Registered No. 17

1. PLACE OF DEATH Blawie Registration District No. 40
County of Blawie Primary Registration District No. 2168
City of Croft (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Maggie Nelson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH February 10 1891
(Month) (Day) (Year)

7. AGE 31 yrs. 1 mos. 10 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

Housewife
General House Work

9. BIRTHPLACE
(State or Country)

Troy, Idaho

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER
(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER
(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. H. Hefley
Croft, Idaho

15.

Filed

Mar 30 1922

J. H. Fairly
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March 20th 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from February 22 1921, to March 20th 1922 that I last saw her alive on March 17th 1922 and that death occurred on the date stated above, at 12:10 A. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) Unknown yrs. mos. ds.
Contributory (Secondary) Insanity

(Duration) Unknown yrs. mos. ds.
(Signed) J. H. Hefley M. D.
3/20 1922 (Address) Croft, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 3 yrs. 0 mos. 27 ds. In the State 31 yrs. 1 mos. 10 ds.
Where was disease contracted,
If not at place of death?
Former or usual residence Deary, Idaho

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Troy, Ida Mar 23 1922

20. UNDERTAKER

ADDRESS

H. A. Shaw Croft, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Chambers* Registration District No. *90*
City of *Camden* Registration District No. *2168*
If death occurs away from usual residence, give facts called for under special information.

RECEIVED
APR 21 1922
BUREAU OF VITAL STATISTICS

2. FULL NAME

Clairinda Frazier

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. *37521*
Registered No. *18*
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female *white*

Married
(Write the word.)

6. DATE OF BIRTH.

Sept *25* *1845*
(Month) (Day) (Year)

7. AGE

76 Yrs. *6* Mos. *ds.*

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

Geo Washington Miller

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Margaret Weaver

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. C. Frazier
Camden, Mo.

15. FILED

Apr 1 *1922*

Local Registrar.

16. DATE OF DEATH

Mar *25* *1922*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
March 14 *1922* to *March 25* *1922*

that I last saw him alive on 191....
and that death occurred on the date stated above, at *7 A.M.*

The CAUSE OF DEATH* was as follows:

*Acute Bronchitis with
Chronic Myocarditis*

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) *E. M. Morsell* M. D.

Apr 15 *1922* (Address) *Camden, Mo.*
*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days, State yrs. mos. days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Camden, Mo.

DATE OF BURIAL

Mar 27 *1922*

20. UNDERTAKER

W. A. Shaw

ADDRESS

Camden

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Custer* District No. *76*
City of *Moore* Registration District No. *2153*
St.)File No. *37622*

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

BUREAU OF VITAL STATISTICS

John Henry Murphy

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

(Write the word.)

6. DATE OF BIRTH

*Aug**29**1917*

(Month)

(Day)

(Year)

7. AGE

4 Yrs. *7* Mos. *ds.*

IF LESS than 1 day

how many _____ hrs.

or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

child

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

John Murphy

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Amin Gillboy

13. BIRTHPLACE OF MOTHER

(State or Country)

Kans.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John Murphy

(Address)

Moore, Id.

15. Filed

*4/17**1922**Re Nowak*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

*March**29**1922*

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mch 25 19*22*, to *Mch 29* 19*22*that I last saw him alive on *Mch 29* 19*22*and that death occurred on the date stated above, at *6:30 A.M.*

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration)

Yrs.

mos.

ds.

Contributory (Secondary)

Appendicitis

(Duration)

Yrs.

mos.

ds.

(Signed)

Carroll B Jensen

M. D.

3/27/1922

(Address)

Moore, Id.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

Yrs.

In the

days.

State

Yrs.

mos.

days

Where was disease contracted if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of CusterCity of Maekay

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED CERTIFICATE OF DEATH

Registration District No. 76Primary Registration District No. 2153

STABLE

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 37624

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mch 5 1922 to Mch 5 1922

that I last saw him alive on Mch 5 1922

and that death occurred on the date stated above, at 3:00 P.M.

The CAUSE OF DEATH* was as follows:

(Chronic Phthisis) Chronic Phthisis

(Duration) 20 Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

3/8 1922

(Address) Maekay, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 74County of ElmorePrimary Registration District No. 2020City of Intn Home(No.)(St.)File No. 37626Registered No. 71

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mrs Sarah Margaret McManis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F.

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widowed
(Write the word.)

6. DATE OF BIRTH

Feb. 20 1847
(Month) (Day) (Year)

7. AGE

75 Yrs. 21 Mos. 21 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Retiree of house

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Clark Co Iowa

10. NAME OF FATHER

Geo W. Conyers

11. BIRTHPLACE OF FATHER

(State or Country)

Tenn

12. MAIDEN NAME OF MOTHER

Sarah Bradford

13. BIRTHPLACE OF MOTHER

(State or Country)

Tenn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. A. F. Galindo

(Address)

Intn Home

15.

Filed

4-1-1922J. E. Curran

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar. 11 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 11 1922 to March 11 1922that I last saw her alive on March 11 1922and that death occurred on the date stated above, at 10:00 M.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus.
Diabetic Coma.
Acute obstruction of bowels

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

L. O. Hamilton M. D.3-14-1922(Address) Intn Home Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Intn Home Mar 14 1922

20. UNDERTAKER

ADDRESS

A. W. Conover Intn Home

✓ CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Lampkin
City of PrestonRegistration District No. 27
Primary Registration District No. 3119
(No. _____, _____ St.)File No. 37627
Registered No. 19

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Hellen Eugenia Larsen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WID-OWED OR DIVORCED
(Write the word.)

6. DATE OF BIRTH

Dec 2 1922
(Month) (Day) (Year)

7. AGE

3 Yrs. 14 Mos. 14 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Baroda India

10. NAME OF FATHER

Harold A. Larsen

11. BIRTHPLACE OF FATHER

(State or Country) Sweden

12. MAIDEN NAME OF MOTHER

Ellen Ringblom

13. BIRTHPLACE OF MOTHER

(State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harold A. Larsen
(Address) Baroda, Idaho15. Filed Apr. 8 1922 Mrs. H. Lippel
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

3 16 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from 3-10 1922 to 3-16 1922that I last saw her alive on 3-14 1922
and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia / Bronchitis(Duration) _____ Yrs. 1 mos. _____ ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) R. P. Outley M.D.3-16-1922 (Address) Preston, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Baroda

DATE OF BURIAL

Mar 18 1922

20. UNDERTAKER

W. C. Redmon

ADDRESS

Preston, Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Franklin
City of Preston IdaRegistration District No. 2779 27
Primary Registration District No. 2119
(No. _____, _____ St.)File No. 37628
Registered No. 20

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Gladys C. Peterson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH

Mar 16 1908
(Month) (Day) (Year)

7. AGE

13 Yrs. 11 Mos. 30 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)at home

9. BIRTHPLACE

(State or Country) Preston

10. NAME OF FATHER

Baltzer Peterson

11. BIRTHPLACE OF FATHER

(State or Country) Richville, Ky., U.S.A.

12. MAIDEN NAME OF MOTHER

Marinda C. Peterson

13. BIRTHPLACE OF MOTHER

(State or Country) Preston Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Baltzar Peterson
(Address) Preston Idaho15. Filed Apr 8 1922 Mrs. Ida L. Timp
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 5 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar 5 1922 to Mar 5 1922
that I last saw h. or alive on Mar 5 1922
and that death occurred on the date stated above, at 5 P. M.
The CAUSE OF DEATH* was as follows:Pneumonia(Duration) Yrs. 3 mos. 3 ds.Contributory Acute Osteomyelitis of humerus
(Secondary)(Duration) Yrs. 3 mos. 3 ds.(Signed) A. R. C. J. M. D.Apr 8 1922 (Address) Preston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Preston Idaho

DATE OF BURIAL

Mar 11 1922

20. UNDERTAKER

W. A. Skidmore

ADDRESS

Preston Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

Registration District No.

Primary Registration District No.

(No.)

St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

19.22

Local Registrar

16. DATE OF DEATH

(Month)

(Day)

19.22
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

4-6 1922 to 4-7 1922

that I last saw h..... alive on 4-6 1922

and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(Duration) Yrs. mos. 4 ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) H. P. Cutler M. D.

4-7-1922 (Address) Preston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... day

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Franklin
 City of Preston

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 27
 Primary Registration District No. 2119
 (No. St.)

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 37630
 Registered No. 15

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Eleanor Borcham Jensen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
 (Write the word.)

6. DATE OF BIRTH Jan 29 1882
 (Month) (Day) (Year)

7. AGE 40 Yrs. 1 Mos. 28 ds.
 IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

Charles F Borcham

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Martha Walters

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Anton H. Jensen

(Address)

Preston Idaho

15.

Filed Apr 8 19 22 Mrs Ida Typpel
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 27 19 22
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 19 22, to Mar 27 19 22, that I last saw her alive on Mar 27 19 22, and that death occurred on the date stated above, at 7 P. M. The CAUSE OF DEATH* was as follows:

Purpural hemorrhage

(Duration) Yrs. mos. ds.
 Contributory (Secondary) Complete placenta previa
 (Duration) yrs. mos. ds.
 (Signed) G. R. Cutler M. D.
 19..... (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Preston Cemetery Apr 1 19 22
 20. UNDERTAKER W. C. Spidmon ADDRESS Preston Idaho

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Franklin
 City of Preston

Registration District No. 27
 Primary Registration District No. 2119
 (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Preston Jensen

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 37631
 Registered No. 16

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED

M. | W. | Single
 (Write the word.)

6. DATE OF BIRTH

Mar. 27 1922
 (Month) (Day) (Year)

7. AGE

IF LESS than 1 day
 how many 18 hrs.
 or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Preston

10. NAME OF FATHER

Antone H Jensen

11. BIRTHPLACE OF FATHER

(State or Country)

Preston

12. MAIDEN NAME OF MOTHER

Elinor Worcham

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Antone H Jensen

(Address)

Preston, Ida

15.

Filed

Apr 8 1922

Mrs Ida Jensen

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar. 28 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar. 27 1922, to Mar. 28 1922
 that I last saw him alive on Mar. 28 1922
 and that death occurred on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Stroke

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
 (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

P. R. Gether M. D.

19

(Address)

Preston, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Preston Cemetery

DATE OF BURIAL

Apr 1 1922

20. UNDERTAKER

W. H. Skidmore

ADDRESS

Preston

1. PLACE OF DEATH

County of Franklin
 City of Weston

If death occurs away from usual residence, give facts called for under special information.

CERTIFICATE OF DEATH

Registration District No. 27
 Primary Registration District No. 2119
 (No. _____ St.)

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 37632
 Registered No. 13

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Lila Helma J. Abel

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
 (Write the word.)

6. DATE OF BIRTH

May 9 1922
 (Month) (Day) (Year)

7. AGE

21 Yrs. 10 Mos. 28 ds.

IF LESS than 1 day
 how many _____ hrs.
 or _____ min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Weston Ida

10. NAME OF FATHER

Henry Jensen

11. BIRTHPLACE OF FATHER

(State or Country)

Denmark

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Harold Abel

(Address)

Weston Idaho

15.

Filed Apr. 8 1922

Mrs. Ida Juppato
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 6 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 11 1922 to April 5 1922

that I last saw her alive on April 1 1922

and that death occurred on the date stated above, at 1922

The CAUSE OF DEATH* was as follows:

Pertussis

(Duration) 1 Yrs. 2 mos. _____ ds.

Contributory Sumner of Rickets
 (Secondary)

(Duration) 1 yrs. _____ mos. _____ ds.

(Signed) Thos. B. Holder M. D.

19 (Address) Weston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Weston Idaho

DATE OF BURIAL

Apr. 8 1922

20. UNDERTAKER

Wm. Skidmore

ADDRESS

Weston Idaho

✓
CERTIFICATE OF DEATHState of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Franklin
City of FranklinRegistration District No. 27
Primary Registration District No. 2119
(No. St.)File No. 37633
Registered No. 18

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Emma Carolina Anderson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W.5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDMarried
(Write the word.)

6. DATE OF BIRTH

Aug 11 1873
(Month) (Day) (Year)

7. AGE

49 Yrs. 7 Mos. 0 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Housewife

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Martin Hansen

11. BIRTHPLACE OF FATHER

(State or Country)

Norway

12. MAIDEN NAME OF MOTHER

Emma Caroline Olsen

13. BIRTHPLACE OF MOTHER

(State or Country)

Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Skidmore S. Skidmore

(Address)

Whitney Idaho

15.

Filed Apr 8 1922 Mrs Ida Tippels

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar. 11 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar. 7 1922 to Mar. 11 1922
that I last saw her alive on Mar. 11 1922
and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Bronchitis Pneumonia(Duration) Yrs. mos. 2 ds.Contributory
(Secondary)(Duration) yrs. mos. 5 ds.

(Signed)

J. R. Cutler Jr. M. D.3-14-1922 (Address) Preston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Midvale Utah Mar. 17 1922

20. UNDERTAKER

ADDRESS

W. A. Skidmore Preston

✓
CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Franklin
City of Fairview IdaRegistration District No. 27
Primary Registration District No. 2119
(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Myrl Haslam WiserState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 37634Registered No. 17

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDchild
(Write the word.)

6. DATE OF BIRTH

July 28 1918
(Month) (Day) (Year)

7. AGE

3 Yrs. 6 Mos. 10 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Fairview Idaho

10. NAME OF FATHER

William Harry Wiser

11. BIRTHPLACE OF FATHER

(State or Country) Utah

12. MAIDEN NAME OF MOTHER

Emma Haslam

13. BIRTHPLACE OF MOTHER

(State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William H. Wiser(Address) Fairview Idaho

15.

Filed Apr 8 1922 Mrs Ida Zipp

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 6 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan. 30 1922 to Feb 6 1922that I last saw him alive on Feb 6 1922and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis(Duration) _____ Yrs. _____ mos. 10 ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W. H. Wiser

M. D.

19 (Address) Lewiston Utah

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lewiston Utah Feb 7 1922

20. UNDERTAKER

ADDRESS

W. H. Wiser Fairview Idaho

1. PLACE OF DEATH

County of Franklin
 City of Preston

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No. 27
 Primary Registration District No. 2119
 (No. _____ St.)

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 37635
 Registered No. 12

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

Jan 26 1853
 (Month) (Day) (Year)

7. AGE

69 Yrs. 2 Mos. 5 ds.

IF LESS than 1 day
 how many _____ hrs.
 or _____ min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer)

Lumberman

9. BIRTHPLACE

(State or Country)

Ogden Utah

10. NAME OF FATHER

Gilbert R Belnap

11. BIRTHPLACE OF FATHER

(State or Country)

U.S. A.

12. MAIDEN NAME OF MOTHER

Adaline Knight

13. BIRTHPLACE OF MOTHER

(State or Country)

W.V. U.S.A.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Joseph Belnap
Preston, Ida

15.

Filed

Apr. 81922Mrs. Ida Lipe

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 1 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar. 13 1922 to Mar 29 1922

that I last saw him alive on Mar 29 1922

and that death occurred on the date stated above, at 9¹⁵ A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia Bronchial

(Duration) Yrs. _____ mos. 14 ds.

Contributory
 (Secondary)

(Duration) Yrs. _____ mos. 21 ds.

(Signed)

R. R. Butler

1-2 1922 (Address) Preston Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Ogden Utah

DATE OF BURIAL

Apr. 8 1922

20. UNDERTAKER

W. A. Skidmore

ADDRESS

Preston Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Fremont
City of Marysville

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ernest Leslie Cordingley .

CERTIFICATE OF DEATH

Registration District No. 103

Primary Registration District No. 6

(No.) St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37636
Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male White Single
(Write the word.)

6. DATE OF BIRTH

October 5 1910
(Month) (Day) (Year)

7. AGE

11 Yrs. 6 Mos. 18 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. At Home
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Marysville Idaho

10. NAME OF FATHER

Ernest, E. Cordingley .

11. BIRTHPLACE OF FATHER

(State or Country) Utah.

12. MAIDEN NAME OF MOTHER

Permelia Huggins.

13. BIRTHPLACE OF MOTHER

(State or Country) Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ernest. E Cordingley.

(Address) Marysville Idaho.

15.

Filed 4-24-22 Clyde
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April. 23 / 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

2-3-1922 to 4-23-22

that I last saw him alive on 4-19-22

and that death occurred on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(Signature) Pharmaceutical
Contributory (Secondary)

(Duration) — yrs. — mos. — ds.

(Signed) Clyde M. D.

(Address) Ashton, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death — yrs. — mos. — days. In the State — yrs. — mos. — days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Ashton Idaho.

DATE OF BURIAL

4/25/22

20. UNDERTAKER

Lewis Kiser

ADDRESS

Ashton Idaho

1. PLACE OF DEATH

County of *Gordiey*
City of *Gordiey*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No. *1022*Primary Registration District No. *TAL*(No. *TAL* St.)State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *37637*

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

6. DATE OF BIRTH

November 10th 1910
(Month) (Day) (Year)

7. AGE

11 Yrs. *4* Mos. *24* ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

school

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Salt Lake City

10. NAME OF FATHER

J. H. Hardman

11. BIRTHPLACE OF FATHER

(State or Country)

Salt Lake City

12. MAIDEN NAME OF MOTHER

Millie May

13. BIRTHPLACE OF MOTHER

(State or Country)

Leunach

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. H. Hardman

(Address)

Gordiey

15.

Filed

4-7-1922 *W. H. Hays*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 4th 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *Mar 14 1922* to *April 4 1922*that I last saw him alive on *Apr 4 1922*
and that death occurred on the date stated above, at *4:30 P.M.*

The CAUSE OF DEATH* was as follows:

Acute Phoria(Duration) Yrs. mos. *2* ds.Contributory (Secondary) *Endocarditis*(Duration) yrs. mos. *7* ds.(Signed) *J. H. Crumell* M. D.*4/7 1922* (Address) *Gordiey Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Gordiey Ida

DATE OF BURIAL

4/7-1922

20. UNDERTAKER

W. B. Thompson

ADDRESS

Gordiey Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

1. PLACE OF DEATH.

County of Twin Falls
City of Bliss

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Hulda Ernest

RECEIVED CERTIFICATE OF DEATH.

Resident of 1922 District No. 24
Primary Registration District No. 1
City of Bliss St. Idaho

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 37638
Registered No. 37638

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH.

Nov 1 1879
(Month) (Day) (Year)

7. AGE

42 Yrs. 4 Mos. 19 ds.

IF LESS than 1 day
how many hrs. or
..... min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country) Iceland

10. NAME OF FATHER

Ben Runolfson

11. BIRTHPLACE OF FATHER

(State or Country) Iceland

12. MAIDEN NAME OF MOTHER

Don't Know

13. BIRTHPLACE OF MOTHER

(State or Country) Iceland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. J. Ernest (Husband)
(Address) Bliss Idaho

15.

Filed 3-20 1922

J. J. Ernest

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 20 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 18 1922, to Mar 20 1922, that I last saw him alive on Mar 19 1922, and that death occurred on the date stated above, at 3:45 AM.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. J. Ernest M. D.
3/19/22 (Address) Bliss, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Hagerman

DATE OF BURIAL

3/20 1922

20. UNDERTAKER

W. E. Thompson

ADDRESS

Bliss, Idaho

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics1. PLACE OF DEATH **Idaho** Registration District No. **106**
County of **Idaho** County Registration District No. **2184**
City of **Shutts** (St.)File No. **37639**
Registered No. **122**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Joseph Marion Winfield**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Widowed**6. DATE OF BIRTH. **April 24 1853**
(Month) (Day) (Year)7. AGE **68** Yrs. **11** Mos. **7** ds.IF LESS than 1 day
how many.....hrs. or
.....min.?8. OCCUPATION **Blacksmith**(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....9. BIRTHPLACE **Arkansas**
(State or Country)10. NAME OF FATHER **Joseph Marion Winfield**11. BIRTHPLACE OF FATHER **Texas**
(State or Country)12. MAIDEN NAME OF MOTHER **Unknown**13. BIRTHPLACE OF MOTHER **Unknown**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) **Anna With**(Address) **Shutts Ida**15. Filed **April 2 1922**Local Registrar **J. M. Burkholder**16. DATE OF DEATH **Mar 31 1922**
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from **Feb 1st 1922** to **Mar 31 1922**
that I last saw him alive on **Mar 31 1922**
and that death occurred on the date stated above, at **6:50 P. M.**

The CAUSE OF DEATH* was as follows:

Chronic gastritis - Chronic cough - Invalid for many years -
(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) **H. W. Wentworth** M. D.(Address) **Shutts Ida**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **Shutts**DATE OF BURIAL **Apr 2 1922**20. UNDERTAKER **Geo. J. ...**ADDRESS **Dorckin**

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12 **RECEIVED** CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. **APR 24 1922**
Registration District No. 106
County of Idaho BUREAU OF VITAL STATISTICS
City of Kootenai (No. 2184 St.)

File No. 37640
Registered No. 124

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Allie Foulke

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH Nov 25 1855
(Month) (Day) (Year)

7. AGE 66 yrs. 4 mos. 1 ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Hotel Keeper
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Alabama

10. NAME OF FATHER James Cowart

11. BIRTHPLACE OF FATHER
(State or Country) Not obtainable

12. MAIDEN NAME OF MOTHER Not obtainable

13. BIRTHPLACE OF MOTHER
(State or Country) Not obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H. E. Foulke
(Address) Kootenai

15. Filed Mar 17 1922 J. M. Underknecht
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH March 16 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 8 1922 to March 16 1922
that I last saw him alive on March 15 1922
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:
Influenza - Bronchopneumonia

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. M. Underknecht M. D.

Mar 17 1922 (Address) Kootenai - Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Kootenai Cemetery DATE OF BURIAL March 18 1922

20. UNDERTAKER Geo. Truany ADDRESS Kootenai - Idaho

1. PLACE OF DEATH.

RECEIVED

Registration District No. 106County of Idaho

APR 21 1922

Primary Registration District No. 2184City of Kooskia

BUREAU OF VITAL

STATISTICS

St.)

Registered No. 123

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Dog

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

Indian5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.Widowed

(Write the word.)

6. DATE OF BIRTH.

8. not know

(Month)

(Day)

(Year)

7. AGE

About 84 yrs

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country)

Washington

10. NAME OF FATHER

Hat. get - new - help - fair - ma.

11. BIRTHPLACE OF FATHER

(State or Country)

Washington

12. MAIDEN NAME OF MOTHER

8. not know

13. BIRTHPLACE OF MOTHER

(State or Country)

Washington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Ben Harrison

(Address)

Kooskia, Ida.

15.

Filed March 15 1922J. M. Webster
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March141922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 10 1922 to March 14 1922that I last saw him alive on March 12 1922and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia
Influenza

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. M. Webster M. D.March 1922 (Address) Kooskia

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

191

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. **RECEIVED**
County of Idaho District No. 106
City of Kooskia Primary Registration District No. 2184
(No. 1002) St.)

File No. 37642
Registered No. 122

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Betsy Betts

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH January 31 1845
(Month) (Day) (Year)

7. AGE _____ yrs. _____ mos. _____ ds.
IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE Steuben Co. N. Y.
(State or Country)

10. NAME OF FATHER Hiram Hayes

11. BIRTHPLACE OF FATHER Don't know
(State or Country)

12. MAIDEN NAME OF MOTHER Don't know

13. BIRTHPLACE OF MOTHER Don't know
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas. H. Schofield
(Address) Kooskia

15. Filed March 9 1922 J. M. W. Burkness
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH March 9 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 4 1922 to March 9 1922
that I last saw him alive on March 9 1922
and that death occurred on the date stated above, at 9¹⁵ a.m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary) Influenza

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. M. W. Burkness M. D.
March 9 1922 (Address) Kooskia Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. _____ yrs. _____ mos. _____ days. In the State. _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL Kooskia Cemetery DATE OF BURIAL March 11 1922

20. UNDERTAKER Geo. J. J. J. ADDRESS Kooskia Idaho

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 37643

Registered No. 121

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Idaho
City of New RoskidaRECEIVED
APR 2 1922
BUREAU OF VITAL STATISTICSRegistration District No. 106
Registration District No. 2184
(No.) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Edd Brown

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married

6. DATE OF BIRTH.

June 9 1888
(Month) (Day) (Year)

7. AGE

80 Yrs. 8 Mos. 26 ds.

IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...

Rancher

9. BIRTHPLACE

(State or Country)

Norway

10. NAME OF FATHER

Bryngal Brown

11. BIRTHPLACE OF FATHER

(State or Country)

Norway

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Berlin Brown

(Address)

Roski Ida

15.

Filed

March 9 1922

J. M. Kubinski

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 7th 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Aug 12 1920, to Mar 7th 1922, that I last saw him alive on 1919 and that death occurred on the date stated above, at 10³⁰ A.M.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation Heart

(Duration) 22 Yrs. Sick ds.

Contributory (Secondary)

Old prostate
Scurvy

(Duration) 1 Yrs. 1 Mos. ds.

(Signed) H. W. W. Smith M. D.

Mar 19 1922 (Address) Sates

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Roski

DATE OF BURIAL

Mar 10 1922

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

1. PLACE OF DEATH.

County of Idaho
City of Brangerville

Registration District No. 103
Primary Registration District No. 1001
(No. St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 37644Registered No. 10

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mari J. Mason

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widow

(Write the word.)

6. DATE OF BIRTH.

Sept 15 1846
(Month) (Day) (Year)

7. AGE

76 Yrs. 6 Mos. 2 ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

Housewife

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

Carlson

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Mrs. Gizzie HarrisBrangerville

15.

Filed

April 11912E. S. Hancock

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 17 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 12 1922 to March 17 1922, that I last saw her alive on March 16 1922 and that death occurred on the date stated above, at 8 A. M. The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) Yrs. mos. 14 ds.

Contributory (Secondary)

Influenza

(Duration) Yrs. mos. ds.

(Signed)

E. S. Hancock

M. D.

3/19/1922 (Address) Brangerville, Ida

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Prairie ViewMarch 19, 1922

20. UNDERTAKER

ADDRESS

E. S. HancockBrangerville

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD.
N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

1. PLACE OF DEATH.

County of Idaho
City of mt Idaho

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH.

Registration District No. 103
Primary Registration District No. 2181
(No. _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 37645Registered No. 4

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widower

(Write the word.)

6. DATE OF BIRTH.

June

29

1834

(Month)

(Day)

(Year)

7. AGE

87

Yrs.

9

Mos.

ds.

If LESS than 1 day
how many hrs. or
..... min. 21

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

Don't know

11. BIRTHPLACE OF FATHER

(State or Country)

Don't know

12. MAIDEN NAME OF MOTHER

Margaret Lile Kinder

13. BIRTHPLACE OF MOTHER

(State or Country)

Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. Pauline Stithell

(Address)

Grangerville Idaho

15.

Filed

April 1

1922

G. S. Stockton

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 12 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1922 to March 12 1922, that I last saw him alive on Feb 21 1922, and that death occurred on the date stated above, at 10 P. M. The CAUSE OF DEATH* was as follows:

Valvular disease of heart

(Duration) Yrs. mos. ds.

Contributory (Secondary) arteriosclerosis

(Duration) Yrs. mos. ds.

(Signed) G. S. Stockton M. D.

19 (Address) Grangerville Ida

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

mt Idaho

3/14 1922

20. UNDERTAKER

ADDRESS

G. S. Stockton

Grangerville

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Idaho
City of Greencreek

Registration District No. 105

Primary Registration District No. 2183

File No. 6
Registered No. 37646

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Sallia Jansen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female White Married
(Write the word.)

6. DATE OF BIRTH

Dec 31 1848
(Month) (Day) (Year)

7. AGE

71 Yrs. 2 Mos. 23 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. House wife
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Ill

10. NAME OF FATHER

Ferdinand Kaufmann

11. BIRTHPLACE OF FATHER

(State or Country) Germany

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Barny J. Stubbs
(Address) Cerulea R. Ida.

15.

Filed Apr. 10 1922 W. F. Orr
Local Registrar

16. DATE OF DEATH

March 23 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 1 1921 to Nov 23 1922
that I last saw h. or alive on Mar-10 1922
and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 15 Yrs. mos. ds.

Contributory (Secondary)

Mitral regurgitation

(Duration) 2 yrs. mos. ds.

(Signed)

Wesley F. Orr M. D.

3/24 1922

(Address) Coltonwood Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Greencreek Idaho 3. 25 1922

20. UNDERTAKER

ADDRESS

Allen Coltonwood Ida

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of IdahoCity of Coltonwood

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No. 105Primary Registration District No. 2183(No. 1 St.)State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 5Registered No. 37647

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

Dec.
(Month)6
(Day)1883
(Year)

7. AGE

39 Yrs. 4 Mos. 9 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

New York City

10. NAME OF FATHER

Dayline

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Casper Elom mers

(Address)

Coltonwood Idaho

15.

Filed

Apr. 10 19 22W. F. Orr
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar
(Month)15
(Day)1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 1 19 22 to Mar 15 19 22that I last saw her alive on Mar 15 19 22and that death occurred on the date stated above, at 7:00 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Interchymal Nephritis3rd degree Contracted pelvis
(Duration)..... Yrs. 5 mos. ds.Contributory
(Secondary)Caesarian Section

(Duration)..... yrs. mos. ds.

(Signed) Wesley F. Orr M. D.3/15 19 22 (Address) Coltonwood Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Coltonwood Idaho

DATE OF BURIAL

3-18 19 22

20. UNDERTAKER

H. Nam

ADDRESS

Coltonwood Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 105
County of Idaho Primary Registration District No. 2183
City of Reisterstown (No. 100) (St.)File No. 8
Registered No. 37648

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John J. Whelan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

Feb. 16 1837
(Month) (Day) (Year)

7. AGE

89 Yrs. 1 Mos. 14 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

Farmer

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Gerhard Whelan

(Address)

Reisterstown, Idaho

15.

Filed

Apr 10 1922W. F. Orr

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar. 30 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Feb. 20 1922 to Mar. 30 1922that I last saw him alive on Mar. 29 1922and that death occurred on the date stated above, at 2:50 P.M.

The CAUSE OF DEATH* was as follows:

Senile disintegration

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Wesley F. Orr M. D.
3/31 1922 (Address) Reisterstown, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Gertrude's ConventApril 1st 1922

20. UNDERTAKER

ADDRESS

Rev. Father James O.S.B.St. Gertrude's Convent

✓ CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Idaho*City of *Cottonwood*

If death occurs away from usual residence, give facts called for under special information.

Registration District No. *105*Primary Registration District No. *2183*(No. *105* St.)File No. *7*
Registered No. *37649*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Joseph C. Weber

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male White Single
(Write the word.)

6. DATE OF BIRTH

Oct 26 1895
(Month) (Day) (Year)

7. AGE

26 Yrs. 5 Mos. 3 ds.
IF LESS than 1 day how many yrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).*farmer*

9. BIRTHPLACE

(State or Country)

Nebraska

10. NAME OF FATHER

Henry J. Weber

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Keronika Kolnig

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Leo J. Weber

(Address)

Cottonwood Idaho

15.

Filed

*Apr. 10 1922**W. F. Orr*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 29 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

*Mar. 15 1922, to Mar. 29 1922*that I last saw him alive on *Mar. 25 1922*and that death occurred on the date stated above, at *6:08 P.M.*

The CAUSE OF DEATH* was as follows:

Cardiac Embolism

(Duration) Yrs. mos. ds.

Contributory (Secondary) *Pneumonia - Infarction*

(Duration) yrs. mos. ds.

(Signed) *Wesley F. Orr* M. D.*3/30 1922* (Address) *Cottonwood Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Cottonwood Idaho

DATE OF BURIAL

3-31 1922

20. UNDERTAKER

W. F. Orr Cottonwood Idaho

ADDRESS

1. PLACE OF DEATH

County of Jefferson
City of Reilly

If death occurs away from usual residence, give facts called for under special information.

CERTIFICATE OF DEATH

Registration District No. 98
Primary Registration District No. 2176
(No. _____ St.)State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 37651
Registered No. 30

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Millennium Fisher

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

Aug 31 1845
(Month) (Day) (Year)

7. AGE

76 Yrs. 5 Mos. 20 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)At home

9. BIRTHPLACE

(State or Country)

Illinois

10. NAME OF FATHER

Milo Andrus

11. BIRTHPLACE OF FATHER

(State or Country)

New York

12. MAIDEN NAME OF MOTHER

Abigail Jane Daley

13. BIRTHPLACE OF MOTHER

(State or Country)

New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ray Fisher

(Address)

Reilly, Ida

15. Filed

Mar 10 - 1922Ray Fisher

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 20 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 19 1922 to Feb 20 1922
that I last saw him alive on Feb 20 1922
and that death occurred on the date stated above, at 10:30 A.M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris(Duration) _____ Yrs. _____ mos. four ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Feb 20 1922

(Address)

Reilly, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Oxford, Idaho

DATE OF BURIAL

Feb 24 1922

20. UNDERTAKER

Berkeley

ADDRESS

Idaho Falls

WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Jefferson
City of Boise

Registration District No. 98

Primary Registration District No. 2176

(No. Boise, Ida. St.)

File No. 37653

Registered No. 28

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Geo. Thompson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single

(Write the word.)

6. DATE OF BIRTH

Aug 28
(Month) (Day) (Year)

7. AGE

18 Yrs. Mos. ds.
IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

Rancher

9. BIRTHPLACE

(State or Country)

Oregon

10. NAME OF FATHER

Wm Thompson

11. BIRTHPLACE OF FATHER

(State or Country)

Oregon

12. MAIDEN NAME OF MOTHER

Gertrude Powell

13. BIRTHPLACE OF MOTHER

(State or Country)

Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed 4-10 19 22 Ray H. Bissell

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 6 19 22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19..... to 19.....

that I last saw h..... alive on 19.....

and that death occurred on the date stated above, at M.....

The CAUSE OF DEATH* was as follows:

Gun Shot
accident
(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Just B. Alver M. D.

19..... (Address) Boise, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Brownsville Oregon 19.....

20. UNDERTAKER ADDRESS

Walt H. Hume Walt H. Hume

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Jefferson*City of *Idaho*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No. *98*Primary Registration District No. *2176*

(No. _____ St.)

File No. *32655*Registered No. *32655*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

Sept 14 1871
(Month) (Day) (Year)

7. AGE

45 Yrs. *6* Mos. *15* ds.
IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

Farming

9. BIRTHPLACE

(State or Country)

Salt Lake Co. Utah

10. NAME OF FATHER

Wm. Horace Walker

11. BIRTHPLACE OF FATHER

(State or Country)

Peack co. Ill.

12. MAIDEN NAME OF MOTHER

Adeline Louisa Bingham

13. BIRTHPLACE OF MOTHER

(State or Country)

Handcock Co. Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *E. Walker*(Address) *Township Idaho*

15. Filed

4-10-22 *Ray H. Fisher*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 29 1922
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from *March 22 1922* to *March 29 1922*, that I last saw him alive on *March 29 1922*, and that death occurred on the date stated above, at *6:11* M.The CAUSE OF DEATH* was as follows:
Pneumonia (Lobar) following Influenza(Duration) _____ Yrs. _____ mos. *10* ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) *Geo. S. Moore*

M. D.

19 _____ (Address) *Nevo*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Memorial *3/29 1922*

20. UNDERTAKER

ADDRESS

Ed. Gillman *Right*

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Jefferson
City of RigbyRegistration District No. 95
Primary Registration District No. 2176
(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Agnes WilkersonState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 37656
Registered No. 28

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH

4 22 1867
(Month) (Day) (Year)

7. AGE

14 Yrs. 10 Mos. 28 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Nevada

10. NAME OF FATHER

Meshaeh S Williams

11. BIRTHPLACE OF FATHER

(State or Country)

Wales

12. MAIDEN NAME OF MOTHER

Elizabeth Lewis

13. BIRTHPLACE OF MOTHER

(State or Country)

South Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. E. Williams
Rigby, Ida

(Address)

15. Filed 4 10 22 Ray H. Fisher
Local Registrar

16. DATE OF DEATH

March 20 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from June 20 1921 to March 17 1922
that I last saw her alive on March 17 1922
and that death occurred on the date stated above, at 12:30 M.

The CAUSE OF DEATH* was as follows:

mitral insufficiency(Duration) 20 Yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) A. M. Quinn M. D.19 (Address) Rigby, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Maskay, Ida

DATE OF BURIAL

Mar 23 1922

20. UNDERTAKER

W. H. Haynes

ADDRESS

Idaho Falls

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Jefferson
City of ParisRegistration District No. 98
Primary Registration District No. 3176
(No. _____ St.)File No. 37657
Registered No. 24

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Parley H. Ricks

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH

12 20 1884
(Month) (Day) (Year)

7. AGE

37 Yrs. 2 Mos. 21 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Farmer
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Joseph Ricks

11. BIRTHPLACE OF FATHER

(State or Country) Utah

12. MAIDEN NAME OF MOTHER

Daphnia Nelson

13. BIRTHPLACE OF MOTHER

(State or Country) Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Peter J. Ricks
(Address) Reynolds Idaho

15.

Filed 4-10 19 22 Ray H. Fish
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar. 11 - 22
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Mar. 9 1922 to Mar. 11 1922that I last saw him alive on Mar 10 1922
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory:
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Samuel Tree M. D.19. (Address) Paris Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Reynolds Idaho 3-14 19 22

20. UNDERTAKER

ADDRESS

Edw. Egan Reynolds

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 98

County of Jefferson

Primary Registration District No. 2176

File No. 37658

City of Rigby PD#3 (No. St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alta Melly Murdock

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Female White

(Write the word.)

6. DATE OF BIRTH

4 5 1922
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

1 Yrs. 11 Mos. 21 ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Rigby ID#3

10. NAME OF FATHER

Roy J. Murdock

11. BIRTHPLACE OF FATHER

(State or Country)

Ogden Utah

12. MAIDEN NAME OF MOTHER

Melissa Cheney

13. BIRTHPLACE OF MOTHER

(State or Country)

Okeley Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Roy J. Murdock
Rigby ID#3

15.

Filed

Apr. 10 1922 Ray Stiker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mch 26 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Mch 1st 1922, to Mch 3rd 1922 that I last saw him alive on Mch 23rd 1922 and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

(Duration) Yrs. 4 mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Sam. J. Price M. D.

3/27/1922 (Address) Rigby River, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Blackfoot, Ida.

Mch 29 1922

20. UNDERTAKER

ADDRESS

E. D. Giltner Rigby, Ida.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37659
Registered No. 22

1. PLACE OF DEATH

County of JeffersonRegistration District No. 98City of Regley, Ida.Primary Registration District No. 2176

(No.)

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Sarah Bale

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Fr

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widowed
(Write the word.)

6. DATE OF BIRTH

Mar. 9 - 1899
(Month) (Day) (Year)

7. AGE

82 Yrs. 10 Mos. 29 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

At home

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

Robert Miller

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Ellen Clifford

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wm. T. Bowles

(Address)

Regley, Ida.

15.

Filed

Feb 10 1922
Wm. T. Bowles
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb. 4 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 3rd 1922 to Feb 4th 1922that I last saw Fr alive on Feb 2nd 1922and that death occurred on the date stated above, at 4th M.

The CAUSE OF DEATH* was as follows:

General Debility(Duration) Yrs. few mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

Feb 5th 1922 (Address) Regley, Ida.
Ray H. Gibe M. D.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Memph, Utah

DATE OF BURIAL

Feb 7th 1922

20. UNDERTAKER

W. E. Duniway

ADDRESS

Idaho Falls

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Jefferson*
City of *Ririe Ida*

Registration District No. *98*
Primary Registration District No. *2176*
(No. St.)

File No. *37560*
Registered No. *37560*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Isaac Chase

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*
(write the word.)

6. DATE OF BIRTH *July 21 1852*
(Month) (Day) (Year)

7. AGE *69* Yrs. *7* Mos. *28* ds. IF LESS than 1 day how many.....hrs. or.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. *Farmer*
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) *Utah*

10. NAME OF FATHER

Isaac Chase

11. BIRTHPLACE OF FATHER

(State or Country) *Michigan*

12. MAIDEN NAME OF MOTHER

Elizabeth Calvert

13. BIRTHPLACE OF MOTHER

(State or Country) *Illinois*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *E. T. Radford.*
(Address) *Ririe Idaho*

15. Filed *4-10-22* *Ray H Fisher*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *May 19 1922*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Dec 13* 19*21*, to *Dec 30* 19*21*, that I last saw him alive on *Dec 30* 19*21*, and that death occurred on the date stated above, at *6 AM*.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis - probably

(Duration) *One* Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) *H. A. Anderson* M. D.

19. (Address) *Ririe, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Ririe Idaho

DATE OF BURIAL

3-20-1922

20. UNDERTAKER

Edw. L. Linn

ADDRESS

Ririe

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Jefferson
City of LouisvilleRegistration District No. 98Primary Registration District No. 2126

(No. St.)

File No. 37661Registered No. 20

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Adolph Bryant Hoffman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

married
(Write the word.)

6. DATE OF BIRTH

November 1 1924
(Month) (Day) (Year)

7. AGE

48 Yrs. 5 Mos. 16 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Electrician

(b) General nature of industry, business or establishment in which employed (or employer)

Farming

9. BIRTHPLACE

(State or Country)

Malin Sweden

10. NAME OF FATHER

Herman Hoffman

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Don't Know

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Missie G. Ellsworth(Address) Bigby Idaho

15.

Filed 4-10 1922Ray H. Fisher
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 22 1927
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Mar 13 1927 to Mar 17 1927that I last saw him alive on Mar 16 1927
and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Robert Pneumonia(Duration) Yrs. mos. 5 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas B. Moody M. D.19. (Address) Merone

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Louisville Idaho

DATE OF BURIAL

3-18 1922

20. UNDERTAKER

Ed. Fisher

ADDRESS

Bigby Id.

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

REC

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Jefferson
City of Bozeman

Registration District No. 95
Primary Registration District No. 2176
(No. St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37662
Registered No. 19

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Bessie Leach Jensen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH

2 12 1895
(Month) (Day) (Year)

7. AGE

27 Yrs. 1 Mos. 4 ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

House-wife

9. BIRTHPLACE

(State or Country) Annies, Idaho

10. NAME OF FATHER

Robert Dinsdale

11. BIRTHPLACE OF FATHER

(State or Country) Utah

12. MAIDEN NAME OF MOTHER

Sarah Louder

13. BIRTHPLACE OF MOTHER

(State or Country) Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. L. Jensen

(Address) Bozeman, Ida.

15.

Filed 4-10-22 Ray H. Fisher
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 27 1922
Mar 1 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar 17 1922 to Mar 16 1922

that I last saw her alive on Mar 15 1922

and that death occurred on the date stated above, at 7 1/2 M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) Yrs. mos. 16 ds.

Contributory (Secondary) Pneumonia

(Duration) yrs. mos. 3 ds.

(Signed) Chas S. Moody M. D.

19. (Address) Bozeman

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Annies, Idaho

DATE OF BURIAL

19

20. UNDERTAKER

Ed Sullivan

ADDRESS

Bozeman

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of JeffersonCity of Idaho FallsRegistration District No. 78Primary Registration District No. 2176

(No. _____ St.)

File No. 37663

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Kenneth Marshall Kay

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Boy

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

July

(Month)

1st

(Day)

1922

(Year)

7. AGE

8

Yrs.

Mos.

ds.

IF LESS than 1 day

how many _____ hrs.

or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho, Ida

10. NAME OF FATHER

F H Kay

11. BIRTHPLACE OF FATHER

(State or Country)

Florida

12. MAIDEN NAME OF MOTHER

Louise Corbourn

13. BIRTHPLACE OF MOTHER

(State or Country)

Polper Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

F H Kay
Right #3

15.

Filed

4-10

19

22Kay H Fisher
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar

(Month)

12

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar 10 1922 to Mar 12 1922that I last saw him alive on Mar 12 1922and that death occurred on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Influenza complicated with cerebrospinal meningitis

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

W. H. Harrison M. D.3-12-1922

(Address)

Rushburg, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Right Idaho3-13-1922

20. UNDERTAKER

ADDRESS

Ed. FisherRight

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH

Bureau of Vital Statistics

File No. 37664

Registered No. 19122

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of *Thermon* Registration District No. *98*
City of *Thermon* Primary Registration District No. *2176*
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ida Learson Scott

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married

6. DATE OF BIRTH.

April *30* *1886*
(Month) (Day) (Year)

7. AGE

35 Yrs. *9* Mos. *6* ds.IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)*Housewife*

9. BIRTHPLACE

(State or Country)

Smithfield

10. NAME OF FATHER

Peter Olef Carlson

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME OF MOTHER

Mary Katharine Anderson

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Orson M. Scott*

(Address)

15. Filed

Feb 10 *1912* *Ray Fisher*
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb *6* *1912*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 30 *1912* to *Feb 6* *1912*that I last saw him alive on *Nov 2* *1911*and that death occurred on the date stated above, at *2 P.* M.

The CAUSE OF DEATH* was as follows:

Encephalitis(Duration) Yrs. *8* mos. ds.Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) *H. A. Anderson* M. D.19 (Address) *Regy Idaho*

*State the Disease Causing Death; for in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days, State yrs. mos. daysWhere was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Idaho

DATE OF BURIAL

Feb 9 *1912*

20. UNDERTAKER

W. J. ...

ADDRESS

Regy Idaho

MAINTAIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 98

County of Jefferson

Primary Registration District No. 2126

City of Near Hamer

(No. _____, _____ St.)

File No. 37665

Registered No. 16

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Bradley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

Jan. 27 1922
(Month) (Day) (Year)

7. AGE

yrs. mos. ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of industry
business, or establishment in
which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Jefferson Co. Idaho

10. NAME OF FATHER

Eugene Van Bradley

11. BIRTHPLACE OF FATHER

(State or Country)

Pa.

12. MAIDEN NAME OF MOTHER

Goldie Francis Gill

13. BIRTHPLACE OF MOTHER

(State or Country)

Ind.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

4-10 1922 Ray H. Fisher
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan. 28 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
Jan. 27 1922 to Jan. 28/22 1922that I last saw him alive on Jan. 28th. '22 1922
and that death occurred on the date stated above, at 5.20 A.M.

The CAUSE OF DEATH* was as follows:

Non cl sure foramen ovale

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

19 (Address) Roberts, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted
if not at place of death?Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL

Ranch near Hamer

DATE OF BURIAL

1/28/22 1921

20. UNDERTAKER

None

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

1. PLACE OF DEATH. Jerome Registration District No. 23
County of Jerome Primary Registration District No. 1017-2017
City of Jerome (No. VITAL St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Chas Lyman Bolburn

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 37668

Registered No. _____
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH.

Sept 30 1855
(Month) (Day) (Year)

7. AGE

66 Yrs. 7 Mos. 5 ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country) New York

10. NAME OF FATHER

Andrew Bolburn

11. BIRTHPLACE OF FATHER

(State or Country) New York

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country) New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs M. A. Safford(Address) Jerome

15.

Filed Apr 519122E. D. Piper M.D.

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 5 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 20 1922 to April 3 1922
that I last saw him alive on April 4 1922
and that death occurred on the date stated above, at 3 A. M.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) Yrs. mos. ds.

Contributory Arterial Atherosclerosis,
(Secondary) Chronic nephritis

(Duration) yrs. mos. ds.

(Signed) Chas. B. Keller M. D.

19. (Address) _____

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Jerome Cemetery 4-6 1922

20. UNDERTAKER

ADDRESS

Ed. L. Harrison Jerome

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 37669

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH **RECEIVED**
Registration District No. 23
County of Jerome Primary Registration District No. 1012-2017
City of Jerome (No. _____) St. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John D. Singer

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single6. DATE OF BIRTH. Mar 28 1881
(Month) (Day) (Year)7. AGE 41 Yrs. X Mos. X ds.IF LESS than 1 day
how many _____ hrs. or
_____ min.)8. OCCUPATION Miner(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).9. BIRTHPLACE Indiana
(State or Country)10. NAME OF FATHER John Singer11. BIRTHPLACE OF FATHER Ohio
(State or Country)12. MAIDEN NAME OF MOTHER Anna Beech13. BIRTHPLACE OF MOTHER Kentucky
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M. Folkman(Address) Jerome Ida15. Filed Mar 28 1922 E.D. Pfen M.D.
Local Registrar16. DATE OF DEATH Mar 28 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Mar 15 1922 to Mar 28 1922that I last saw him alive on Mar 28 1922
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Tubercular Phthisis(Duration) 5 Yrs. _____ mos. _____ ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Chas. B. Keller M. D.19. (Address) Jerome Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Jerome CemeteryDATE OF BURIAL 3-30 192220. UNDERTAKER W. A. KatherisADDRESS Jerome

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

County of JeromeCity of JeromeRegistration District No. 23Primary Registration District No. 1017-2017

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lucy Fanny SummersState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 37670

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female Americanmarried

(Write the word.)

6. DATE OF BIRTH.

August 281899

(Month)

(Day)

(Year)

7. AGE

62 Yrs. 6 Mos. 13 ds.IF LESS than 1 day
how many _____ hrs. or
_____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...

(b) General nature of industry, business, or establishment in which employed (or employer).....

Housewife

9. BIRTHPLACE

(State or Country)

Cedar County Missouri

10. NAME OF FATHER

Alie Barnes.

11. BIRTHPLACE OF FATHER

(State or Country)

don't know

12. MAIDEN NAME OF MOTHER

Drucella Davis

13. BIRTHPLACE OF MOTHER

(State or Country)

Cedar County Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Joe SummersJerome Idaho

15.

Filed

Mar 13 1922E. D. P. for Reg.

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 13

(Month)

13

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb. 15 1922 to Mar. 13 1922that I last saw her alive on March 12 1922

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation & Cardiac
degeneration

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)Influenza

(Duration)

yrs.

mos.

ds.

(Signed)

Char. P. Zeller M. D.

19. (Address)

Jerome, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Jerome CemeteryMar 14 1922

20. UNDERTAKER

ADDRESS

W. H. L. Horner, Jerome

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 23County of JeromePrimary Registration District No. 107-2017City of Jerome

(No. _____ St.)

File No. 37671

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Harry Elmer Broadman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married

6. DATE OF BIRTH

(Month) _____ (Day) _____ (Year) _____

7. AGE

57 Yrs. _____ Mos. _____ ds.IF LESS than 1 day
how many _____ hrs. or
_____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Hartshorn(Address) Jerome

15.

Filed Apr 2 1922E.D. Piper

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 31 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar. 1 1922 to Mar. 31 1922that I last saw him alive on Mar. 31 1922

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) C. T. Keller M. D.4/1 1922 (Address) Jerome

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Jerome CemeteryApr 2 1922

20. UNDERTAKER

ADDRESS

S. A. Henning Jerome

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

1. PLACE OF DEATH RECEIVED
Registration District No. 28
County of Jerome MAY 1 1922
Primary Registration District No. 1017-2017
City of Jerome (No. 1017 St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 37672

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Leland Richard Johnson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED. single
(Write the word.)

6. DATE OF BIRTH.

July 29 1921
(Month) (Day) (Year)

7. AGE

Yrs. 7 Mos. _____ ds. _____

IF LESS than 1 day
how many _____ hrs. or
_____ min. 2]

8. OCCUPATION

(a) Trade, profession or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country) Jerome, Idaho

10. NAME OF FATHER

Arthur R. Johnson

11. BIRTHPLACE OF FATHER

(State or Country) Colo.

12. MAIDEN NAME OF MOTHER

Jessie B. Scott

13. BIRTHPLACE OF MOTHER

(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas. F. Keller(Address) Jerome, Idaho

15.

Filed

Mar 4 1922

1922

E. D. P. P. M. D.

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 3 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb. 18 1922 to Mar. 3 1922

that I last saw him alive on Mar. 2 1922

and that death occurred on the date stated above, at 9 a. M.

The CAUSE OF DEATH* was as follows:

Bronchitis Pneumonia

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Chas. F. Keller M. D.

19 _____ (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days In the State _____ yrs. _____ mos. _____ days

Where was disease contracted
if not at place of death? _____

Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Jerome Cemetery

3/5 1922

20. UNDERTAKER

ADDRESS

Forther

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37673
Registered No.

1. PLACE OF DEATH. Registration District No. 23
County of Jerome Primary Registration District No. 1017-2017
City of Jerome (No. 1017-2017 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Unnamed Mullins

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
(Write the word.)

6. DATE OF BIRTH. Mar. 1 1922
(Month) (Day) (Year)

7. AGE Yrs. 1 Mos. 1 ds. IF LESS than 1 day how many hrs. or min.

8. OCCUPATION (a) Trade, profession or particular kind of work... (b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER Leo T. Mullins

11. BIRTHPLACE OF FATHER MO (State or Country)

12. MAIDEN NAME OF MOTHER Viola T. Scott

13. BIRTHPLACE OF MOTHER MO (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) L. T. Mullins. (Address) Jerome Ida.

15. Filed Mar 3 1922 C. D. Piper M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar. 2 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 1 1922 to Mar. 2 1922 that I last saw him alive on Mar. 1 1922 and that death occurred on the date stated above, at M. The CAUSE OF DEATH* was as follows:

Premature Infant

(Duration) Yrs. mos. ds. Contributory (Secondary) (Signed) Chas. T. Keller M. D. 1922 (Address) Jerome Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) At place of death... yrs... mos... days In the State... yrs... mos... days Where was disease contracted if not at place of death? Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Jerome Cemetery DATE OF BURIAL 3/3 1922 20. UNDERTAKER Father ADDRESS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 37674

Registered No. _____

1. PLACE OF DEATH.

Registration District No. 23
County of Jerome
City of Jerome
(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Maggie May Talkington
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female White Married
(Write the word.)

6. DATE OF BIRTH.

Nov 16 1881
(Month) (Day) (Year)

7. AGE

41 Yrs. 3 Mos. 11 ds.

IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

House wife

9. BIRTHPLACE

(State or Country)

Arkansas

10. NAME OF FATHER

Andy Moore

11. BIRTHPLACE OF FATHER

(State or Country)

Arkansas

12. MAIDEN NAME OF MOTHER

Money Pathy

13. BIRTHPLACE OF MOTHER

(State or Country)

Arkansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

W. E. Talkington

(Address)

Jerome Idaho

15.

Filed

Feb 28 1922

E. D. P. M. D.

Local Registrar

16. DATE OF DEATH

Feb 27 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 15 1922 to Feb 27 1922
that I last saw her alive on Feb 27 1922
and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(Duration) Yrs. mos. ds.

Contributory Recurrent severe valvular disease
(Secondary)

(Duration) yrs. 1 1/2 mos. ds.

(Signed) E. D. P. M. D.

Feb 28 1922 (Address) Jerome Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Jerome Cemetery

Feb 28 1922

20. UNDERTAKER

ADDRESS

W. E. Talkington

Jerome Idaho

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Jerome Registration District No. 23
City of Jerome Primary Registration District No. 1017-2017
(No.) St.)File No. 37675
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Annie M. Shephard

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widow
(Write the word.)

6. DATE OF BIRTH.

April 20 1868
(Month) (Day) (Year)

7. AGE

65

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).Home wife

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

Mourae Pritchett

11. BIRTHPLACE OF FATHER

(State or Country)

Missouri

12. MAIDEN NAME OF MOTHER

Don't know

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mr G. E. Chur

(Address)

Jerome Idaho

15.

Filed

Apr 17 1912E. D. P. Jr

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Apr 15 1912
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Apr 1912 to Apr 1912that I last saw her alive on Apr 1912
and that death occurred on the date stated above, at 99 M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum(Duration) 24 yrs. 24 mos. 24 ds.Contributory
(Secondary)(Duration) 24 yrs. 24 mos. 24 ds.(Signed) E. D. P. Jr M. D.19. (Address) Jerome Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bellingham Wash1912

20. UNDERTAKER

ADDRESS

D. G. L. Henson

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

(No. 705)

Indiana

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

37677

Registered No.

1048

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

Yrs. 2 Mos. 4 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed April 5, 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 29

(Month)

(Day)

1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 27, 1922, to March 29, 1922

that I last saw him alive on March 29, 1922

and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration)

Yrs.

mos. 5

ds.

Contributory (Secondary)

(Duration)

Yrs.

mos. 15

ds.

(Signed)

W. H. Hoedner M. D.

3/29, 1922

(Address) Cour d'Alene Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

Yrs.

mos.

In the

days

State

Yrs.

mos.

days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Forest Cemetery

3/30, 1922

20. UNDERTAKER

ADDRESS

R. B. Mooney

Cour d'Alene Ida.

FORM V. S. No. 5-A—25 M. 1-19.

1. PLACE OF DEATH

County of *Mortonai*
City of *Born de Plene*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Theresa Dyer*RECEIVED
CERTIFICATE OF DEATHRegistration District No. _____
Primary Registration District No. _____
(No. _____) St. _____State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *37679*Registered No. *104*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *F* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED *Widowed*
(Write the word.)

6. DATE OF BIRTH

August 18 18*87*
(Month) (Day) (Year)

7. AGE

84 Yrs. *8* Mos. *15* ds.
IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work *House wife*
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) *Indiana*

10. NAME OF FATHER

Henry Jackson

11. BIRTHPLACE OF FATHER

(State or Country) *Virginia*

12. MAIDEN NAME OF MOTHER

Theresa Jackson

13. BIRTHPLACE OF MOTHER

(State or Country) *North Carolina*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Henry J. Dyer*
(Address) *Born de Plene Idaho*15. Filed *April 5* 19*22* *D. D. Brennan*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

McH 3 19*22*
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *McH 2* 19*22* to *McH 3* 19*22*that I last saw h. *er* alive on *McH 2* 19*22*
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus(Duration) *4* Yrs. *4* mos. *✓* ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

J. H. Kading M. D.
3/4 19*22* (Address) *Born de Plene Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Forest Cemetery *3/6* 19*22*

20. UNDERTAKER

ADDRESS

C. Cassidy *B. D. Brennan*

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 37680

Registered No. 1045

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of FootwallCity of Coverdole

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 30Primary Registration District No. 251(No. 506 Coverdole one St.)

2. FULL NAME

George E Overjorde Jr

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

(Write the word.)

6. DATE OF BIRTH

Mar41922

(Month)

(Day)

(Year)

7. AGE

— Yrs. — Mos. — ds.IF LESS than 1 day
how many 15 hrs.
or — min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

Iowa

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo E Overjorde Jr(Address) Coverdole 78a

15.

Filed April 5-22 1922

Local Registrar

SYN-YORK CO. PRINTERS & BINDERS. BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar51922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

3/0 1922 to 3/5 1922that I last saw him alive on 3/5 1922and that death occurred on the date stated above, at 4 M.

The CAUSE OF DEATH* was as follows:

Infection of Bowel

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) D. D. Brennan M. D.

19 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Forest Cemetery

DATE OF BURIAL

3/6 1922

20. UNDERTAKER

V. B. Mooney

ADDRESS

Forest Cemetery

1. PLACE OF DEATH

County of *Idaho*City of *Coeur d'Alene*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No. *30*Primary Registration District No. *1451*(No. *1224*)St. *9th*State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *37681*Registered No. *1824*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

7

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

October 27
(Month) (Day)*1888*
(Year)

7. AGE

33 Yrs. *5* Mos. *9* ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Housewife

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Washington

10. NAME OF FATHER

George W. W. W.

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Lola Sum

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Will Edie

(Address)

Coeur d'Alene

15.

Filed *April 5 1922**1922*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 6
(Month) (Day)*1922*
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 4 1922 to *March 6 1922*that I last saw *her* alive on *March 6 1922*and that death occurred on the date stated above, at *99 A.M.*

The CAUSE OF DEATH* was as follows:

Influenza Pneumonia(Duration) Yrs. mos. *10* ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

*W. H. K. edie**3/6 1922* (Address) *Coeur d'Alene Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Coast Cemetery

DATE OF BURIAL

3-9 1922

20. UNDERTAKER

E. Gaudy

ADDRESS

Coeur d'Alene

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Kootenai* Registration District No. *30*
City of *Coeur d'Alene* (No. *325*) Primary Registration District No. *1151* Reid St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Margaret Stanley*File No. *37682*
Registered No. *1845*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *F.* 4. COLOR OR RACE *W.* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *widowed*
(Write the word.)

6. DATE OF BIRTH

2 - 6 - 1860
(Month) (Day) (Year)

7. AGE

62 Yrs. *1* Mos. *8* ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).*House wife*

9. BIRTHPLACE

(State or Country)

Scotland

10. NAME OF FATHER

Robert Porteous

11. BIRTHPLACE OF FATHER

(State or Country)

Scotland

12. MAIDEN NAME OF MOTHER

Stewart

13. BIRTHPLACE OF MOTHER

(State or Country)

Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Florence E. Stanley*
(Address) *525 Reid St.*

15.

Filed *April 5 - 1922*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 14 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 15 1919 to *March 14 1922*
that I last saw him alive on *March 14 1922*
and that death occurred on the date stated above, at *3:30 P.*
The CAUSE OF DEATH* was as follows:*Broncho-pneumonia*(Duration) Yrs. mos. *2* ds.Contributory (Secondary) *Influenza*

(Duration) Yrs. mos. ds.

(Signed) *J. D. Brown* M. D.*3/16 1922* (Address) *Coeur d'Alene, Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL *Forest Cem. Co. Alene* DATE OF BURIAL *3 - 16 1922*20. UNDERTAKER *Carsey* ADDRESS *Co Alene*

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Butte*
City of *Coeur d'Alene*

Registration District No. *30*
Primary Registration District No. *1051*
(No. _____ St.)

File No. *37683*
Registered No. *846*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Frank Joseph Herzog

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

M *W* *Married*
(Write the word.)

6. DATE OF BIRTH

November 10 19*22*
(Month) (Day) (Year)

7. AGE

22 Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

Labour

9. BIRTHPLACE

(State or Country)

South Dakota

10. NAME OF FATHER

George Herzog

11. BIRTHPLACE OF FATHER

(State or Country)

Iowa

12. MAIDEN NAME OF MOTHER

Edo Krump

13. BIRTHPLACE OF MOTHER

(State or Country)

Wis

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Fred Herzog
118 Youngsboro Cedar Park

15.

Filed

5 19*22*

Local Registrar

16. DATE OF DEATH

Mar 18 19*22*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar 18 19*22* to *Mar 18* 19*22*
that I last saw him alive on *11* *18* 19*22*
and that death occurred on the date stated above, at *11* P. M.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(Duration) Yrs. mos. ds.

Contributory (Secondary)

Drunk Had only Heart mal

(Duration) Yrs. mos. ds.

(Signed)

Dr. Herzog

M. D.

11 19*22* (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Butte, S Dakota

3/22 19*22*

20. UNDERTAKER

ADDRESS

L. Cassidy

Coeur d'Alene

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Portland*
City of *Boeur d'Alene*

Registration District No.

Primary Registration District No.

(No. *Boeur Hospital* St.)File No. *37684*Registered No. *37684*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Grace E Nelson

If death occurred in hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(write the word.)

6. DATE OF BIRTH

July 7 1878
(Month) (Day) (Year)

7. AGE

43 Yrs. *8* Mos. *10* ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

House Wife

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idio

10. NAME OF FATHER

Edgar Nelson

11. BIRTHPLACE OF FATHER

(State or Country)

New York

12. MAIDEN NAME OF MOTHER

Mary Powell

13. BIRTHPLACE OF MOTHER

(State or Country)

Idio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Oscar Nelson

(Address)

Boeur d'Alene, Ida.

15.

Filed

July 5 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

3 19 22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mich. 11 1922, to Mich. 14 1922

that I last saw him..... alive on..... 19.....

and that death occurred on the date stated above, at *3:30 P.M.*

The CAUSE OF DEATH* was as follows:

Diabetic Coma

(Duration) Yrs..... mos..... ds.

Contributory
(Secondary)*Idio*

(Duration) yrs..... mos..... ds.

(Signed)

H. D. Drennan M. D.*3/21 1922* (Address) *Boeur d'Alene*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Forest Cemetery

DATE OF BURIAL

3/21 1922

20. UNDERTAKER

H. D. Drennan Boeur d'Alene Ida

ADDRESS

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

(No. *Idaho* St.)State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 30
County of Boonville Primary Registration District No. 1051
City of Coeur d'Alene (No. 305 Coeur d'Alene St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Rose Marie FosterFile No. 37686
Registered No. 1049

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)6. DATE OF BIRTH February 8 1922
(Month) (Day) (Year)7. AGE 3 Yrs. 1 Mos. 14 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).9. BIRTHPLACE Coeur d'Alene, Idaho
(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER
(State or Country)12. MAIDEN NAME OF MOTHER Lucia Stevens13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Bert Rice
(Address) Coeur d'Alene, Ida15. Filed April 6 1922 J. D. Drennan
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 22 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from March 5 1922, to March 20 1922, that I last saw him alive on March 20 1922, and that death occurred on the date stated above, at 11:45 A.M. The CAUSE OF DEATH* was as follows:
Bronchopneumonia(Duration) Yrs. mos. 12 ds.
Contributory (Secondary) Influenza
(Duration) Yrs. mos. 20 ds.
(Signed) J. H. Koedeen M.D.
3/24/1922 (Address) Coeur d'Alene

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Forest Cemetery DATE OF BURIAL 3/24/192220. UNDERTAKER C. Cassidy ADDRESS Coeur d'Alene, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37687
Registered No. 114

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene
Registration District No. _____
Primary Registration District No. 5th
(No. 1829 St.)
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME Adma Webb

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX F. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
(Write the word.)

16. DATE OF DEATH
March 27 1922
(Month) (Day) (Year)

6. DATE OF BIRTH
8 2 1850
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 23 1922, to March 25 1922, that I last saw him alive on March 23 1922 and that death occurred on the date stated above, at 2.4 M. The CAUSE OF DEATH* was as follows:
Myocardial Thrombosis.

7. AGE 71 Yrs. 7 Mos. 24 ds.
IF LESS than 1 day how many hrs. or min.?

(Duration) Yrs. 2 mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

8. OCCUPATION
(a) Trade, profession or particular kind of work. Housewife
(b) General nature of industry, business or establishment in which employed (or employer)

(Signed) John O'Leary M. D.
Mar 27 1922 (Address) Coeur d'Alene - Ida.

9. BIRTHPLACE
(State or Country) Genesee Co. Mich.

10. NAME OF FATHER Warren Thomas

11. BIRTHPLACE OF FATHER
(State or Country) N. Y.

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Delia M. Wilbur
(Address) 1301 2nd St. C. O. A. Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

15. Filed April 1 1922
Local Registrar

19. PLACE OF BURIAL OR REMOVAL Forest Cem. Coeur d'Alene DATE OF BURIAL 2-28 1922
20. UNDERTAKER C. Cassidy ADDRESS Coeur d'Alene, Ida.

RECEIVED
APR 21 1922

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Kootenai*
City of *Rathdrum*Registration District No. *30*Primary Registration District No. *1051*

(No. _____)

(St. _____)

File No. *37688*Registered No. *1051*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Hamilton Davis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widowed
(Write the word.)

6. DATE OF BIRTH

October 27 1840
(Month) (Day) (Year)

7. AGE

*81 Yrs 5 Mos 17 ds.*IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

Retired

9. BIRTHPLACE

(State or Country)

Michigan

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mrs Joseph Waldecker*
(Address) *Spirit Lake Idaho*

15.

Filed *April 6 1922**D. P. [Signature]*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 16 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 1 1922 to March 13 1922
that I last saw him alive on *March 13 1922*
and that death occurred on the date stated above, at *7:40 P.M.*
The CAUSE OF DEATH* was as follows:
Epicardial infarction(Duration) _____ Yrs. _____ mos. *18* ds.
Contributory (Secondary) *Old age*(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) *Frank [Signature]* M. D.*3/18/1922* (Address) *Rathdrum, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Providence Cemetery - Rathdrum *3/19 1922*

20. UNDERTAKER

C. L. Cassidy *Rathdrum*

1. PLACE OF DEATH

County of *Kootenai*
City of *Harrison*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED
APR 21 1922
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH
District No. *126*
Primary Registration District No. *2204**Molly Louise Peterson*37680 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. *2*
Registered No. *94*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

*White*5. SINGLE, MARRIED, WIDOWED OR DIVORCED
(Write the word.)
Married

6. DATE OF BIRTH

Sept 1 89
(Month) (Day) (Year)

7. AGE

31 Yrs. *6* Mos. *9* ds.
IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)*Housewife*

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

*Frank Billups**Idaho*

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Don't know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

*H. S. Peterson**Harrison Ida*

15. Filed

Mar 28 22
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 28 22
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
Mar 11 1922 to *Mar 28 1922*
that I last saw *her* alive on *Mar 28 1922*
and that death occurred on the date stated above, at *2:20 P.M.*

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

3-28-22 (Address) *2 Harrison*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Residence Ida

DATE OF BURIAL

3-31-22

20. UNDERTAKER

C. L. Cassidy

ADDRESS

Coeur d'Alene

RECEIVED

APR 21 1922

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Latay*City of *Potlatch*Registration District No. *65*Registration District No. *2145*

(No.)

(St.)

File No.

37690

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Harvey Albert Schatz

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

single
(Write the word.)

6. DATE OF BIRTH

2 (Month) *14* (Day) *1922* (Year)

7. AGE

Yrs. *1* Mos. ds.IF LESS than 1 day
how many hrs.
or min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Infant

(b) General nature of industry, business or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country)

Latay co

10. NAME OF FATHER

I George Schatz

11. BIRTHPLACE OF FATHER

(State or Country)

Latay co

12. MAIDEN NAME OF MOTHER

Francis E Giger

13. BIRTHPLACE OF MOTHER

(State or Country)

Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

I George Schatz

(Address)

Potlatch

15.

Filed *3/16-**1922**D. J. Thompson*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

3 (Month) *15* (Day) *1922* (Year)

17. I HEREBY CERTIFY, That I attended deceased from

2-15 *1922* to *3-15* *1922*that I last saw him alive on *3-15* *1922*and that death occurred on the date stated above, at *12 M*

The CAUSE OF DEATH* was as follows:

Suppuration(Duration) Yrs. mos. *8* ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. S. Leard

M. D.

3/15 *1922*

(Address)

Potlatch

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Potlatch Cemetery

DATE OF BURIAL

3/17 *1922*

20. UNDERTAKER

Parents

ADDRESS

Potlatch

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED

Deliver This Certificate to Your Local Registrar. Not to the State Board of Health.

37692

PLACE OF DEATH

State Board of Health

Registration D. No. 65
Record No. 65County of Sabat

BUREAU OF VITAL STATISTICS

City or Town of Pottatch RFD.

CERTIFICATE OF DEATH

Registered No. 2145

Registration Dist. No. _____

(No. _____)

St.; _____ Ward)

[If death occurs away from USUAL RESIDENCE give facts called for under item 18.]

FULL NAME

Ella May Browning

[If death occurred in a Hospital or Institution give its NAME instead of street and number.]

Personal and Statistical Particulars

3 Sex

Female

4 Color or Race

White

5 Single, Married, Widowed, or Divorced (Write the word)

Married

6 Date of Birth

Mar 3

(Month)

(Day)

1902 (Year)

7 Age

21 yrs.1 mos.2 ds.

If LESS than

1 day, _____ hrs.

or _____ min?

8 Occupation

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

Housewife

9 Birthplace

(State or country)

Washington

10 Name of Father

John Thomas

11 Birthplace of Father

(State or country)

Arkansas

12 Maiden name of Mother

Ella Long

13 Birthplace of Mother

(State or country)

Arkansas

14 The above is true to the best of my knowledge

(Informant)

Mrs. Ella Thomas

(Address)

Pottatch RFD.

15

Filed

April 41922Dr. J. H. Thompson

Registrar.

I HEREBY CERTIFY, That I have been unable to secure answers to Questions

(Insert numbers of unanswered questions)

E. M. Brown

(Signature of Undertaker)

Medical Certificate of Death

16 Date of Death

April 3

(Month)

(Day)

1922 (Year)

17

I HEREBY CERTIFY, That I attended deceased from

March 301922

to

April 31922that I last saw him alive on March 31, 1912and that death occurred, on the date above, at 4:30 AM

The CAUSE OF DEATH* was as follows:

Bronchopneumonia(Duration) _____ yrs. _____ mos. 11 ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

April 31922

(Address)

Garfield Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 Length of Residence (For Hospitals, Institutions, Transients, or Recent Residents)

At Place

of death

_____ yrs.

_____ mos.

_____ ds.

In the

State

_____ yrs.

_____ mos.

_____ ds.

Where was disease contracted, if not at place of death?

Former or

usual residence

19 Place of Burial or Removal

Date of Burial

BreezeJuneMar 41922

20 Undertaker

Address

P. House

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

37693

Deliver This Certificate to Your Local Registrar. Not to the State Board of Health.

PLACE OF DEATH Idaho Idaho State Board of Health Registration 65
 Record No.

BUREAU OF VITAL STATISTICS
 COUNTY OF Idaho
 City or Town of Parmington CERTIFICATE OF DEATH Primary Registered No. 2145

Registration Dist. No. (No.) St. Ward
 [If death occurs away from USUAL RESIDENCE give facts called for under item 18.] FULL NAME Rachel E. Stout [If death occurred in a Hospital or Institution give its NAME instead of street and number.]

Personal and Statistical Particulars				Medical Certificate of Death	
3 Sex <u>Female</u>	4 Color or Race <u>White</u>	5 Single, Married, Widowed or Divorced <u>Married</u> (Write the word)	16 Date of Death <u>4</u> <u>5</u> <u>22</u> (Month) (Day) (Year)		
6 Date of Birth <u>Nov</u> <u>18</u> <u>1840</u> (Month) (Day) (Year)			17 I HEREBY CERTIFY, That I attended deceased from <u>Mar 31</u> , 191 <u>2</u> , to <u>4-5</u> , 191 <u>2</u> , that I last saw her alive on <u>4-5</u> , 191 <u>2</u> , and that death occurred, on the date above, at <u>8</u> <u>9</u> a.m.		
7 Age <u>81</u> yrs. mos. ds. If LESS than 1 day, hrs. or min?			The CAUSE OF DEATH* was as follows: <u>Influenza</u> (Duration) yrs. mos. <u>14</u> ds.		
8 Occupation (a) Trade, profession or particular kind of work (b) General nature of industry, business or establishment in which employed (or employer) <u>Housewife</u>			Contributory (Secondary) <u>Myocarditis</u> (Duration) yrs. mos. <u>7</u> ds.		
9 Birthplace (State or country) <u>Iowa</u>			(Signed) <u>J. J. Loney</u> , M. D. <u>45</u> <u>1912</u> (Address) <u>Parmington</u>		
PARENTS	10 Name of Father <u>H. Allen</u>		*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.		
	11 Birthplace of Father (State or country) <u>Iowa</u>		18 Length of Residence (For Hospitals, Institutions, Transients, or Recent Residents) At Place of death yrs. mos. ds. In the State yrs. mos. ds.		
	12 Maiden name of Mother <u>Snodden</u>		Where was disease contracted, if not at place of death? Former or usual residence		
	13 Birthplace of Mother (State or country) <u>Not known</u>		19 Place of Burial or Removal <u>Polk</u>		
14 The above is true to the best of my knowledge (Informant) <u>Madame D. Pieper</u> (Address) <u>512 Hughes Street</u>			Date of Burial <u>April 8</u> 191 <u>2</u>		
15 Filed <u>April 7</u> , 191 <u>2</u> <u>D. J. W. Thwayer</u> Registrar.			20 Undertaker <u>C. M. Lown</u>		
I HEREBY CERTIFY, That I have been unable to secure answers to Questions. (Insert numbers of unanswered questions) <u>C. M. Lown</u> (Signature of Undertaker)					

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH

County of *Polk*
City of *Polk*

BUREAU OF VITAL
STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Theresa Grafe

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

File No. *37684*
Registered No.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WID-OWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH.

Dec. 19
April 3 19*48*
(Month) (Day) (Year)

7. AGE

73 Yrs. *3* Mos.ds.

IF LESS than 1 day
how manyhrs. or
....min.

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

Frank. Licke Haues

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Mrs. Kuehn

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Theresa Grafe

(Address)

Polk 2nd St.

15.

Filed *April 3* 19*48*

Dr. J. M. Thompson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 3 19*48*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 6 19*48* to *April 3* 19*48*

that I last saw her alive on *April 3* 19*48*

and that death occurred on the date stated above, at *1 P.* M.

The CAUSE OF DEATH* was as follows:

Pneumonia - (Croupous)

(Duration) Yrs.mos. *4* ds.

Contributory (Secondary)

Intest. Insufficiency

(Duration) *10* yrs.mos.ds.

(Signed)

J. M. Thompson

M. D.

4/3/1948 (Address) *Polk*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death....yrs....mos....days In the State....yrs....mos....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Viola

DATE OF BURIAL

April 5 19*48*

20. UNDERTAKER

E. Drwin

ADDRESS

Salouse Wood

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of ValleCity of Grimes

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 1Primary Registration District No. 1

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 37695Registered No. 3

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Melvin Hubert Rader

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Baby

(Write the word.)

6. DATE OF BIRTH

Mar

(Month)

23

(Day)

1922

(Year)

7. AGE

Yrs.

Mos.

7

ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Grimes

10. NAME OF FATHER

William Rader

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Marion E Gage

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

William Rader

(Address)

Grimes Idaho

15.

Filed

3-31-1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

(Year)

Mar 30 1922

17. I HEREBY CERTIFY, That I attended deceased from

Mar 23 1922 to Mar 30 1922that I last saw him alive on Mar 30 1922and that death occurred on the date stated above, at 3 A.M.

The CAUSE OF DEATH* was as follows:

Premature Birth
Starvation(Duration) Yrs. mos. 7 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

C. F. Twomey M. D.Mar 31 1922(Address) Grimes

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Grimes3-31-1922

20. UNDERTAKER

ADDRESS

F. E. HammettGrimes

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Latah
City of Genesee

Registration District No.

Primary Registration District No. 2142

(No.)

St.)

File No. 37696Registered No. 2

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Andrew Mark Wardrobe

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

August 3 1837
(Month) (Day) (Year)

7. AGE

84 Yrs. 7 Mos. 2 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Glasgow Scotland

10. NAME OF FATHER

Andrew Wardrobe

11. BIRTHPLACE OF FATHER

(State or Country)

Glasgow Scotland

12. MAIDEN NAME OF MOTHER

Elizabeth Russell

13. BIRTHPLACE OF MOTHER

(State or Country)

Glasgow Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mary B. Wardrobe

(Address)

Genesee Idaho

15.

Filed 3-6-192210:10 AM

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 5 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 24 1922 to March 5 1922that I last saw him alive on March 6 1922and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolism(Duration) Yrs. mos. 1 ds.Contributory
(Secondary)(Duration) Yrs. mos. 9 ds.

(Signed)

W. E. Keen M. D.3-6-1922 (Address) Genesee

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Genesee

DATE OF BURIAL

3-7 1922

20. UNDERTAKER

F. E. Lambert

ADDRESS

Genesee

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of *Idaho*City of *Idaho*

If death occurs away from usual residence, give facts called for under special information.

RECEIVED

APR 21 1922

CERTIFICATE OF DEATH

Registration District No. *62*Primary Registration District No. *2142*

BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *37897*Registered No. *37897*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME *Jacob Scambitich*

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married

(Write the word.)

6. DATE OF BIRTH

July 20th

(Month)

(Day)

1881
(Year)

7. AGE

90 Yrs. *7* Mos. *27* ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

Farmer

9. BIRTHPLACE

(State or Country)

Austria

10. NAME OF FATHER

Anton Scambitich

11. BIRTHPLACE OF FATHER

(State or Country)

Austria

12. MAIDEN NAME OF MOTHER

Dont know

13. BIRTHPLACE OF MOTHER

(State or Country)

Austria not likely

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

F. H. Bruegeman

(Address)

Cervin, T. L. Idaho

15.

Filed *3-20**1922**2210 Hotel*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 19 19*22*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar 15 19*22* to *Mar 19* 19*22*
that I last saw him alive on *Mar 19* 19*22*
and that death occurred on the date stated above, at *9:00* M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage(Duration) Yrs. mos. *9* ds.Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

W. J. Querry M.D.
Mar 20 19*22* (Address) *Genesee Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Genesee

DATE OF BURIAL

3-22-1922

20. UNDERTAKER

J. E. Lambert

ADDRESS

Genesee

1. PLACE OF DEATH **RECEIVED**
 County of *Latah* Registration District No. *2147*
 City of *Arvo* Primary Registration District No. *67*
BUREAU OF VITAL STATISTICS

2. FULL NAME *Mary Wood*

37698 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. *3*
 Registered No. *43*

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *F* 4. COLOR OR RACE *W.* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Widowed*
 (Write the word.)

6. DATE OF BIRTH *July 25 1937*
 (Month) (Day) (Year)

7. AGE *85* Yrs. *6* Mos. *17* ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. *H. W.*
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE *Don't know*
 (State or Country)

10. NAME OF FATHER *Purdy*

11. BIRTHPLACE OF FATHER *Penn.*
 (State or Country)

12. MAIDEN NAME OF MOTHER *Don't know*

13. BIRTHPLACE OF MOTHER *Penn.*
 (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) *R. G. Faust*
 (Address) *Deary*

15. *3/1* 19 *22* *R. G. Faust*
 Filed Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *Feb. 28 1922*
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Jan. 1922* to *Feb. 28 1922*, that I last saw her alive on *Feb. 15 1922* and that death occurred on the date stated above, at *1922*.

The CAUSE OF DEATH was as follows:
Myocardial Insufficiency

(Duration) *?* Yrs. mos. ds.
 Contributory (Secondary) *Senility*

(Duration) *?* Yrs. mos. ds.
 (Signed) *R. G. Faust* M. D.

3/1 19 *22* (Address) *Deary*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Arvo Cem.* DATE OF BURIAL *3/2 1922*

20. UNDERTAKER *Ed. Irwin* ADDRESS *Blouse*

FORM V. S. No. 5-A—25 M. 1-19.

1. PLACE OF DEATH

County

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

(No.

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15. Filled

19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at A.M.,
The CAUSE OF DEATH* was as follows:

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Idaho*City of *Moscow*

If death occurs away from usual residence, give facts called for under special information.

Registration District No. *601*Primary Registration District No. *1011*(No. *1011*)

St.)

File No. *37700*Registered No. *14*

2. FULL NAME

Bertha Sarah Nedrow

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

F

4. COLOR OR RACE

*W*5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

Jan. 15 1922

(Month)

(Day)

(Year)

7. AGE

1 Yrs. *1* Mos. *14* ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Harry Nedrow

11. BIRTHPLACE OF FATHER

(State or Country)

May, land

12. MAIDEN NAME OF MOTHER

Velma A. Hayden

13. BIRTHPLACE OF MOTHER

(State or Country)

Washington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Harry Nedrow

(Address)

Moscow

15. SIGNED

*Mich. H. 72**W. H. Carithers*

Local Registrar

16. DATE OF DEATH

March 1 1922

(Month)

(Day)

19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb. 28 1922, to *Feb. 28 1922*that I last saw her alive on *Feb. 28 1922*and that death occurred on the date stated above, at *12 M.*

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia(Duration) *Not known* yrs. mos. ds.

Contributory (Secondary)

(Duration) _____ yrs. mos. ds.

(Signed) *W. H. Carithers* M. D.3/7/22 (Address) *Moscow, Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Idaho

DATE OF BURIAL

20. UNDERTAKER

John Rice

ADDRESS

Moscow

FORM V. S. No. 5-A—25 M. 1-19.

1. PLACE OF DEATH

County of *Idaho*City of *Moose*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District

Primary Registration District

(No. *2141* St.)*Samuel S. Stewart*State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *37301*Registered No. *13*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *M* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Not known*
(Write the word.)6. DATE OF BIRTH *Jan 25 1853*
(Month) (Day) (Year)7. AGE *69* Yrs. *6* Mos. *4* ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

Common Laborer

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15. *Feb 2 22* *W. H. Barthers*
Filed *19* Local Registrar16. DATE OF DEATH *Feb 1 22*
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *Jan 26 1922* to *Feb 1 1922* that I last saw him alive on *Feb 1 1922* and that death occurred on the date stated above, at *4437* M.

The CAUSE OF DEATH* was as follows:

Central Hemorrhage

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) *W. H. Barthers* M. D.*2/2 1922* (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Moose**Feb 2 22*

20. UNDERTAKER

ADDRESS

*John Price**Moose*

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Latah Registration District No. 61
City of Viola Primary Registration District No. 2141
St.)File No. 37702
Registered No. 15

If death occurs away from usual residence, give facts called for under special information.

BUREAU OF VITAL STATISTICS

2. FULL NAME

Obe McWay

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-OWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH

Aug 22 1882
(Month) (Day) (Year)

7. AGE

42 Yrs. 8 Mos. 20 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Farmer.

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Adam McWay

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Langley

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Mary McWay

(Address)

Viola, Idaho

15

FILED

Mich 12 22 M. H. H. H. H.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 11 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Mar 4 1922, to Mar 11 1922, that I last saw him alive on March 11 1922, and that death occurred on the date stated above, at 7 AM.

The CAUSE OF DEATH* was as follows:

Myocarditis(Duration) Yrs. mos. 10 ds.

Contributory (Secondary)

Influenza(Duration) yrs. mos. 14 ds.

(Signed)

V. M. Gilchrist M. D.3/12 1922 (Address) Moscow, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Viola

DATE OF BURIAL

Mar 21

20. UNDERTAKER

E. M. Chwin

ADDRESS

PalmerDr. Gilchrist

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37703
Registered No. 16

1. PLACE OF DEATH. Registration District No. 61
County of Salah Primary Registration District No. 2141
City of Farmington (No. 1020 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

George W Kern

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male White Married (Write the word.)

6. DATE OF BIRTH

Aug 21 1886
(Month) (Day) (Year)

7. AGE

35 yrs. 6 mos. 19 ds.

IF LESS than 1 day
how many.....hrs. or
.....min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Dallas Texas

10. NAME OF FATHER

George Kern

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Euphemia Rubel

13. BIRTHPLACE OF MOTHER

(State or Country)

Texas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Henry Kern
Farmington

15.

Filed

Nov 31 1922 W. H. Caruthers
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov 18 19122
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 5 19122, to Nov 18 19122

that I last saw him alive on Nov 17 19122

and that death occurred on the date stated above, at 7:50 A.M.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) yrs. mos. ds.

Contributory (Secondary) Broncho pneumonia

(Duration) yrs. mos. ds.

(Signed) P. E. Naezel M. D.
3/18 1922 (Address) Garfield Wash

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted,
If not at place of death?

Former or
usual residence.....

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Farmington Wash Nov 20 19122

20. UNDERTAKER

ADDRESS

H. S. Brunning Bozefar Wash

File No. 37704
Registered No. 19

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Edward Spiner

MEDICAL CERTIFICATE OF DEATH.

male	white	married
------	-------	---------

6. DATE OF BIRTH Feb. 22 1867
(Month) (Day) (Year)

7. AGE 65 yrs. 1 mos. 8 ds. IF LESS than 1 day
how many.....hrs. or
.....min?

(a) Trade, profession or particular kind of work..... *farmer*

(b) General nature of industry business or establishment in which employed (or employer)

10. NAME OF FATHER

**11. BIRTHPLACE
OF FATHER**
(State or Country)

12. MAIDEN NAME
OF MOTHER *e*

**13. BIRTHPLACE
OF MOTHER**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Maggie Grimes
(Address) Garfield Wash

15. 0
Filed meW31 10/22 RS Harthurs
Local Registrar

16. DATE OF DEATH

_____ March 30 _____ 1912²
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 13 1942, to March 30 1942
that I last saw him alive on March 27 1942
and that death occurred on the date stated above, at 5 A.M.
The CAUSE OF DEATH* was as follows:

**Contributory
(Secondary)**

..... (Duration) yrs. mos. ds.
(Signed) PE Miesel M. D.
Mch 30 1974 (Address) Garfield Hall

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place	In the
of death.....yrs.....mos.....ds.	State.....yrs.....mos.....ds.
Where was disease contracted,	
If not at place of death?.....	
Former or	
usual residence.....	

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Garfield Nash	April 1, 1915

20. UNDERTAKER	ADDRESS
H. L. Greening - Co. for Nat	

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Idaho
County of *Latah*
City of *Moscow*

Registration District No. *61*

Primary Registration District No. *2141*

(No. *TAL* St.)

File No. *37705*

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Eva Sooner

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married

6. DATE OF BIRTH

May 50

Unknown

(Month) (Day) (Year)

7. AGE

50

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

Charles

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Not Known

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. H. Sooner

(Address)

Moscow

15.

Filed

3/27 22

19

W. H. Caruth

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 27 22

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar 21 1922 to *Mar 26 1922*

that I last saw him alive on *Mar 26 1922*

and that death occurred on the date stated above, at *5:17 P.M.*

The CAUSE OF DEATH* was as follows:

Coronary of large intestine

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) *J. H. Clarke* M. D.

3/27 1922 (Address) *Moscow*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Moscow

3/28 22

20. UNDERTAKER

ADDRESS

Glenn Miller

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Latah*City of *Troy*

If death occurs away from usual residence, give facts called for under special information.

RECEIVED

BUREAU

Registration District No. *64*Primary Registration District No. *2144*

(No.)

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *37707*

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Dena Evaline Clemen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

March 21 1922
(Month) (Day) (Year)

7. AGE

13 Yrs. Mos. ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country) *Troy, Idaho*

10. NAME OF FATHER

J. Walter Clemen

11. BIRTHPLACE OF FATHER

(State or Country) *Ill*

12. MAIDEN NAME OF MOTHER

Leda Gladys Ivut

13. BIRTHPLACE OF MOTHER

(State or Country) *Ida.*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *J. H. Clemen*(Address) *Troy, Idaho*

15.

Filed *April 30 1922* *Lucy M. Pickard*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 3 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *March 21 1922* to *April 3 1922*that I last saw her alive on *March 27 1922*and that death occurred on the date stated above, at *5 P.* M.

The CAUSE OF DEATH* was as follows:

Congenital Heart Insufficiency(Duration) Yrs. mos. *13* ds.Contributory
(Secondary).....

(Duration) yrs. mos. ds.

(Signed) *R. G. Nelson* M. D.*44* 19 *21* (Address) *Troy, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bullitt cemetery April 5 1922

20. UNDERTAKER

ADDRESS

John J. Pickard Troy Idaho

1. PLACE OF DEATH.

County of *Lincoln*
City of *Salmon*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Davis

RECEIVED CERTIFICATE OF DEATH

Registration District No. *41*Registration District No. *2116*

NOTARY

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *37708*

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH.

April 2
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....*None.*

9. BIRTHPLACE

(State or Country)

Idaho.

10. NAME OF FATHER

Robert Ray Davis

11. BIRTHPLACE OF FATHER

(State or Country)

Kansas

12. MAIDEN NAME OF MOTHER

Emma Parsons

13. BIRTHPLACE OF MOTHER

(State or Country)

Kansas.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

C. Stratton

(Address)

Salmon, Ida

15.

Filed *April 10* 19*22**Clio Bellamy*
Def. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 2
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *April 2* 19*22* to *April 2* 19*22*that I last saw him alive on *April 2* 19*22*

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Asphyxia pulchida

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

W. Stratton

M. D.

(Address)

Salmon, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death.....yrs.....mos.....days State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Salmon, Ida

DATE OF BURIAL

4/2 19*22*

20. UNDERTAKER

H. A. Davis

ADDRESS

Salmon, Ida

1. PLACE OF DEATH RECEIVED
 County of Lehigh APR 21 1922
 City of Salmon BUREAU OF VITAL STATISTICS
 Registration District No. 41
 Primary Registration District No. 2116
 (Note) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Sarah Maria Smith
 If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 37709

Registered No. _____

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED Married
 (Write the word.)

6. DATE OF BIRTH Not known
 (Month) (Day) (Year)

7. AGE 48
 Yrs. Mos. ds.
 IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
 (a) Trade, profession or particular kind of work...
 (b) General nature of industry, business, or establishment in which employed (or employer) Proprietress of Lodging house.

9. BIRTHPLACE Indiana
 (State or Country)

10. NAME OF FATHER Not known

11. BIRTHPLACE OF FATHER Not known
 (State or Country)

12. MAIDEN NAME OF MOTHER Not known

13. BIRTHPLACE OF MOTHER Not known
 (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W.C. Joebler
 (Address) Salmon, Ida.

15. Filed April - 10 - 1922 Chio Bellamy
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 20 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 6 1921 to March 20 1922
 that I last saw h. or alive on March 2 1922
 and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:
Cerebral thrombosis

(Duration) 5 mos. ds.

Contributory (Secondary) Infarction

(Duration) 5 mos. ds.

(Signed) W.C. Joebler M. D.
 (Address) Salmon, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death... yrs... mos... days In the State... yrs... mos... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Salmon Cemetery 3-21 1922

20. UNDERTAKER ADDRESS

W.C. Joebler Salmon, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 37710

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of *Leucine*City of *Salmon*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

BUREAU OF VITAL STATISTICS

John Taylor

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Sept. 21 1862
(Month) (Day) (Year)

7. AGE

59 Yrs. *5* Mos. *28* ds.IF LESS than 1 day
how many.....hrs. or
.....min.

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...*Miner*

9. BIRTHPLACE

(State or Country)

Illinois

10. NAME OF FATHER

Frank Taylor

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Leona M. Mowell
Salmon, Ida

(Address)

15.

Filed *April - 10 1922**Chas Bellom*
ab

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

3 - 20 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *July 14 1922* to *Mar. 20 1922*
that I last saw him alive on *Mar. 19 1922*
and that death occurred on the date stated above, at *490 A.M.*
The CAUSE OF DEATH* was as follows:*Pulmonary Tuberculosis*(Duration) *Several* yrs. mos. ds.

Contributory (Secondary)

Influenza(Duration) *6* yrs. mos. ds.

(Signed)

J. P. Stetson M. D.
Salmon, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Salmon Cemetery

DATE OF BURIAL

3-22 1922

20. UNDERTAKER

W C Joebler

ADDRESS

Salmon, Ida

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 37711Registered No. 13

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Lemhi
City of Leadore

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jerre H. Clayton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

divorced
(Write the word.)

6. DATE OF BIRTH.

February 7 1853
(Month) (Day) (Year)

7. AGE

69 Yrs. 1 Mos. 11 ds.IF LESS than 1 day
how many hrs. or
..... min. >]

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)Rancher farmer
Gallagher

9. BIRTHPLACE

(State or Country)

State of Illinois

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

Not known

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Albert Sleith Clayton
Leadore Idaho 8374

15.

Filed

April 10 - 1922Chas. Dillon
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 18 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to 191that I last saw h. alive on 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

severed jugular vein
suicidal
(I never knew deceased)

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Irvin B. Keller M. D.3/20/1922 (Address) Leadore Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Dillon Cemetery3-23-1922

20. UNDERTAKER

ADDRESS

Chas. C. JoeblerLeadore Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH

County of Lemhi
City of Salmon

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No. 41Primary Registration District No. 2116

(No. 1000)

St.)

Eliza Edgerton MatherState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 37712

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widowed

(Write the word.)

6. DATE OF BIRTH

January 10 1849
(Month) (Day) (Year)

7. AGE

74 Yrs. 2 Mos. 6 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

House wife

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Illinois

10. NAME OF FATHER

Josiah H. Edgerton

11. BIRTHPLACE OF FATHER

(State or Country)

Do not know

12. MAIDEN NAME OF MOTHER

Pamelia S. Benedict

13. BIRTHPLACE OF MOTHER

(State or Country)

Do not know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. H. M. Stadley

(Address)

Salmon, Idaho

15.

Filed

April 10 - 1922Chas Bellamy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 16 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 6th 1922 to March 15th 1922that I last saw him alive on March 15th 1922and that death occurred on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia(Duration) Yrs. _____ mos. 6 ds.Contributory
(Secondary)Influenza(Duration) yrs. _____ mos. 6 ds.

(Signed)

J. S. Wright

M. D.

4/4 1922

(Address)

Salmon

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Salmon Cemetery

DATE OF BURIAL

3-18-1922

20. UNDERTAKER

M. C. Doabler

ADDRESS

Salmon
Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED
APR 21 1922

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Sevier Registration District No. 41
City of Salmon Registration District No. 2116
State No. STAT. St.)

File No. 37713

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles Orla South

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH. Not known
(Month) (Day) (Year)

7. AGE 62 IF LESS than 1 day
Yrs. Mos. ds. how many hrs. or min.?

8. OCCUPATION Quartz mines
(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE Iowa
(State or Country)

10. NAME OF FATHER Not known

11. BIRTHPLACE OF FATHER Not known
(State or Country)

12. MAIDEN NAME OF MOTHER Not known

13. BIRTHPLACE OF MOTHER Not known
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W.C. Joebler
(Address) Salmon, Ida.

15. Filed April 10 1922 Chas. Bellamy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar. 12 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 22 1922 to Mar 12 1922, that I last saw him alive on Mar 12 1922 and that death occurred on the date stated above, at 10.00 A.M.

The CAUSE OF DEATH* was as follows:
Pulmonary tuberculosis
Complications of liver

(Duration) Small yrs. mos. ds.
Contributory (Secondary) Influenza
(Duration) Small yrs. mos. 3 ds.
(Signed) W.C. Joebler M. D.
1922 (Address) Salmon, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death... yrs. mos. days. In the State... yrs. mos. days.

Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Salmon Cemetery DATE OF BURIAL 3-14-1922

20. UNDERTAKER W.C. Joebler ADDRESS Salmon Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH.

County of *San Joaquin*
City of *Salmon*RECEIVED
APR 5 1922
BUREAU
STA

CERTIFICATE OF DEATH.

Registration District No. *41*Primary Registration District No. *2116*(No. *41*)

St.)

State of *Idaho*
BOARD OF
Bureau of Vital StatisticsFile No. *37714*Registered No. *37714*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John B. Martin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widowed

(Write the word.)

6. DATE OF BIRTH.

Nov-3d-

(Month)

1854

(Day)

1854

(Year)

7. AGE

68 Yrs. *4* Mos. *6* ds.IF LESS than 1 day
how many hrs. or
..... min. 2

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Pippin Mo -

10. NAME OF FATHER

Geo. H. Martin

11. BIRTHPLACE OF FATHER

(State or Country)

New York - N.Y.

12. MAIDEN NAME OF MOTHER

Cynthia Naomi Welch

13. BIRTHPLACE OF MOTHER

(State or Country)

New York - N.Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Geo. A. Martin

(Address)

Salmon Idaho

15.

Filed

*April 10 1922**Chas. Bellon*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 9th

(Month)

(Day)

1922
(Year)17. I HEREBY CERTIFY, That I attended deceased from *Dec 2nd* 191*21* to *March 9th* 192*2*that I last saw him alive on *March 9* 192*2*and that death occurred on the date stated above, at *8 P. M.*

The CAUSE OF DEATH* was as follows:

Primary Cancer Anterior
*2nd Implosion**cannot say*
(Duration) Yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *Geo. A. Kenney* M. D.19. (Address) *Salmon Idaho*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Salmon Cemetery

DATE OF BURIAL

3-13-1922

20. UNDERTAKER

W. C. Decker

ADDRESS

Salmon Idaho

1. PLACE OF DEATH

County of *Lemhi*
City of *Salmon*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

James Beattie

RECEIVED CERTIFICATE OF DEATH

Registration District No. *41*
Primary Registration District No. *2116*

BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *37715*

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widowed
(Write the word.)

6. DATE OF BIRTH

July 15 18*86*
(Month) (Day) (Year)

7. AGE

85 Yrs. *7* Mos. *22* ds.
IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

Farmer retired

9. BIRTHPLACE

(State or Country)

Scotland

10. NAME OF FATHER

James Beattie

11. BIRTHPLACE OF FATHER

(State or Country)

Scotland

12. MAIDEN NAME OF MOTHER

Not known

13. BIRTHPLACE OF MOTHER

(State or Country)

Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *W. L. Beattie*(Address) *Salmon*

15.

Filed *April 10* 19*22*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 9 19*22*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 19*22*, to *Jan* 19*22*
that I last saw him alive on *Jan* 20 19*22*
and that death occurred on the date stated above, at *8:45* M.

The CAUSE OF DEATH* was as follows:

Old Age

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed) *J. B. Wright* M. D.*44* 19*22* (Address) *Salmon Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Salmon Cemetery

DATE OF BURIAL

3-12 19*22*

20. UNDERTAKER

W. C. Dobbs

ADDRESS

*Salmon**Idaho*

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 37716

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

Registration District No. 41
County of Lemhi Primary Registration District No. 2116
City of Salmon BUREAU OF VITAL STATISTICS St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jakov Tomjonova

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single Married
(Write the word.)

6. DATE OF BIRTH.

July 11 1868
(Month) (Day) (Year)

7. AGE

54

Yrs. 1922 Mos. Mar 7/68

IF LESS than 1 day
how many... hrs. or min. 2

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...

Farmer

9. BIRTHPLACE

(State or Country)

Lunger

10. NAME OF FATHER

Mijo Tomjonova

11. BIRTHPLACE OF FATHER

(State or Country)

Lunger

12. MAIDEN NAME OF MOTHER

Marija Maron

13. BIRTHPLACE OF MOTHER

(State or Country)

Lunger

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Lunger M. Kropal

(Address)

Adetno Kroveski

15.

April 10 1922

Filed

Apr 10 1922

Chas Bellamy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 6 1922 to March 8 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 6 1922, to March 8 1922,

that I last saw him alive on March 8 1922,

and that death occurred on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:

Acute peritonitis
(accidental trauma)

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas F. Nunn M. D.

March 10 1922 (Address) Salmon

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death... yrs... mos... days. In the State... yrs... mos... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Salmon Cemetery

3-10 1922

20. UNDERTAKER

W. C. Doubler

ADDRESS

Salmon Idaho

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 37717

Registered No.

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

1. PLACE OF DEATH

County of Lemhi Registration District No. 41
City of Gibbonsville Primary Registration District No. 2116
St.)If death occurs away from
usual residence, give facts
called for under special
information.

2. FULL NAME

John H. Hennessey

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Male4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.White

(Write the word.)

6. DATE OF BIRTH.

July 1846

(Month)

(Day)

1

(Year)

7. AGE

70

Yrs.

Mos.

8 ds.IF LESS than 1 day
how many hrs. or
..... min.)

8. OCCUPATION

(a) Trade, profession or
particular kind of work...
(b) General nature of in-
dustry, business, or estab-
lishment in which employ-
ed (or employer).....Miner

9. BIRTHPLACE

(State or Country)

Germany10. NAME OF
FATHERnot known11. BIRTHPLACE
OF FATHER

(State or Country)

Germany12. MAIDEN NAME
OF MOTHERnot known13. BIRTHPLACE
OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

J. J. Bauer

(Address)

Gibbonsville, Idaho

15.

Filed

April 10 - 19221922Chapellamy

Local Registrar

16. DATE OF DEATH

7 March 1922

(Month)

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 10th 1912 to July 10th 1922that I last saw him alive on July 10th 1922

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)Syphilis (?)

(Duration)

Yrs.

mos.

ds.

(Signed)

J. J. Bauer

M. D.

4/4 1922 (Address) Gibbonsville*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place

of death.....

yrs.....

mos.....

days

In the

State.....

yrs.....

mos.....

days

Where was disease contracted
if not at place of death?.....Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Gibbonsville3-10 1922

20. UNDERTAKER

ADDRESS

J. J. BauerGibbonsville

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 37718

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
 County of Lemhi
 City of Leadore
 Registration District No. 2153
 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frederick W. Purcell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
 (Write the word.)

6. DATE OF BIRTH. April 10 1905
 (Month) (Day) (Year)

7. AGE 16 Yrs. 10 Mos. 18 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business, or establishment in which employed (or employer)

School boy

9. BIRTHPLACE

(State or Country)

Lemhi Co Ida

10. NAME OF FATHER

Mark R Purcell

11. BIRTHPLACE OF FATHER

(State or Country)

Lemhi Co Ida

12. MAIDEN NAME OF MOTHER

Lillie M. Ireland

13. BIRTHPLACE OF MOTHER

(State or Country)

Lemhi Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Pete Ireland
Leadore Idaho

15.

Filed April 18 1922

Chris Bellamy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 1st 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 15th 1922 to March 1st 1922, that I last saw him alive on March 1st 1922, and that death occurred on the date stated above, at 6:30 P.M.

The CAUSE OF DEATH was as follows:

Influenza

(Duration) Yrs. mos. 13 ds.

Contributory (Secondary)

none

(Duration) Yrs. mos. ds.

(Signed) Dr. B. Teller M. D.

3/3/1922 (Address) Leadore Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Junction Cemetery

3-3 1922

20. UNDERTAKER

ADDRESS

W.C. Teller

Sakun

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH		CERTIFICATE OF DEATH		State of Idaho BOARD OF HEALTH Bureau of Vital Statistics	
Registration District No. <u>41</u>		Registration District No. <u>2116</u>		File No. <u>37719</u>	
County of <u>Tenebi</u>		City of <u>Salmon</u>		Registered No. _____	
If death occurs away from usual residence, give facts called for under special information.		2. FULL NAME <u>Chas. Foa</u>		If death occurred in a hospital, institution or camp, give its NAME instead of street and number.	
PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH		
3. SEX <u>Male</u>	4. COLOR OR RACE <u>Yellow</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. <u>Single</u> (Write the word.)	16. DATE OF DEATH <u>Jan 14</u> (Month) (Day) (Year)		
6. DATE OF BIRTH <u>Not known</u> (Month) (Day) (Year)			17. I HEREBY CERTIFY, That I attended deceased from <u>Jan 1912</u> to <u>Jan 14 1912</u>		
7. AGE <u>101</u> Yrs. <u>9</u> Mos. <u>—</u> ds.			that I last saw him alive on <u>Jan 13 1912</u> and that death occurred on the date stated above, at <u>6 A</u> M.		
8. OCCUPATION (a) Trade, profession or particular kind of work... (b) General nature of industry, business, or establishment in which employed (or employer).....			The CAUSE OF DEATH* was as follows: <u>Perile debilit</u>		
9. BIRTHPLACE (State or Country) <u>Chinamen</u>			(Duration) _____ Yrs. _____ mos. _____ ds.		
10. NAME OF FATHER <u>not known</u>			Contributory (Secondary) _____		
11. BIRTHPLACE OF FATHER (State or Country) " "			(Duration) _____ yrs. _____ mos. _____ ds.		
12. MAIDEN NAME OF MOTHER " "			(Signed) <u>Chas F. Hammer</u> M. D.		
13. BIRTHPLACE OF MOTHER (State or Country) " "			19____ (Address) <u>Salmon</u>		
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) <u>W C Daehler</u> (Address) <u>Salmon Ida</u>			*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.		
15. <u>April 10</u> Filed <u>May 10</u> 19 <u>12</u>			18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days Where was disease contracted if not at place of death?..... Former or usual residence		
19. PLACE OF BURIAL OR REMOVAL <u>Salmon Cemetery</u>			DATE OF BURIAL <u>1-16</u> 19 <u>12</u>		
20. UNDERTAKER <u>W C Daehler</u> Local Registrar			ADDRESS <u>Salmon Ida</u>		

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Lemhi Registration District No. 42
City of Leadore Primary Registration District No. 2153
St. Idaho

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

James Alvin SteeleFile No. 37720Registered No. 14

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

single

(Write the word.)

6. DATE OF BIRTH

Sept. 97 1922
(Month) (Day) (Year)

7. AGE

5 Yrs. 95 Mos. 5 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Joseph Steele

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Virvan Maude Peterson

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Joseph Steele

(Address)

Leadore - Ida

15.

Filed

4/10/1922Geo C. Bellamy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 22nd 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 21st 1922, to March 22nd 1922that I last saw him alive on March 22nd 1922and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. B. Keller M. D.4/6 1922 (Address) Leadore, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Leadore Ida

DATE OF BURIAL

Mar 24 1922

20. UNDERTAKER

John Cemetery

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH
County of Lehigh
City of Salmon

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Albert Russel Taylor

RECEIVED
APR 21 1922
BUREAU OF VITAL STATISTICS
Registration District No. 41
Registration District No. 2116
St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37721
Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE American 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. _____
(Write the word.)

6. DATE OF BIRTH. March 22 1857
(Month) (Day) (Year)

7. AGE 65 Yrs. 11 Mos. 7 ds.
IF LESS than 1 day how many hrs. or min. _____

8. OCCUPATION Laborer
(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE California
(State or Country)

10. NAME OF FATHER Jim Taylor

11. BIRTHPLACE OF FATHER Missouri
(State or Country)

12. MAIDEN NAME OF MOTHER Jane A. Hunter

13. BIRTHPLACE OF MOTHER Missouri
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Cliff Taylor
(Address) Salmon, Idaho

15. Filed April 17 1922
Cliff C. Bellan
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
(Month) (Day) (Year) Sept 1919

17. I HEREBY CERTIFY, That I attended deceased from Sept 1919 to Feb 21 1922
that I last saw him alive on Feb 21 1922
and that death occurred on the date stated above, at 7 A. M.
The CAUSE OF DEATH* was as follows:
Apoplexy

(Duration) 3 Yrs. _____ mos. _____ ds.
Contributory (Secondary) _____
(Signed) Chas. F. Hume M. D.
Address Salmon

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Salmon Cemetery DATE OF BURIAL Feb 23 1922
UNDERTAKER H. C. Woobler ADDRESS Salmon, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH *Levi* Registration District No. *47*
County of *Levi* Primary Registration District No. _____
City of *Russell* (No. _____ St.)

File No. *37722*
Registered No. *78*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Edith M. Schlad*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. *Single*
(Write the word.)

6. DATE OF BIRTH *Feb 23 1920*
(Month) (Day) (Year)

7. AGE *7* yrs. *8* mos. *8* ds. IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work *nurse*
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) *Idaho*

10. NAME OF FATHER

George Schlad

11. BIRTHPLACE OF FATHER

(State or Country) *Iowa*

12. MAIDEN NAME OF MOTHER

Katherine Kachekman

13. BIRTHPLACE OF MOTHER

(State or Country) *Idaho*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *George Schlad*

(Address) *My Place Ida*

15.

Filed *4-6* 19*22* *Albert Huff*
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

April 1 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *March 31 1922* to *March 31 1922*

that I last saw her alive on *March 31 1922*

and that death occurred on the date stated above, at *4 P.M.*

The CAUSE OF DEATH* was as follows:

Acute Indigestion

(Duration) yrs. mos. *one* ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) *J. M. D.*

(Address) *Prof. Ind. Ida*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Catholic Cem. Napa *4-3-1922*

20. UNDERTAKER

ADDRESS

Albert Huff *Napa, Idaho*

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

1. PLACE OF DEATH RECEIVED
 County of Lewis MAY 4 1922
 City of Craigmont BUREAU OF VITAL STATISTICS Registration District No. 50
 Primary Registration District No. 3129 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Chester Earl Pearsall.

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 37724
 Registered No. 4

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

male white Single
 (Write the word.)

6. DATE OF BIRTH.

Oct. 22 1905
 (Month) (Day) (Year)

7. AGE

16 Yrs. 5 Mos. 14 ds.

IF LESS than 1 day
 how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
 (b) General nature of industry, business, or establishment in which employed (or employer)...

School boy

9. BIRTHPLACE

(State or Country) Idaho.

10. NAME OF FATHER

Henry Jeremiah Pearsall

11. BIRTHPLACE OF FATHER

(State or Country) No.

12. MAIDEN NAME OF MOTHER

Sarah Nevil

13. BIRTHPLACE OF MOTHER

(State or Country) Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs James McLean
 (Address) Craigmont, Idaho.

15.

Filed 4/5 1922. P. E. Glovis
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 4 1922.
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 2 1922 to April 4 1922, that I last saw him alive on April 4 1922, and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

pleuro-pneumonia
(Influenza type)

(Duration) Yrs. 5 mos. ds.

Contributory pyelitis
 (Secondary)

(Duration) 3 yrs. mos. ds.

(Signed) P. E. Glovis M. D.

4/5 1922 (Address) Craigmont, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

O. O. F. Cemetery 4/5 1922.

20. UNDERTAKER ADDRESS

E. E. Glovis

Craigmont

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Lewis*City of *Winchester*Registration District No. *30*Primary Registration District No. *2429*(No. *70*)

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Ada B Keelf*State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *37725*Registered No. *5*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Divorced
(Write the word)

6. DATE OF BIRTH

June 18 1869
(Month) (Day) (Year)

7. AGE

*52 Yrs. 9 Mos. 23 ds.*IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Illinois

10. NAME OF FATHER

Erastus Colson

11. BIRTHPLACE OF FATHER

(State or Country)

Illinois

12. MAIDEN NAME OF MOTHER

Ellen A. Sholes

13. BIRTHPLACE OF MOTHER

(State or Country)

Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Ellen A. Fox
Winchester Ida

(Address)

15.

Filed

4/12 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 11 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Apr 11th 1922 to Apr 11 1922
that I last saw him alive on *April 11 1922*
and that death occurred on the date stated above, at *9 P.M.*

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Death in 5 hours

(Duration) . Yrs. mos. ds.

Contributory
(Secondary)*Highblood Pressure*

(Duration) 3 Yrs. mos. ds.

(Signed)

*John Laughtlin M. D.**Apr 11 1922* (Address) *Winchester*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death... yrs... mos... days. In the State... yrs... mos... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

O.O. Cemetery, Craigmont 4/16 1922

20. UNDERTAKER

ADDRESS

C.E. Clorick Craigmont

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **37726**
Registered No. **EX 6**

1. PLACE OF DEATH.

County of **Lewis** Registration District No. **50**
City of **Prigmont** Primary Registration District No. **2129**
City of **Prigmont** (No. of St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Virinda Tout Buttrey**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX **female** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **widowed**
(Write the word.)

16. DATE OF DEATH

April 15 19**22**.
(Month) (Day) (Year)

6. DATE OF BIRTH.

1921 **15** **1921**
1921 **15** **1921**
1921 **15** **1921**
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day
how many hrs. or
..... min. 2)

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....
Housekeeper

9. BIRTHPLACE

(State or Country) **Indiana**

10. NAME OF FATHER

William Tout

11. BIRTHPLACE OF FATHER

(State or Country) **Unknown**

12. MAIDEN NAME OF MOTHER

Carr

13. BIRTHPLACE OF MOTHER

(State or Country) **Unknown.**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) **James Buttrey**
(Address)

15.

Filed **4/17** 19**22**. **R. E. Dwyer**
Local Registrar

17. I HEREBY CERTIFY, That I attended deceased from **April 11** 19**22** to **April 15** 19**22**, that I last saw her alive on **April 15** 19**22**, and that death occurred on the date stated above, at **5** P. M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) Yrs. mos. **8** ds.

Contributory Arteriosclerosis
(Secondary)

(Duration) **Some** yrs. mos. ds.

(Signed) **R. E. Dwyer** M. D.

4/16 19**22** (Address) **Prigmont, Idaho.**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

I. O. F. Cemetery

4/17 19**22**.

20. UNDERTAKER

ADDRESS

C. E. Clovis

Prigmont, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 47

County of Lewis

Preceding Registration District No.

File No. 37727

City of Nezperce, Idaho (No. 2)

St.

Registered No. 79

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Isadora Mary Cecelia Kachelmeier
If death occurred in a hospital, institution or camp, give its NAME, street and number. nm.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

female

white

single (Write the word.)

6. DATE OF BIRTH

Feb 10 1922
(Month) (Day) (Year)

7. AGE

34 yrs. mos. ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Nezperce Route 2

10. NAME OF FATHER

Alois John Kachelmeier

11. BIRTHPLACE OF FATHER

(State or Country)

Fairfax Minor

12. MAIDEN NAME OF MOTHER

Cecilia Ahlers

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Alois John Kachelmeier

(Address)

Nezperce, Idaho

15.

Filed

April 16 1922

Albert Hoff

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 16 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191... to 191...

that I last saw him alive on 191...

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Fractured ribbed in swimming
had the flu.
acute Myocarditis

(Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

E. W. Anderson M. D.

4/9 1922 (Address) Nezperce, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death... yrs... mos... days. In the State... yrs... mos... days.

Where was disease contracted if not at place of death?

Former or usual residence...

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Nezperce Catholic Cemetery

Mar 17 1922

20. UNDERTAKER

ADDRESS

Albert Hoff

Nezperce, Idaho

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37729
Registered No. 6

1. PLACE OF DEATH

County of Lincoln
City of Shoshone

Registration District No. 16

Primary Registration District No. 1016

(No.)

(St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

George Stewart Lane

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Divorced

6. DATE OF BIRTH

Nov 2nd 1891
(Month) (Day) (Year)

7. AGE

30 Yrs. 4 Mos. 29 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Hdw Merchant

(b) General nature of industry, business or establishment in which employed (or employer)

Hardware Ranch

9. BIRTHPLACE

(State or Country)

Frontier Co Nebr

10. NAME OF FATHER

B. G. Lane

11. BIRTHPLACE OF FATHER

(State or Country)

Iowa

12. MAIDEN NAME OF MOTHER

Annie S. Pusey

13. BIRTHPLACE OF MOTHER

(State or Country)

Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

B. G. Lane

(Address)

Shoshone Idaho

15.

Filed 4-4

1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 1st 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 1st 1922, to April 1st 1922
that I last saw him alive on April 1st 1922
and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Recent wound through head.

Duration Yrs. mos. ds.

Contributory (Secondary)

720

Duration Yrs. mos. ds.

(Signed)

April 4, 1922

(Address)

Shoshone Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Shoshone

DATE OF BURIAL

4-5 1922

20. UNDERTAKER

O. J. Munson

ADDRESS

Shoshone

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Shoshone*
City of *Shoshone*

Registration District No.

Primary Registration District No.

(No. St.)

File No. *37730*Registered No. *4*

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Melville W. Harler

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single (Write the word.)

6. DATE OF BIRTH

November 15th 1904
(Month) (Day) (Year)

7. AGE

17 Yrs. *4* Mos. *28* ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

Schoolboy

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

J W Wheeler

11. BIRTHPLACE OF FATHER

(State or Country)

Iowa

12. MAIDEN NAME OF MOTHER

Lena M Harris

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J W Wheeler

(Address)

Shoshone Idaho

15. FILED

March 13 1922 J. L. Fuller

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 11 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *March 5 1922* to *March 11 1922*that I last saw him alive on *March 11 1922*and that death occurred on the date stated above, at *5:30 P.M.*

The CAUSE OF DEATH* was as follows:

Spasmodic Convulsions(Duration) Yrs. mos. ds. *3 hrs*
Contributory (Secondary) *Chronic Interstitial Nephritis*(Duration) Yrs. mos. ds. *3 hrs*(Signed) *J. L. Fuller* M. D.*3/12 1922* (Address) *Shoshone Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Shoshone

DATE OF BURIAL

3/13 1922

20. UNDERTAKER

O. J. Munnaw Shoshone

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

RECEIVED

APR 21 1922

BUREAU OF VITAL STATISTICS

2. FULL NAME

Conrad David Anders

Registration District No.

Registration District No.

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37731
Registered No. 16

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED
married
(Write the word.)

6. DATE OF BIRTH

Oct-15-1883

(Month)

(Day)

(Year)

7. AGE

39 Yrs. 4 Mos. 24 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Housewife

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Erastus P. Lee

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Emmie E. Island

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. P. Lee

(Address)

Creston, Idaho

15.

Filed

3/10/22

19

G. W. Wolfe

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 9 1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 30 1922 to March 9 1922

that I last saw her alive on March 9 1922

and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Acute Granular Nephritis

(Duration)

Yrs. 1 mos. 9 ds.

Contributory
(Secondary)

Pregnancy

(Duration)

Yrs. 7 mos. ds.

(Signed)

A. O. Martin M. D.

Mar 11 1922 (Address) Creston, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Creston

DATE OF BURIAL

3/11/22

20. UNDERTAKER

John Phillips

ADDRESS

Creston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD.
N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH.

County of *Madison*
City of *Reley*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED

Registration District No.

Primary Registration District No.

BUREAU OF VITAL STATISTICS

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. *37732*

Registered No. *23*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-OWED OR DIVORCED.

6. DATE OF BIRTH.

7. AGE

IF LESS than 1 day how many.....hrs. or.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15.

Filed

Local Registrar

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

(Duration)

Yrs. mos. ds.

Contributory (Secondary)

(Duration)

Yrs. mos. ds.

(Signed)

(Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

✓
CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Madison
City of Rexburg

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100Primary Registration District No. 2178RECEIVED
APR 21 1922BUREAU OF VITAL
STATISTICSState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 37733Registered No. 22

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ethel Mc Bride Alvois

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married

(Write the word.)

6. DATE OF BIRTH

April 16 1895
(Month) (Day) (Year)

7. AGE

26 yrs. 11 mos. 14 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Housewife

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Wyoming

10. NAME OF FATHER

Peter C Paul

11. BIRTHPLACE OF FATHER

(State or Country)

Denmark

12. MAIDEN NAME OF MOTHER

Lilly Nichols

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Patrick Alvois(Address) Rexburg Idaho.

15.

Filed 4/1 22

19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 31 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 30 1922, to March 30 1922that I last saw her alive on March 30 1922and that death occurred on the date stated above, 2-20 A. M.

The CAUSE OF DEATH was as follows:

Peritonitis(Duration) Yrs. 4 mos. 4 ds.Contributory
(Secondary)(Duration) Yrs. 5 mos. 5 ds.

(Signed)

5/1 1922 (Address) Rexburg Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Park City Utah

DATE OF BURIAL

19

20. UNDERTAKER

J. R. Young

ADDRESS

Rexburg

1. PLACE OF DEATH

County of MadisonCity of Sugar

If death occurs away from usual residence, give facts called for under special information.

CERTIFICATE OF DEATH

RECEIVED

Registration District No.

Primary Registration District No.

BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 37734Registered No. 37

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Gordon J. Holman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male WhiteSingle
(Write the word.)

6. DATE OF BIRTH

March 28th 1922
(Month) (Day) (Year)

7. AGE

2 Yrs. 2 Mos. 2 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Ezekial L. Holman

11. BIRTHPLACE OF FATHER

(State or Country) Idaho

12. MAIDEN NAME OF MOTHER

Stella Jacobs

13. BIRTHPLACE OF MOTHER

(State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(Address) _____

15. 3/30 1922
Filed _____

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

3 - 30 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

3 - 28 - 1922 to 3 - 30 - 1922that I last saw him alive on 3 - 30 - 1922and that death occurred on the date stated above, at P. M.

The CAUSE OF DEATH* was as follows:

Cyanosis(Duration) Yrs. 3 mos. 3 ds.Contributory
(Secondary)(Duration) Yrs. 1 mos. 1 ds.(Signed) Louise L. Rich M. D.3/31 1922 (Address) Rexburg Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Rexburg

DATE OF BURIAL

3/31 1922

20. UNDERTAKER

David R. Young

ADDRESS

Rexburg

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of MadisonCity of Sugar

If death occurs away from usual residence, give facts called for under special information.

APR 21 1922

Registration District No.

Primary Registration District No.

(No.)

St.)

2. FULL NAME

Etta Palmer BeanState of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

37735

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDMarried

(Write the word.)

6. DATE OF BIRTH

January

(Month)

10th

(Day)

1890

(Year)

7. AGE

322

Mos.

12

ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

House Wife

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Luther C. Palmer

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Agnes Jack

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Leffel G. Bean

(Address)

Sugar City, Ida.

15.

3/23

19

22Local Registrar

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 22

(Month)

(Day)

1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 22

19

22

to

March 22

19

22

that I last saw h.e. alive on March 22

19

22

and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Edema of Lungs

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

Louis F. Nichols
Reeburg Idaho3/25

19

22

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

yrs.

mos.

days.

In the

State

yrs.

mos.

days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Sugar City

DATE OF BURIAL

3/27

19

22

20. UNDERTAKER

ADDRESS

David P. Young
Reeburg Idaho

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Madison Registration District No. 100
 City of Sugar Primary Registration District No. 2178 St.)
 BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Haruko Adachi

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female Japanese Single
 (Write the word.)

6. DATE OF BIRTH

March 19 1922
 (Month) (Day) (Year)

7. AGE

— Yrs. — Mos. 3 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

None

9. BIRTHPLACE

(State or Country) Sugar City, Ida.

10. NAME OF FATHER

Tom Suichi Adachi

11. BIRTHPLACE OF FATHER

(State or Country) Japan

12. MAIDEN NAME OF MOTHER

Kii Sako

13. BIRTHPLACE OF MOTHER

(State or Country) Japan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Haruko Adachi

(Address) Sugar City, Ida.

15. 3/22 1922
 Filed 3/22 1922 G. E. Waspe
 Local Registrar

RECEIVED

APR 21 1922

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 37736
 Registered No. 19

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 21 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

..... 19....., to 19.....

that I last saw h..... alive on..... 19.....

and that death occurred on the date stated above, at 3 A.M.

The CAUSE OF DEATH* was as follows:

No doctor in attendance
but from history and autopsied pneumonia
 (Duration) Yrs. mos. ds.

Contributory
 (Secondary)

(Duration) Yrs. mos. ds.

(Signed) G. E. Waspe M. D.

..... 19..... (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Sugar City 3/22 1922

20. UNDERTAKER

David P. Young Reburg, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25-M. 1-16-13

CERTIFICATE OF DEATH.

1. PLACE OF DEATH **RECEIVED**
Registration District No. 100
County of APR 24 1922 Primary Registration District No. 2178
City of BUREAU (No. 100) St. STATISTICAL
If death occurs away from usual residence, give facts called for under special information.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37737
Registered No. 188

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ivy Mona Keeker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH. June 7 1919
(Month) (Day) (Year)7. AGE 2 Yrs. 9 Mos. 16 ds.
IF LESS than 1 day how many hrs. or min.?8. OCCUPATION Child

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE Idaho
(State or Country)10. NAME OF FATHER Cyril Keeker11. BIRTHPLACE OF FATHER Idaho
(State or Country)12. MAIDEN NAME OF MOTHER Ivy Allen13. BIRTHPLACE OF MOTHER Idaho
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Laura Keeker
(Address) Sunnyside, Idaho

15. Filed 3/23 1922 G. G. Hope
Local Registrar

MEDICAL, CERTIFICATE OF DEATH

16. DATE OF DEATH 3 12 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3/14 1922, to 3/22 1922,
that I last saw her alive on 3/15 1922,
and that death occurred on the date stated above, at 8 P M.
The CAUSE OF DEATH* was as follows:

gastro-enteritis

(Duration) Yrs. mos. ds.
Contributory (Secondary) broncho-pneumonia
(Duration) Yrs. mos. ds.
(Signed) G. G. Hope M. D.
19..... (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Anchor IdaDATE OF BURIAL 3/24 192220. UNDERTAKER None

ADDRESS

RECEIVED

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Greenmont
City of MercedaleDistrict No. 100
Primary Registration District No. 2178
BUREAU OF VITAL STATISTICS St.)File No. 37728
Registered No. 1

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

May Edward Rush

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.Male White

(Write the word.)

6. DATE OF BIRTH.

April 22 1921
(Month) (Day) (Year)

7. AGE

9 Yrs. 29 Mos. 29 ds.IF LESS than 1 day
how many hrs. or
..... min.

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Edward Rush

11. BIRTHPLACE OF FATHER

(State or Country)

Wayne Co., Indiana

12. MAIDEN NAME OF MOTHER

Effie May Johnson

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15.

2/22 1912

Filed

1912G. H. Hesse

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

February 21 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from 2-14- 1912 to 2-20- 1922,
that I last saw him alive on 2-20- 1922,
and that death occurred on the date stated above, at 7:30 A.M.

The CAUSE OF DEATH was as follows:

Broncho Pneumonia

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. B. Evans M. D.19. (Address) Sugar City, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Sugar City

DATE OF BURIAL

2-23, 1922

20. UNDERTAKER

W. M. Hansen

ADDRESS

St. Anthony

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of MadisonCity of Rexburg

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eliza Andrews Beesley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

November 26th 1852
(Month) (Day) (Year)

7. AGE

69 Yrs. 5 Mos. 1 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Housewife

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

John Andrews

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Elizabeth Wise

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed 4/29 1922

Local Registrar

RECEIVED ✓ CERTIFICATE OF DEATH

MAY 3 1922

BUREAU OF STATISTICS

Registration District No. 100Registration District No. 2178

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 37739Registered No. 31

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Apr. 27 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Apr. 22 1922 to Apr. 27 1922
that I last saw her alive on Apr. 27 1922and that death occurred on the date stated above, at 5:45 A.M.

The CAUSE OF DEATH* was as follows:

Uraemia(Duration) Yrs. mos. 7 ds.Contributory few
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Parley Nelson M. D.4-29 1922 (Address) Rexburg, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Provo, Utah.

DATE OF BURIAL

May 1, 1922

20. UNDERTAKER

DAVID R. YOUNG

ADDRESS

REXBURG, IDA.

1. PLACE OF DEATH

County of Madison
 City of Plano

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

James William Rawson

RECEIVED CERTIFICATE OF DEATH

Registration District No. 100

Primary Registration District No. 3178

BUREAU OF VITAL STATISTICS

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 37740

Registered No. 30

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

infant
 (Write the word.)

6. DATE OF BIRTH

May 8th 1921
 (Month) (Day) (Year)

7. AGE

8 Yrs. 11 Mos. 17 ds.

IF LESS than 1 day
 how many _____ hrs.
 or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

Infant

9. BIRTHPLACE

(State or Country)

Linn County

10. NAME OF FATHER

Harry Rawson

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Elizabeth Boyd

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harry Rawson
 (Address) _____

15.

Filed 4/26 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

4 25 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

4-24 1922 to 4-25 1922

that I last saw him alive on 4-24 1922

and that death occurred on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia (Broncho)

(Duration) _____ Yrs. 1 mos. 7 ds.

Contributory (Secondary) _____

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) G. T. Harrison, M.D.

19 _____ (Address) Rephung, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Idaho

DATE OF BURIAL

4/26 1922

20. UNDERTAKER

ADDRESS

Rephung, Ida.

FORM No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 37741

Registered No. 29

1. PLACE OF DEATH
County of Madison Registration District No. 100
City of Independence Registration District No. 2178 St.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Merinda Larsen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Single
(Write the word.)6. DATE OF BIRTH
April 9th 1898
(Month) (Day) (Year)7. AGE 24 Yrs. 0 Mos. 8 ds. IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work None
(b) General nature of industry, business or establishment in which employed (or employer)9. BIRTHPLACE
(State or Country) Utah10. NAME OF FATHER
Louis Larsen11. BIRTHPLACE OF FATHER
(State or Country) Denmark12. MAIDEN NAME OF MOTHER
Maria Petersen13. BIRTHPLACE OF MOTHER
(State or Country) Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Louis Larsen
(Address) Rexburg, R.F.D. #115. Filed 4/11 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Apr. 17 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
Apr. 13 1922 to Apr. 17 1922
that I last saw her alive on Apr. 16 19
and that death occurred on the date stated above, at 7:15 M.

The CAUSE OF DEATH* was as follows:

uraemia
(Duration) Yrs. mos. ds.
Contributory (Secondary) Chronic nephritis
(Duration) Yrs. mos. ds.
(Signed) Parley Nelson M. D.
4-18 1922 (Address) Rexburg Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Burton, Ida. DATE OF BURIAL 4/20 192220. UNDERTAKER David R. Young ADDRESS Rexburg, Ida.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

100 miles
State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37742
Registered No. 28

1. PLACE OF DEATH.

County of Madison
City of Edgar

Registration District No. 100
Primary Registration District No. 2178
(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Rev. H. Winmill

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH.

Aug 7 - 1921
(Month) (Day) (Year)

7. AGE

8 Yrs. 4 Mos. 4 ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

Preaching

9. BIRTHPLACE

(State or Country)

Sugar Idaho

10. NAME OF FATHER

R. W. Winmill

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Lucy L. Gardner

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

R. W. Winmill

(Address)

Sugar

15.

Filed

4/12 19122

Local Registrar

16. DATE OF DEATH

April 11 19122
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 8 19122, to Apr. 11 19122, that I last saw him alive on Apr. 10 19122, and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

General Septicemia

(Duration) Yrs. _____ mos. 5 ds.

Contributory (Secondary)

Stomach

(Duration) yrs. _____ mos. 3 weeks

(Signed)

Carley Nelson M. D.

4-10-1922 (Address) Pyburn Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sugar

4/13 19122

20. UNDERTAKER

ADDRESS

Pyburn

Pyburn

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICAL condition should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAY 3 1922 BUREAU OF VITAL STATISTICS		MEDICAL CERTIFICATE OF DEATH	
City of <u>Reiley</u> (No. _____) (St.) _____		Registered No. <u>318</u>	
If death occurs away from usual residence, give facts called for under special information.		If death occurred in a hospital, institution or camp, give its NAME instead of street and number.	
2. FULL NAME <u>Clara Willmore</u>			
PERSONAL AND STATISTICAL PARTICULARS		MEDICAL CERTIFICATE OF DEATH	
3. SEX <u>F-</u>	4. COLOR OR RACE <u>W</u>	16. DATE OF DEATH <u>4</u> (Month) <u>13</u> (Day) <u>1922</u> (Year)	
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. <u>Bale</u> (Write the word.)		17. I HEREBY CERTIFY, That I attended deceased from <u>3-24-1912</u> to <u>4-13-1912</u> , that I last saw her alive on <u>4-11-1912</u> and that death occurred on the date stated above, at _____ M.	
6. DATE OF BIRTH <u>March 26 1922</u> (Month) (Day) (Year)		The CAUSE OF DEATH* was as follows: <u>Mal Nutrition</u>	
7. AGE <u>19</u> Yrs. <u>19</u> Mos. <u>19</u> ds. IF LESS than 1 day how many _____ hrs. or _____ min.)		(Duration) _____ Yrs. _____ mos. <u>19</u> ds.	
8. OCCUPATION (a) Trade, profession or particular kind of work... <u>Bale</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____		Contributory (Secondary) _____	
9. BIRTHPLACE (State or Country) <u>Reiley Idaho</u>		(Signed) <u>W. H. Harkness</u> 19 (Address) <u>Reiley Idaho</u>	
10. NAME OF FATHER <u>Herbert J. Willmore</u>		*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.	
11. BIRTHPLACE OF FATHER <u>Utah</u>		18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) At place of death... yrs. _____ mos. _____ days In the State... yrs. _____ mos. _____ days Where was disease contracted if not at place of death? _____ Former or usual residence _____	
12. MAIDEN NAME OF MOTHER <u>Brucilla Parker</u>		19. PLACE OF BURIAL OR REMOVAL <u>Reiley</u>	
13. BIRTHPLACE OF MOTHER <u>Reiley Idaho</u> (State or Country)		DATE OF BURIAL <u>4-14 1922</u>	
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) <u>Herbert J. Willmore</u> (Address) <u>Reiley</u>		20. UNDERTAKER <u>Wright</u>	
15. Filed <u>4-15-</u> 1922 Local Registrar <u>W. H. Harkness</u>		ADDRESS <u>Reiley</u>	

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 37744
Registered No. 37744

1. PLACE OF DEATH

Registration District No. 100County of MadisonPrimary Registration District No. 2178City of Sugar

(St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Amy E. Ricks Jacques

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH

December 11 1858
(Month) (Day) (Year)

7. AGE

63 Yrs. 13 Mos. 29 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Housewife

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Thomas E. Ricks

11. BIRTHPLACE OF FATHER

(State or Country)

Kentucky

12. MAIDEN NAME OF MOTHER

Tamer Loader

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. L. Jacques(Address) Sugar City, Ida.

15.

Filed 4/11 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 10th 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from March 23 1922, to March 23 1922that I last saw her alive on March 23 1922, and that death occurred on the date stated above, at 10:20 M.

The CAUSE OF DEATH* was as follows:

Pericious anemia(Duration) 2 Yrs. mos. ds.Contributory
(Secondary)(Duration) 10 yrs. mos. ds.(Signed) Larim L. Rich M. D.4/12 1922(Address) Rexburg Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Sugar City, Ida.

DATE OF BURIAL

4-12 1922

20. UNDERTAKER

David R. Young.

ADDRESS

Rexburg, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 100

County of Madison
City of Sugar

Primary Registration District No. 2178
(No. St.)

File No. 4-366
Registered No. 26

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Amy R. Jaques

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

16. DATE OF DEATH

6. DATE OF BIRTH.

April 10 1912
(Month) (Day) (Year)

December 11 1858
(Month) (Day) (Year)

7. AGE

63 Yrs. 3 Mos. 29 ds.

IF LESS than 1 day
how many hrs. or
min. 2

17. I HEREBY CERTIFY, That I attended deceased from 3/3/22 22 191 to 3/3/22 22 191, that I last saw h. ~~ET~~ alive on 3/3/22 191 and that death occurred on the date stated above, at 10-20M.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

8. OCCUPATION

(a) Trade, profession or particular kind of work... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE

(State or Country) Utah

10. NAME OF FATHER

Thomas E Ricks

11. BIRTHPLACE OF FATHER

Kentucky

(State or Country)

12. MAIDEN NAME OF MOTHER

Tamer Loader

13. BIRTHPLACE OF MOTHER

England

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A.L. Jaques

(Address) Sugar City. Idaho.

15.

Filed 5/6/1922 191

G.G. Espe

Local Registrar

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Sugar City Idaho

DATE OF BURIAL

4/12/22 191

20. UNDERTAKER

David R Young

ADDRESS

Rexburg

Form V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Apr. 8 1922 to Apr. 10 1922

that I last saw him alive on Apr. 9 1922

and that death occurred on the date stated above, at 12:30 AM.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

M. D.

4-10 1922 (Address) Refburg Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED

MAY 3 1922

CERTIFICATE OF DEATH

Rich

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37746
Registered No. 24
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Madison Registration District No. 100
City of Sugar City (No. 2178) St.
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Squires

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED infant
(Write the word.)
6. DATE OF BIRTH April 12 1922
(Month) (Day) (Year)
7. AGE X Yrs. X Mos. X ds. IF LESS than 1 day how many X hrs. or 30 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Infant.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Sugar City, Idaho.

10. NAME OF FATHER Whitney N. Squires

11. BIRTHPLACE OF FATHER
(State or Country) Idaho.

12. MAIDEN NAME OF MOTHER Harriet Henderson

13. BIRTHPLACE OF MOTHER
(State or Country) Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Whitney N. Squires
(Address) Sugar City, Idaho.

15. Filed 4/13 1922
Local Registrar G. W. Herk

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
4 - 12 - 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-12-1922 to 4-12-1922
that I last saw him alive on 4-12-1922
and that death occurred on the date stated above, at 12-M.

The CAUSE OF DEATH* was as follows:
Patulous foramen ovale

(Duration) Yrs. mos. ds.
Contributory (Secondary) Premature birth
(Duration) yrs. mos. ds.
(Signed) Lois F. Rich M. D.
(Address) Rexburg Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Sugar DATE OF BURIAL 4-13-1922
20. UNDERTAKER W. J. Young ADDRESS

1. PLACE OF DEATH

County of *Minidoka*City of *Rupert*

If death occurs away from usual residence, give facts called for under special information.

RECEIVED

APR 21 1922

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. *19*Registration District No. *2013*

St.)

2. FULL NAME

*Edward S Ames*State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

37348

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Nov.
(Month)*15*
(Day)*1921*
(Year)

7. AGE

2 Yrs. *9* Mos. *9* ds.IF LESS than 1 day
how many.....hrs.
or.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Minidoka Idaho

10. NAME OF FATHER

C E Ames

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Sophrona Simons

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

C E Ames

(Address)

Rupert

15.

Filed *4-10* *1922**E. E. E. E. E.*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 10 *1922* to *Jan 24* *1922*that I last saw him alive on *Jan 24* *1922*and that death occurred on the date stated above, at *2 P.M.*

The CAUSE OF DEATH* was as follows:

Respiratory Failure

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) mos. ds.

(Signed)

4-1-1922 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Rupert Cemetery**Jan 17* *1922*

20. UNDERTAKER

ADDRESS

*Alvin (Name)**Rupert*

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Minadoka Registration District No. 19
 City of Keyburn Primary Registration District No. 2013
 (No. 2013 St.)

If death occurs away from usual residence, give facts called for under special information.

BUREAU OF VITAL STATISTICS

2. FULL NAME

Miles Warner

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 37749
 Registered No. 3

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED Single
 (Write the word.)

6. DATE OF BIRTH February 16 1922
 (Month) (Day) (Year)

7. AGE 1 Yrs. 1 Mos. 1 ds. IF LESS than 1 day
 how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

None

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Wallace Delos Warner

11. BIRTHPLACE OF FATHER

(State or Country) Coyote Utah

12. MAIDEN NAME OF MOTHER

Olive Victoria Christensen

13. BIRTHPLACE OF MOTHER

(State or Country) St. David Arizona

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. A. Rich M.D.
 (Address) Burley Idaho

15. Filed 4-10 1922 E. E. E. Moore
 Local Registrar

16. DATE OF DEATH February 17 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 16, 1922, to Feb. 17, 1922,
 that I last saw him alive on Feb. 17, 1922,
 and that death occurred on the date stated above, at 4:00 P.M.

The CAUSE OF DEATH* was as follows:

Congenital Malformation of the heart. (Patent foramen ovale)

(Duration) Yrs. 1 ds.
 Contributory (Secondary) Circulatory failure

(Duration) yrs. 1 ds.

(Signed) C. A. Rich M. D.

Feb. 18, 1922 (Address) Burley Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Keyburn Idaho Feb. 18, 1922

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Copied
State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Minidoka District No. 19
City of Hayden Registration District No. 2015 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Francis Fiala

File No. 37750
Registered No. 7

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

F

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married (word.)

6. DATE OF BIRTH.

Dec 13 1863
(Month) (Day) (Year)

7. AGE

58 Yrs. 2 Mos. 14 ds.
IF LESS than 1 day how many hrs. or min. 2)

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

Housewife

9. BIRTHPLACE

(State or Country)

Bohemia

10. NAME OF FATHER

Jacob Houska

11. BIRTHPLACE OF FATHER

(State or Country)

Bohemia

12. MAIDEN NAME OF MOTHER

Don't know

13. BIRTHPLACE OF MOTHER

(State or Country)

Bohemia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Jerry Fiala
Barley Ida

15.

Filed 4-10 1922 E. H. Ehlers
Local Registrar

16. DATE OF DEATH

March 9 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 6 - 1922 to March 9 - 1922

that I last saw her alive on March 9 - 1922 and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(Duration) — Yrs. — mos. 8 ds.

Contributory (Secondary)

(Duration) — Yrs. — mos. — ds.

(Signed) W. H. Cooper M. D.
1314 E. 1st (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Pleasant View Cemetery, Barley, Ida Mar 13 1922

20. UNDERTAKER

Robert H. Matt Barley, Ida

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Myer
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Edward E. Bryan

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37751
Registered No. 776

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Male | white | Single
(Write the word.)

6. DATE OF BIRTH

_____. _____. _____.
(Month) (Day) (Year)

7. AGE

22 Yrs. ____ Mos. ____ ds.

IF LESS than 1 day
how many ____ hrs.
or ____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Labourer
Farm

9. BIRTHPLACE

(State or Country)

Not Known

10. NAME OF FATHER

W. B. Williamson

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Idaho

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Lorena D. Bryan
Lewiston, Idaho

(Address)

15.

Filed Apr 10 1922

Bryan E. Bruce
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 27 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____. _____. _____. 19____, to _____. _____. _____. 19____.

that I last saw him alive on _____. _____. _____. 19____.

and that death occurred on the date stated above, at _____. M.

The CAUSE OF DEATH* was as follows:

Strychnine poisoning
suicide

(Duration) ____ Yrs. ____ mos. ____ ds.

Contributory
(Secondary)

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed)

W. B. Williamson
3/1 1922 (Address) Lewiston, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Lewiston, Idaho

DATE OF BURIAL

3/1 1922

20. UNDERTAKER

Lewiston, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Yez Perce*
City of *Lewiston*

Registration District No. *96*
Primary Registration District No. *1009*
(No. *✓* St.)

File No. *37752*
Registered No. *37752*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Connelies Dan Dyke

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*
(Write the word.)

6. DATE OF BIRTH

Feb 16 1845
(Month) (Day) (Year)

7. AGE

77 Yrs. *0* Mos. *12* ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Retired

9. BIRTHPLACE

(State or Country)

Holland

10. NAME OF FATHER

Dan Dyke

11. BIRTHPLACE OF FATHER

(State or Country)

Holland

12. MAIDEN NAME OF MOTHER

Not Known

13. BIRTHPLACE OF MOTHER

(State or Country)

Holland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

a. m. van Dyke

(Address)

Lewiston Ida

15.

Filed *Apr 10 1922* *Simon E Bruce*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 28 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Feb 24 1922* to *Feb 27 1922*
that I last saw him alive on *Feb 27 1922*
and that death occurred on the date stated above, at *M.*
The CAUSE OF DEATH* was as follows:
Broncho Pneumonia

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *O. C. Larsson* M. D.

19 (Address) *Lewiston Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lewiston Ida *3/2 1922*

20. UNDERTAKER

ADDRESS

Bassard and Co *Lewiston Ida*

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Boyer
City of LewistonRegistration District No. 96
Primary Registration District No. 1009
(No. _____, St.)File No. 37753
Registered No. 778

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mabel Violet Pitcher

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female WhiteSingle
(Write the word.)

6. DATE OF BIRTH

Sept 24 1905
(Month) (Day) (Year)

7. AGE

16 Yrs. 5 Mos. 8 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Student

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

John M. Pitcher

11. BIRTHPLACE OF FATHER

(State or Country)

Kans.

12. MAIDEN NAME OF MOTHER

Rosie Land

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Laron Pitcher

15.

Filed Apr 10 1922 Laron E. Bruce
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 2 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from 2-14- 1922 to 3-2- 1922
that I last saw h. alive on 3-2- 1922
and that death occurred on the date stated above, at 12 P.M.

The CAUSE OF DEATH* was as follows:

Hypertension gravid-
arum(Duration) _____ Yrs. _____ mos. 23 ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W. F. McMahon M. D.2-4-1922 (Address) Lewiston Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lewiston Ida3/4 1922

20. UNDERTAKER

ADDRESS

Lewiston Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Myer Registration District No. 96
City of Severston Primary Registration District No. 1009
(No. St.)

File No. 37754
Registered No. 777

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robbie Lester Bowen

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH
Jan 30 1922
(Month) (Day) (Year)

7. AGE 1 Yrs. 12 Mos. 12 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Infant
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Idaho

10. NAME OF FATHER C. W. Bowen

11. BIRTHPLACE OF FATHER
(State or Country) Mo.

12. MAIDEN NAME OF MOTHER John Cox

13. BIRTHPLACE OF MOTHER
(State or Country) Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Burrier
(Address) 2208 West Street

15. Filed Apr 10 1922 Susan E. Bruce
Local Registrar

16. DATE OF DEATH
Mar 4 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-17- 1922 to 3-4- 1922
that I last saw him alive on 3-3- 1922
and that death occurred on the date stated above, at 2-4M.

The CAUSE OF DEATH* was as follows:
Lobar pneumonia

(Duration) Yrs. mos. 17 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. F. McMahon M. D.

3-4-1922 (Address) Severston Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Clarkston Mo. DATE OF BURIAL 3/5 1922

20. UNDERTAKER Bassar and Co ADDRESS Severston

CERTIFICATE OF DEATH

Johnson
State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37755
Registered No. 780

1. PLACE OF DEATH

Registration District No. 96
County of *Boise* Primary Registration District No. 1009
City of *Lewiston* (No.) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Bonny Evans

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male *White* *Single*
(Write the word.)

6. DATE OF BIRTH

Mar 1 1922
(Month) (Day) (Year)

7. AGE

Yrs. Mos. *4* ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Infant

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

R. T. Evans

11. BIRTHPLACE OF FATHER

(State or Country)

Lewiston Ida

12. MAIDEN NAME OF MOTHER

Dora A. Gwin

13. BIRTHPLACE OF MOTHER

(State or Country)

Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *R. T. Evans*
(Address) *Lewiston Ida*

15. Filed *Apr 10* 1922 *Eugene E. Bruce*
Local Registrar

16. DATE OF DEATH

Mar 5 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *mch 1 1922* to *mch 5 1922*
that I last saw him alive on *mch 4 1922*
and that death occurred on the date stated above, at *6 A. M.*

The CAUSE OF DEATH* was as follows:

Sclerosis nearstomum

(Duration) Yrs. mos. *5* ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *Paul W. Johnson M.D.*

3/7 1922 (Address) *Lewiston Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lewiston Ida *3/6 1922*

20. UNDERTAKER

ADDRESS

Bassar and Co *Lewiston Ida*

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Nezperce
City of LeicesterRegistration District No. 96
Primary Registration District No. 1009
(No. _____ St.)State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37756
Registered No. 781

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Alvera Henderson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widow
(Write the word.)

6. DATE OF BIRTH

April 27 1897
(Month) (Day) (Year)

7. AGE

74 Yrs. 10 Mos. 10 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

at home

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Ill

10. NAME OF FATHER

Wm Howard

11. BIRTHPLACE OF FATHER

(State or Country)

Ill

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. W. Henderson

(Address)

Southwest Idaho

15.

Filed Apr 10 1922 James E. Bruce
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

3 7 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from 1-15 1922, to 3-7 1922that I last saw him alive on 3-7 1922

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Carcinoma of bladder(Duration) 1 Yrs. _____ mos. _____ ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

John H. Alley M. D.3/8/22(Address) Leicester Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF ~~DEATH~~ OR REMOVALKendrick's IdaDATE OF ~~DEATH~~3/9 1922

20. UNDERTAKER

Bassar and Co

ADDRESS

Leicester
Ida

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Bozeman*City of *Leibniz*

If death occurs away from usual residence, give facts called for under special information.

Registration District No. *96*Primary Registration District No. *1009*(No. *96*)

St.)

2. FULL NAME

*David P. Lister*State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *37757*Registered No. *792*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widower

(Write the word.)

6. DATE OF BIRTH

April 5 1922
(Month) (Day) (Year)

7. AGE

*81 Yrs. 11 Mos. 4 ds.*IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...

President of Lehigh

(b) General nature of industry, business or establishment in which employed (or employer)

Transfer & Storage Co.

9. BIRTHPLACE

(State or Country)

Edinburgh Scotland

10. NAME OF FATHER

Don't no.

11. BIRTHPLACE OF FATHER

(State or Country)

Don't no.

12. MAIDEN NAME OF MOTHER

Don't no.

13. BIRTHPLACE OF MOTHER

(State or Country)

Don't no.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Andrew C. Lister

(Address)

Leibniz Idaho

15.

Filed *Apr 10 1922**Ernest E. Bruce*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 9 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

*May 1 1922 to May 9 1922*that I last saw him alive on *May 9 1922*and that death occurred on the date stated above, at *M.*

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) Yrs. mos. ds.

Contributory (Secondary)

Enlarged prostate gland (Prostatitis)

(Duration) yrs. mos. ds.

(Signed)

*Paul W. Johnson M. D.**3/10/22* (Address) *Clarkston Wash.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Clarkston Wash

DATE OF BURIAL

3/12 1922

20. UNDERTAKER

H. C. Merchant

ADDRESS

Clarkston

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Nez Perce*City of *Lewiston*Registration District No. *96*Primary Registration District No. *1009*(No. *96*)

St.)

File No. *51758*Registered No. *783*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Christian A. Held

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

married
(Write the word.)

6. DATE OF BIRTH

Feb 10

(Month)

(Day)

1

(Year)

7. AGE

77

Yrs.

Mos.

ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Miner

(b) General nature of industry, business or establishment in which employed (or employer)

Retired

9. BIRTHPLACE

(State or Country)

Schleswig Holstein

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Christian A. Held*(Address) *1218 7th St*

15.

Filed *Apr 10* 19 *22**Susan E. Bruce*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 11

(Month)

11

(Day)

19

22

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 29 19 *22* to *Mar 11* 19 *22*that I last saw ~~him~~ alive on *Mar 11* 19 *22*and that death occurred on the date stated above, at *7:45 A.*

The CAUSE OF DEATH* was as follows:

Influenza

(Duration)

Yrs.

6 wks

mos.

ds.

Contributory
(Secondary)*nephritis*

(Duration)

Yrs.

years

mos.

ds.

(Signed)

Paul W. Johnson M. D.*3/11* 19 *22*

(Address)

Lewiston, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

Yrs.

mos.

days.

In the

State

Yrs.

mos.

days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Lewiston Ida

DATE OF BURIAL

3/13 19 *22*

20. UNDERTAKER

Bassar and Co.

ADDRESS

Lewiston Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Johnson
State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Myer
City of Lewiston

Registration District No. 96Primary Registration District No. 1009

(No. _____ St.)

File No. 37360Registered No. 37360

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Marcella Zimmerman

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Single

6. DATE OF BIRTH

Feb 19 1922
(Month) (Day) (Year)

7. AGE

✓ Yrs. ✓ Mos. 22 ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer).

Infant

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

P. A. Zimmerman

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Emma M. Erickson

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

P. A. Zimmerman

(Address)

Spalding Idaho

15. FILED

Apr 10 1922Eugene E. Bruce

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 13th 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 23 1922, to March 13 1922

that I last saw her alive on March 12 1922

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Transition

(Duration) _____ Yrs. _____ mos. 21 ds.

Contributory Cause - Transition

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Julius Johnson M. D.

3/16 1922 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Lewiston, Idaho

DATE OF BURIAL

3-15 1922

20. UNDERTAKER

ADDRESS

Lewiston, Idaho

CERTIFICATE OF DEATH

 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

1. PLACE OF DEATH

 County of Boise
 City of Madison

 Registration District No. 96
 Primary Registration District No. 1009
 (No. St.)

 File No. 37761
 Registered No. 37761

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Amos McDonald

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-OWED OR DIVORCED

Male Indian Married
 (Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

48 Yrs. Mos. ds.

 IF LESS than 1 day
 how many hrs.
 or min. ?

8. OCCUPATION

 (a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Kip Kip Am yeen

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Ampie Allen
Rapier, Idaho

15.

 Filed Apr 10 1922 Susan E Bruce
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 13 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 19 1922 to March 13 1922

 that I last saw him alive on March 17 1922
 and that death occurred on the date stated above, at 7:30 PM.

The CAUSE OF DEATH* was as follows:

General Tuberculosis
Ruptured Appendicitis
Chronic Nephritis

(Duration) Yrs. mos. ds.

 Contributory
 (Secondary)

Same

 (Duration) 2 yrs. mos. ds.

(Signed)

E. L. White
314 1922 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Spalding Id 5/1/22

20. UNDERTAKER

ADDRESS

Vassar Undertaking Co. Lewiston Idaho

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1 PLACE OF DEATH
County Nez Perce State Idaho
Township Indian Reservation or Village _____ or
City _____ No. _____ St. _____ Ward _____
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Amos McDonald
(a) Residence. No. Juliaetta, Idaho St. _____ Ward _____
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Indian 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5a If married, widowed, or divorced HUSBAND of Carrie Eneas (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1847

7 AGE Years 47 Months _____ Days _____ IF LESS than 1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Invalid

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Indian Reservation
(State or country)

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) _____
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) _____
(State or country)

14 Informant _____
(Address)

15 Filed 3/12, 19 1922 Carbett Langer REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13, 1922

17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____,

that I last saw him alive on _____, 19____,

and that death occurred, on the date stated above, at _____m.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) Carbett Langer Lease Clerk, D.
, 19 (Address) Lapwai, Idaho

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Indian Cemetery DATE OF BURIAL 3-14-1922

20 UNDERTAKER Wann, Lapwai, Idaho ADDRESS _____

MARGIN RESERVED FOR BINDING

8-209 d

V. S. No. 98

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Duplicate of 1922-37761 VOIDED 9-6-2013 HNS

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Nez Perce Registration District No. 96
 City of Lewiston Primary Registration District No. 1009
 (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Katherine Farrell

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 37762
 Registered No. 787

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female white single
 (Write the word.)

6. DATE OF BIRTH

_____. _____. _____.
 (Month) (Day) (Year)

7. AGE

70 Yrs. ____ Mos. ____ ds. IF LESS than 1 day
 how many ____ hrs.
 or ____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

at home

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. C. Vassar
 (Address) Lewiston, Ida

15.

Filed Apr 10 1922 Ronan E Bruce
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 14 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar 14 1922 to Mar 19 1922
 that I last saw him alive on Mar 13 1922
 and that death occurred on the date stated above, at ____ M.

The CAUSE OF DEATH* was as follows:

exhaustion

(Duration) Yrs. ____ mos. ____ ds.

Contributory
 (Secondary)

(Duration) yrs. ____ mos. ____ ds.

(Signed) G. W. Shaff M. D.

Mar 22 1922 (Address) Lewiston, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Lewiston, Idaho

DATE OF BURIAL

3/16 1922

20. UNDERTAKER

Lewiston, Idaho

ADDRESS

Lewiston, Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 96
County of Blaine Primary Registration District No. 1009
City of Leviston (No. _____ St.)

File No. 37763
Registered No. 788

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Katherine Elizabeth Glass

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single

(Write the word.)

6. DATE OF BIRTH

March 10 1922
(Month) (Day) (Year)

7. AGE

6 Yrs. 6 Mos. 6 ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Infant

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Ralph Glass

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Mary Nolan

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ralph Glass

(Address) Leviston, Idaho

15.

Filed Apr 10 1922

Eusan E Bruce

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 16 1922
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from March 16 1922 to Mar 16 1922

that I last saw her alive on Mar 16 1922

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) _____ Yrs. _____ mos. 6 ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) O. C. Leaman M. D.

19 _____ (Address) Leviston, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Leviston, Idaho

DATE OF BURIAL

Apr 17 1922

20. UNDERTAKER

VASSAR UNDERTAKING CO.

ADDRESS

Leviston, Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Johnson
State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Myer*City of *Leviston*Registration District No. *96*Primary Registration District No. *1009*

(No.)

St.)

File No. *37764*Registered No. *789*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

(Olga) (Baby) Peden

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Mar 16 1922
(Month) (Day) (Year)

7. AGE

8 hrs

IF LESS than 1 day

how many *8* hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

Infant

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

James Peden

11. BIRTHPLACE OF FATHER

(State or Country)

Scotland

12. MAIDEN NAME OF MOTHER

Aggesta Wolf

13. BIRTHPLACE OF MOTHER

(State or Country)

Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

James E. Peden

(Address)

Clarkston 4th St.

15.

Filed *Apr 10*19 *22*

Swan E Bruce
Local Registrar

16. DATE OF DEATH

Mar 17 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar 17 1922 to Mar 19 1922

that I last saw him alive on 19

and that death occurred on the date stated above, at *7 A.M.*

The CAUSE OF DEATH* was as follows:

Premature birth

..... (Duration) Yrs. mos. ds.

Contributory
(Secondary)

..... (Duration) yrs. mos. ds.

(Signed)

M. D.

19

(Address)

Paul Johnson

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Clarkston**3/17/19*

20. UNDERTAKER

ADDRESS

*Bassar and Co**Leviston*

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Myz Perce
City of Leoviston

Registration District No. 96
Primary Registration District No. 1009
(No. _____ St.)

File No. 37765
Registered No. 792

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

J. Earl Hodges

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-OWED OR DIVORCED

Male White married
(Write the word.)

6. DATE OF BIRTH

Dec. 14 1922
(Month) (Day) (Year)

7. AGE

43 Yrs. _____ Mos. _____ ds. _____
IF LESS than 1 day how many _____ hrs. or _____ min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Farmer.

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

Joseph Hodge

11. BIRTHPLACE OF FATHER

(State or Country)

Penn

12. MAIDEN NAME OF MOTHER

Georgiana Cox

13. BIRTHPLACE OF MOTHER

(State or Country)

Ienn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs J. E. Hodges

(Address)

Myz Perce, Idaho

15.

Filed Apr 10 1922 Susan E Bruce
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

3 17 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

3-15-1922 to 3-17-1922
that I last saw him alive on 3-17-1922
and that death occurred on the date stated above, at 4 AM.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) Yrs. _____ mos. 3 ds.

Contributory (Secondary)

Influenza

(Duration) Yrs. _____ mos. 10 ds.

(Signed)

J. H. Alley M. D.

19

(Address)

Leoviston

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Myz Perce, Ida 3/18/1922

20. UNDERTAKER

ADDRESS

Vassar and Leoviston

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37766
Registered No. 791
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Merger
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

(Baby) M. C. Fadden

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male white

(Write the word.)

6. DATE OF BIRTH

March 16 1922
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

✓ Yrs. ✓ Mos. 2 ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Infant

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Guy P. McFadden

11. BIRTHPLACE OF FATHER

(State or Country)

Orangeville

12. MAIDEN NAME OF MOTHER

Cecil Snyder

13. BIRTHPLACE OF MOTHER

(State or Country)

College Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Guy M. Fadden

(Address)

Blackston Wash

15.

Filed Apr 10 1922 Susan E Bruce
Local Registrar

16. DATE OF DEATH

3 18 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

3 16 1922 to 3-18 1922
that I last saw her alive on 3-17 1922
and that death occurred on the date stated above, at 2 A. M.
The CAUSE OF DEATH* was as follows:

Premature born

(Duration) Yrs. mos. 2 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

John H. Acker M. D.
19 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lewiston Idaho

Mar 19 1922

20. UNDERTAKER

ADDRESS

Lewiston Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of MyerCity of LeovistonRegistration District No. 96Primary Registration District No. 1009

(No. _____)

(St. _____)

File No. 37767Registered No. 792

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Walfred Leonard Swanson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

married
(Write the word.)

6. DATE OF BIRTH

Oct 12 1886
(Month) (Day) (Year)

7. AGE

35 Yrs. 5 Mos. 20 ds.

IF LESS than 1 day

how many _____ hrs.

or _____ min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Orchardist

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ky.

10. NAME OF FATHER

John A Swanson

11. BIRTHPLACE OF FATHER

(State or Country)

Suveden

12. MAIDEN NAME OF MOTHER

Johanna

13. BIRTHPLACE OF MOTHER

(State or Country)

Suveden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Jane Manning a Swanson
Leoviston, Idaho

15.

Filed Apr 10 1922Susan E Bruce
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 20 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 18 1922 to March 20 1922that I last saw him alive on March 20 1922
and that death occurred on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH* was as follows:

Abscess of Brain, from middle
ear complication of following
Influenza.(Duration) _____ Yrs. _____ mos. 3 ds.Contributory
(Secondary)Influenza(Duration) _____ Yrs. _____ mos. 15 ds.

(Signed)

Edgar L White

M. D.

322 1922 (Address) Leoviston 2da

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

_____ or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Chicago Ill

DATE OF BURIAL

19 _____

20. UNDERTAKER

ADDRESS

Leoviston Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Nez Perce*
City of *Leoviston*

Registration District No. *96*
Primary Registration District No. *1009*
(No. _____ St.)

File No. *37789*
Registered No. *37789*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Sinora Pasella Brown

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*
(Write the word.)

6. DATE OF BIRTH

Feb 21 1872
(Month) (Day) (Year)

7. AGE

50 Yrs. *1* Mos. *2* ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

at home

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

Hill Collins

11. BIRTHPLACE OF FATHER

(State or Country)

Mo

12. MAIDEN NAME OF MOTHER

Myra Stringer

13. BIRTHPLACE OF MOTHER

(State or Country)

Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J P Brown

(Address)

1806-10, Ave.

15.

Filed

Apr 10

1922

Susan E. Bruce
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 23rd 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Did not attend
that I last saw him alive on _____
and that death occurred on the date stated above, at _____ A.M.

The CAUSE OF DEATH* was as follows:

Cancer of breast

(Duration) *1* Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

John H. Allen M. D.

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Leoviston Idaho

DATE OF BURIAL

3/24 1922

20. UNDERTAKER

PASSAN UNDERTAKING

ADDRESS

Leoviston Idaho

CERTIFICATE OF DEATH

Carson
State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Boise
City of Revolution

Registration District No. 96
Primary Registration District No. 1009
(No. _____ St.)

File No. 37770
Registered No. 37770

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Julia Schnable

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH

Feb 28 1846
(Month) (Day) (Year)

7. AGE

76 Yrs. — 23 Mos. 23 ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

at home

9. BIRTHPLACE

(State or Country)

Mich

10. NAME OF FATHER

John Elbert

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Robert R. Schnable
(Address) 2503 - E Main St.

15.

Filed Apr 10 1922 Susan E. Bruce
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 23rd 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 18 1922 to Mar 23rd 1922

that I last saw her alive on Mar 23rd 1922
and that death occurred on the date stated above, at P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia Pneumonia

(Duration) _____ Yrs. _____ mos. 5 ds.

Contributory
(Secondary)

Influenza

(Duration) _____ yrs. _____ mos. 5 ds.

(Signed) W. C. Carson M. D.

19. (Address) Carson Id.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Leoviston, Idaho

DATE OF BURIAL

3/30 1922

20. UNDERTAKER

ASSAR UNDERTAKING CO.

ADDRESS

Leoviston, Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *My Perse*
City of *Leoviston Idaho*Registration District No. *96*Primary Registration District No. *1009*

(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Baby Berryman*State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *37771*Registered No. *796*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female White(Write the word.) *Single*

6. DATE OF BIRTH

Mar 16 22
(Month) (Day) (Year)

7. AGE

Yrs. *8* Mos. _____ ds.

IF LESS than 1 day

how many _____ hrs.

or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Farmer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

Levi Berryman

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Victory

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

S. J. Fuller

(Address)

Leoviston

15.

Filed *Apr 10* 19*22**Susan E Bruce*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 23 19*22*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

3-16 19*22* to *3-22* 19*22*that I last saw him alive on *3-22* 19*22*and that death occurred on the date stated above, at *6 P* M.

The CAUSE OF DEATH* was as follows:

Premature birth

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) *John H. Ceeley* M. D.

19. (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Leoviston Ida

DATE OF BURIAL

3/26 19*22*

20. UNDERTAKER

Vassar's and Co. Leoviston Id

ADDRESS

CERTIFICATE OF DEATH

Braddock
State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Jefferson*City of *Lewiston*Registration District No. *96*Primary Registration District No. *1009*

(No. _____)

St. _____)

File No. *37672*Registered No. *797*

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Evelyn W. Durbin

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED*Widowed*
(Write the word.)

6. DATE OF BIRTH

July 25 1896
(Month) (Day) (Year)

7. AGE

76 Yrs. *6* Mos. *1* ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min. ?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

Undertaker & Embalmer
Retired.

9. BIRTHPLACE

(State or Country)

*Ohio*10. NAME OF
FATHER*unknown*11. BIRTHPLACE
OF FATHER

(State or Country)

*no*12. MAIDEN NAME
OF MOTHER*no*13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Frank S. Durbin*(Address) *Lewiston, Idaho*

15.

Filed *Apr 10 1922**1922*

Susan E. Bruce
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 24 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Jan 13 1922 to *March 24 1922*
that I last saw him alive on *March 23 1922*
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation(Duration) Yrs. *6* mos. _____ ds.Contributory *Arteriosclerosis*

(Secondary)

(Duration) *5* yrs. _____ mos. _____ ds.(Signed) *Elmer & Braddock* M. D.

3-14 1922 (Address) *Lewiston, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted
if not at place of death? _____

Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cinchoga Falls, Ohio *3/26 1922*

20. UNDERTAKER

ADDRESS

Wasserman & Co *Lewiston*

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Nez Perce
City of LewistonRegistration District No. 96Primary Registration District No. 1009

(No. _____ St.)

File No. 37773Registered No. 798

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Walter Robinson Parr

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

married
(Write the word.)

6. DATE OF BIRTH

May
(Month)3
(Day)1871
(Year)

7. AGE

50 Yrs. 10 Mos. 22 ds.

IF LESS than 1 day

how many _____ hrs.

or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Clergyman

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Liverpool, Eng land

10. NAME OF FATHER

Alexander Parr

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Matilda Richards

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. W. R. Parr

(Address)

Lewiston Richards

15.

Filed

Apr 101922Susan E Bruce
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

3
(Month)28
(Day)1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

3 - 19 1922 to 3 24 1922that I last saw him alive on 3 24 1922and that death occurred on the date stated above, at 7:15 AM

The CAUSE OF DEATH* was as follows:

Influenza(Duration) _____ Yrs. _____ mos. 6 ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

John H. Alley M. D.19

(Address)

Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Lewiston Ida

DATE OF BURIAL

3/26/1922

20. UNDERTAKER

Dassar and Co.

ADDRESS

Lewiston

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Myer
City of LeavistonRegistration District No. 96Primary Registration District No. 1009

(No. _____ St.)

File No. 37774Registered No. 799

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Albert Augustus Steinhaus
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDMale White Single
(Write the word.)

6. DATE OF BIRTH

July 30 1920
(Month) (Day) (Year)

7. AGE

1 Yrs. 7 Mos. 25 ds.
IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Infant.

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

F. C. Steinhaus

11. BIRTHPLACE OF FATHER

(State or Country)

Kans

12. MAIDEN NAME OF MOTHER

Mary Elizabeth Bringerhoff

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Bringerhoff

(Address)

Leaviston, Ida

15.

Filed Apr 10 1922Ernest E. Bruce

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

3 24 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

3 22 1922 to 3 24 1922that I last saw him alive on 3 24 1922and that death occurred on the date stated above, at 7 AM.

The CAUSE OF DEATH* was as follows:

Infant(Duration) _____ Yrs. 2 mos. 20 ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) John H. Alley M. D.

19. _____ (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Leaviston, Ida3/26 1922

20. UNDERTAKER

ADDRESS

WASSAR UNDERTAKING CO. Leaviston, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Neppes
City of Leicester

Registration District No. 96Primary Registration District No. 1009

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Alexander McQuibb

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 37775Registered No. 800

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Don't Know

(Month)

(Day)

1857
(Year)

7. AGE

65

Yrs.

Mos.

da.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Stockman (Retired)
4 years

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Meranel Point Wisconsin

10. NAME OF FATHER

Don't Know

11. BIRTHPLACE OF FATHER

(State or Country)

" "

12. MAIDEN NAME OF MOTHER

" "

13. BIRTHPLACE OF MOTHER

(State or Country)

" "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

N. Hostetler

(Address)

Asotin Wash

15.

Filed

Apr 101922

Susan E Bruce
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

3

(Month)

28

(Day)

1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

3/24 1922 to 3/28 1922that I last saw him alive on 3/28 1922

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Myocardial Regurgitation

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed)

3/28 1922

(Address)

Asotin Wash

M. D.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

Asotin Wash

19. PLACE OF BURIAL OR REMOVAL

Clackston Wash

DATE OF BURIAL

3/28 1922

20. UNDERTAKER

H R Meacham

ADDRESS

Clackston

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Nezperce
City of Leicester

Registration District No. 96
Primary Registration District No. 1009
(No. _____ St.)

File No. 37776
Registered No. 401

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Charles Oden Davis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH Sept. 27 1905
(Month) (Day) (Year)

7. AGE 16 Yrs. 5 Mos. 8 ds. IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

At School

9. BIRTHPLACE mouth of Wilson, Virginia
(State or Country)

10. NAME OF FATHER T. H. Davis

11. BIRTHPLACE OF FATHER North Carolina
(State or Country)

12. MAIDEN NAME OF MOTHER Flourence Parson

13. BIRTHPLACE OF MOTHER mouth of Wilson, Virginia
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. T. J. Parson
(Address) Cloverland Wash

15. Filed Apr 10 - 1922 Ernan E Bruce
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH mech 31 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from mech 20 1922 to mech 31 1922
that I last saw him alive on mech 30 1922
and that death occurred on the date stated above, at a M.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) Yrs. _____ mos. 11 ds.
Contributory (Secondary) Empyema left pleura

(Duration) yrs. _____ mos. 7 ds.
(Signed) Paul W Johnson M. D.

3/31 1922 (Address) Leicester Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. 3 days. In the _____ State _____ yrs. _____ mos. 3 days

Where was disease contracted if not at place of death? Clarkston Wash

Former or usual residence Cloverland Wash

19. PLACE OF BURIAL OR REMOVAL Cloverland Wash DATE OF BURIAL April 2 1922

20. UNDERTAKER H R Merchant ADDRESS Clarkston Wash

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

37777

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Nez Perce Registration District No. 92
City of Bufford Primary Registration District No. 2170
(No. 0 St.)File No. 5
Registered No. 44

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Lydia J. A. Neese

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-OWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH

September 7th 1887
(Month) (Day) (Year)

7. AGE

34 Yrs. 7 Mos. 18 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)House wife

9. BIRTHPLACE

(State or Country) Kansas

10. NAME OF FATHER

Fred Kridenauer

11. BIRTHPLACE OF FATHER

(State or Country) Germany

12. MAIDEN NAME OF MOTHER

Minis Vager

13. BIRTHPLACE OF MOTHER

(State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Emma Stollger
(Address) Bufford, Idaho

15.

Filed 4/25 1922 E. E. Watts
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

4 1922 24 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from 4-24 1922, to 4-24 1922that I last saw her alive on 4-24 1922and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Gangrene of bowels(Duration) Yrs. mos. 1 ds.
Contributory (Secondary) Dysentery(Duration) yrs. mos. 4 ds.
(Signed) E. E. Watts M. D.4-24-22 (Address) Bufford

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Good Hope, Brn

DATE OF BURIAL

4-26 1922

20. UNDERTAKER

W. E. Stoddard

ADDRESS

Bufford

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED CERTIFICATE OF DEATH.

1. PLACE OF DEATH.

County of *oneida*City of *Malad*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

MAY 1922

Registration District No.

BUREAU of Registration District No. *2069*

STATE OF IDAHO

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *37778*Registered No. *14*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married

6. DATE OF BIRTH.

Apr 17 1867
(Month) (Day) (Year)

7. AGE

55 Yrs. *11* Mos. *11* ds.IF LESS than 1 day
how many.....hrs. or
.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....*Farmer*

9. BIRTHPLACE

(State or Country)

Bingham City

10. NAME OF FATHER

James L Johnson

11. BIRTHPLACE OF FATHER

(State or Country)

Denmark

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Charles E Johnson

15.

Filed

*Apr 26 1922**R. T. Mares*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 28 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 2 1922 to *Mar 24 1922*
that I last saw him alive on *Mar 24 1922*and that death occurred on the date stated above, at *49* M.

The CAUSE OF DEATH* was as follows:

aortic regurgitation(Duration) Yrs. *6* mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

R. T. Mares

M. D.

Mar 24 1922 (Address) *Malad, Idaho*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Malad, Idaho

DATE OF BURIAL

Mar 31 1922

20. UNDERTAKER

J. Guy Benson

ADDRESS

Malad, Idaho

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 29
County of Spencer Primary Registration District No. 2069
City of Spencer (Vital St.)

If death occurs away from usual residence, give facts called for under special information.

BUREAU OF VITAL STATISTICS

2. FULL NAME

Thomas PierceFile No. 37779Registered No. 12

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

WhiteMarried

6. DATE OF BIRTH

June 27 1849
(Month) (Day) (Year)

7. AGE

72 Yrs. 8 Mos. 26 ds.IF LESS than 1 day
how many.....hrs. or
.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....Farming

9. BIRTHPLACE

(State or Country)

Wales

10. NAME OF FATHER

Thomas Pierce

11. BIRTHPLACE OF FATHER

(State or Country)

Wales

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Dr. H. K. Kier
Spencer

15.

Filed

April 15 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 23 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Mar 20 1922 to Mar 23 1922
that I last saw him alive on Mar 22 1922
and that death occurred on the date stated above, at 4 P M.
The CAUSE OF DEATH was as follows:Pneumonia

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

J. J. Allen M. D.
3-23 1922 (Address) Malone

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

Spencer
Woodland Under St John

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bannock Registration District No. 83
City of Hawney Registration District No. 2160
(State) _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Charles William Evans

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37780
Registered No. 10

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH Oct 9 1894
(Month) (Day) (Year)

7. AGE 38 Yrs. 4 Mos. 24 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Farmer
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE Hawney, Idaho
(State or Country)

10. NAME OF FATHER C. R. Evans

11. BIRTHPLACE OF FATHER Brigham Utah
(State or Country)

12. MAIDEN NAME OF MOTHER Louise Jane Smith

13. BIRTHPLACE OF MOTHER Millsville Idaho
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John L. Evans
(Address) Hawney Idaho

15. Filed Nov 5 1922
J. H. Hargis
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 5 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 15 1922 to March 5 1922
that I last saw him alive on March 5 1922
and that death occurred on the date stated above, at 11 A. M.
The CAUSE OF DEATH* was as follows:
Influenza Pneumonia

(Duration) Yrs. mos. ds. 18
Contributory (Secondary)
(Duration) Yrs. mos. ds.
(Signed) J. H. Hargis M. D.
3-5-1922 (Address) Hawney, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place 38 yrs. 4 mos. 24 days. In the State yrs. mos. days

Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Malad Ida. DATE OF BURIAL 3-7 1922

20. UNDERTAKER D. E. Johnson ADDRESS Malad

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-22

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. **RECEIVED MAY 4 1922**
County of Oneyda Registration District No. 26
City of Malad (No. 2069 St.)

File No. 37781Registered No. 9

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ida Adeline Christensen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married

6. DATE OF BIRTH.

May 21 1880
(Month) (Day) (Year)

7. AGE

41 Yrs. 9 Mos. 20 ds.

IF LESS than 1 day
how many.....hrs. or
.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

New York

10. NAME OF FATHER

Frank Scaper

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Id

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

J. M. Christensen
Malad, Idaho

15.

Filed

April 22 1922R. M. Auer

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 11 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 28 1922, to Mar 11 1922

that I last saw h. or alive on Mar 11 1922and that death occurred on the date stated above, at 1 a. M.

The CAUSE OF DEATH* was as follows:

Septicemia(Duration) Yrs. mos. 3 ds.

Contributory (Secondary)

Pneumonia(Duration) yrs. mos. 8 ds.

(Signed)

R. M. Auer

M. D.

Mar 11 1922 (Address) Malad, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

MaladMar 14 1922

20. UNDERTAKER

ADDRESS

Robt. J. AuerMalad

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37782

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of BoyerCity of Homedale

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 130
Primary Registration District No. Homedale
(No. St.)

2. FULL NAME

George R Berge

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
(Write the words)

6. DATE OF BIRTH

Mar 31 1893
(Month) (Day) (Year)

7. AGE

68 Yrs. 11 Mos. 23 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Farmer

9. BIRTHPLACE

(State or Country)

Ill

10. NAME OF FATHER

Joseph A Berge

11. BIRTHPLACE OF FATHER

(State or Country)

N Y

12. MAIDEN NAME OF MOTHER

Adeline Shepperd

13. BIRTHPLACE OF MOTHER

(State or Country)

Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Stacy Berge

(Address)

Homedale

15.

Filed Apr 1 1922 S Hopper
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 23 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar 20 1922 to Mar 23 1922
that I last saw him alive on Mar 22 1922
and that death occurred on the date stated above, at 4 M.
The CAUSE OF DEATH* was as follows:Pneumonia(Duration) Yrs. mos. 3 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Simon Hopper M. D.19..... (Address) Homedale

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Roswell19

20. UNDERTAKER

ADDRESS

Peckham CaseFarma

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37783

1. PLACE OF DEATH

County of Layelle Registration District No. 1922
City of Franklin Primary Registration District No. 1922 St. Idaho

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Glady M. Rathel

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Married

6. DATE OF BIRTH

Mar 2 1863
(Month) (Day) (Year)

7. AGE

59 Yrs. 24 ds.

If LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Mich

10. NAME OF FATHER

B. F. Chapman

11. BIRTHPLACE OF FATHER

(State or Country)

N. Y.

12. MAIDEN NAME OF MOTHER

Mary Jackson

13. BIRTHPLACE OF MOTHER

(State or Country)

Mich

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. C. Rathel

(Address)

Franklin Idaho

15.

Filed 3-28- 1922 6. E. Parton

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 26 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar 23- 1922 to Mar 26 1922
that I last saw h. alive on 3/24- 1922
and that death occurred on the date stated above, at 6:45 A.M.
The CAUSE OF DEATH* was as follows:

Myocardial degeneration

(Duration) 2 Yrs. 2 mos. 2 ds.

Contributory
(Secondary)

(Duration) 2 Yrs. 2 mos. 2 ds.

(Signed)

W. H. Edwards M. D.

3/27/1922 (Address) Payette Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Payette 3-28 1922

20. UNDERTAKER

ADDRESS

W. H. Edwards Payette Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Payette Registration District No.
City of Payette Primary Registration District No.
City of Payette St.)

File No. 37784
Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jean C. Syme

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH Nov 22 1922
(Month) (Day) (Year)

7. AGE 16 Yrs. 5 Mos. 28 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION (a) Trade, profession or particular kind of work Student
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE Idaho
(State or Country)

10. NAME OF FATHER Crichton Syme

11. BIRTHPLACE OF FATHER Scotland
(State or Country)

12. MAIDEN NAME OF MOTHER Johanna Otterson

13. BIRTHPLACE OF MOTHER Utah
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Johanna Syme
(Address) Payette, Ida

15. Filed April 22, 1922 C. C. Puxton
Local Registrar

16. DATE OF DEATH April 20 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 16 1922, to April 20 1922 that I last saw her alive on April 20 1922 and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:
Malignant Endocarditis

(Duration) Yrs. mos. ds.
Contributory (Secondary) Acute rheumatic fever
(Duration) yrs. mos. ds. 10
(Signed) William J. Keese M. D.
4/21, 1922 (Address) Payette, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Payette Ida DATE OF BURIAL 4-23 1922

20. UNDERTAKER J. McQuinn Payette Ida ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

1. PLACE OF DEATH.

Registration District No.

County of

Primary Registration District No.

City of

(No.)

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37785

Registered No. 19

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hr. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

191

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

March 8, 1922, to April 3, 1922,

that I last saw him alive on April 3, 1922,

and that death occurred on the date stated above, at 4⁴⁵ P.M.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) yrs. Two mos. ds.

Contributory (Secondary) Inanition

(Duration) Indefinite yrs. mos. ds.

(Signed) O. H. Avery, M. D.

Apr 6 1922 (Address) Payette, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Payette, Ida Apr 6 1922

20. UNDERTAKER

ADDRESS

W. A. Davis Payette, Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Payette*City of *Payette*Registration District No. *4*Primary Registration District No. *1008*File No. *37786*Registered No. *20*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Northey Knudsen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

Nov
(Month)*6*
(Day)*1899*
(Year)

7. AGE

62 Yrs. *9* Mos. *1* ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Housewife

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Norway

10. NAME OF FATHER

Don't know

11. BIRTHPLACE OF FATHER

(State or Country)

Norway

12. MAIDEN NAME OF MOTHER

Don't know

13. BIRTHPLACE OF MOTHER

(State or Country)

Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

L.W. Woodward

(Address)

Payette Idaho

15.

Filed

*April 8 1922**J.C. Woodward*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov
(Month)*7*
(Day)*1922*
(Year)17. I HEREBY CERTIFY, That I attended deceased from
Nov. 19 *21* to *April 5* 19 *22*that I last saw her alive on *April 5* 19 *22*,and that death occurred on the date stated above, at *5 A.M.*

The CAUSE OF DEATH* was as follows:

Mitral insufficiency

(Duration) ? Yrs. ? mos. ? ds.

Contributory
(Secondary)*Edema*

(Duration) yrs. 2 mos. ds.

(Signed)

J.R. McDonald

M. D.

4-8-1922 (Address) *Payette Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Payette Idaho

DATE OF BURIAL

4-9-1922

20. UNDERTAKER

Glenn C. Landon

ADDRESS

Payette Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH Payette
County of Payette
City of Payette
Registration District No. 4
Primary Registration District No. 1008
(No. _____ St.)

File No. 37787
Registered No. 21

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Carleton Robertson

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
(Write the word.)

16. DATE OF DEATH

6. DATE OF BIRTH Aug 21 1859
(Month) (Day) (Year)

April 11 1922
(Month) (Day) (Year)

7. AGE 62 Yrs. 7 Mos. 20 ds.
IF LESS than 1 day how many _____ hrs. or _____ min.?

17. I HEREBY CERTIFY, That I attended deceased from March 5 1922, to April 11 1922, that I last saw her alive on April 7 1922, and that death occurred on the date stated above, at 4³⁰ A.M.

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business or establishment in which employed (or employer)

The CAUSE OF DEATH* was as follows:
Interstitial nephritis, Myocarditis, Aortic stenosis

9. BIRTHPLACE
(State or Country) Genevieve Ohio

(Duration) Indefinite mos. _____ ds.

10. NAME OF FATHER John L. Chapman

Contributory (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.

11. BIRTHPLACE OF FATHER
(State or Country) Genevieve Ohio

(Signed) O. H. Avery M. D.
4/11/1922 (Address) Payette, Idaho

12. MAIDEN NAME OF MOTHER Anna Marguerite McRae

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

13. BIRTHPLACE OF MOTHER
(State or Country) Canada

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

(Informant) C. H. Robertson
(Address) Payette Ida

Where was disease contracted if not at place of death? _____

Former or usual residence _____

15. Filed April 11 1922
J. C. Woodward
Local Registrar

19. PLACE OF BURIAL OR REMOVAL Genevieve Mo DATE OF BURIAL 4/12 1922

20. UNDERTAKER O. H. Avery ADDRESS Payette Ida

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 4County of PayettePrimary Registration District No. 1008City of Payette

(No.)

(St.)

File No. 37788Registered No. 22

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Amy Frances Van Valkenburg

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

FemaleWhitesingle
(Write the word.)

6. DATE OF BIRTH

Sept-18
(Month) (Day) (Year)18
(Day) (Year)1913
(Year)

7. AGE

8 Yrs. 6 Mos. 25 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

At School

9. BIRTHPLACE

(State or Country)

Oregon

10. NAME OF FATHER

A.E. Van Valkenburg

11. BIRTHPLACE OF FATHER

(State or Country)

Michigan

12. MAIDEN NAME OF MOTHER

Mary Stalter

13. BIRTHPLACE OF MOTHER

(State or Country)

Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A.E. Van Valkenburg

(Address)

Payette Idaho

15.

Filed

Apr 13 1922J.C. Woodward

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April
(Month)12
(Day)1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 8, 1922 to April 12, 1922that I last saw her alive on April 11, 1922and that death occurred on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:

Reaction of the 'flu'(Duration) Yrs. mos. 4 ds.Contributory
(Secondary)(Duration) yrs. mos. 4 ds.

(Signed)

R.C. QuinnC.S.
M.D.4-12-1922 (Address) 315 N. 10th St
Payette Idaho

*State the Disease Causing Death; or in deaths from violent causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Payette Idaho4-14-1922

20. UNDERTAKER

ADDRESS

Glen E. LandonPayette Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37790
Registered No. 24

1. PLACE OF DEATH Rayette Registration District No. 4
County of Rayette Primary Registration District No. 1008
City of Rayette (No. St.)
If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Louie E Daniel

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH Oct 19 1879
(Month) (Day) (Year)

7. AGE 42 yrs. 6 mos. 9 ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Garment Maker
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE Mass
(State or Country)

10. NAME OF FATHER Joseph Daniel

11. BIRTHPLACE OF FATHER France
(State or Country)

12. MAIDEN NAME OF MOTHER Not known

13. BIRTHPLACE OF MOTHER Not known
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Louie Daniel
(Address) Rayette

15. Filed Apr 30 1922 191 20 Woodward
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH April 27 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 21 1921 to April 27 1922, that I last saw him alive on April 27 1922, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:
Tuberculosis of the Lungs

(Duration) Unknown mos. ds.
Contributory (Secondary)

(Duration) yrs. mos. ds.
(Signed) J. McDaniel M. D.
5-1 1922 (Address) Rayette Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Rayette Ida DATE OF BURIAL Apr 29 1922

20. UNDERTAKER W. H. Daniel ADDRESS Rayette Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

37791

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Power Registration District No. 3
City of American Falls St. (Hannibal)

If death occurs away from
usual residence, give facts
called for under special
information.

2. FULL NAME Hannable Rowe

File No. 9
Registered No. 150

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH.

Oct 1 1941
(Month) (Day) (Year)

7. AGE

80 yrs. 5 mos. 18 ds.

IF LESS than 1 day
how many hrs. or
min. 2)

8. OCCUPATION

(a) Trade, profession or
particular kind of work... Mining
(b) General nature of in-
dustry, business, or estab-
lishment in which employ-
ed (or employer).....

9. BIRTHPLACE

(State or Country) England

10. NAME OF
FATHERNot Known11. BIRTHPLACE
OF FATHER

(State or Country) England

12. MAIDEN NAME
OF MOTHER13. BIRTHPLACE
OF MOTHER

(State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm M. A. A. A. A.
(Address) American Falls, Idaho

15.

Filed

April 22 1942

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 19 1942
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
191 to 191

that I last saw h..... alive on 191
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

No physician in attendance
Immediate cause probably
the grippe
Duration..... Yrs. 6 mos. few ds.
Contributors
(Secondary)

(Signed) Richard F. Mott M. D.
Address American Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted
if not at place of death?.....

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

American Falls Mar 22 1942

20. UNDERTAKER

ADDRESS

W. Davis American Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED
APR 21 1922
BUREAU OF VITAL STATISTICS
Registration District No. 25

1. PLACE OF DEATH.

County of Power
City of American Falls

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Wesley Lee Warf

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 3Registered No. 149

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-OWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH.

May 9th 1920
(Month) (Day) (Year)

7. AGE

One Yrs. 8 Mos. 1 day

IF LESS than 1 day
how many hrs. or
..... min.]

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Lee Warf

11. BIRTHPLACE OF FATHER

(State or Country)

West Va.

12. MAIDEN NAME OF MOTHER

Sylvia Rose Allen

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

R. F. North
American Falls

15.

Filed

April 7 1922 R. F. North
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 10 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 28 1922 to March 10 1922
that I last saw him alive on March 10 1922

and that death occurred on the date stated above, at 6 P. M.

THE CAUSE OF DEATH* was as follows:

General military
tuberculosis

(Duration) Yrs. 2 mos. 3 ds.

Contributory (Secondary)

La Grippe

(Duration) Yrs. 10 mos. 10 ds.

(Signed)

Richard B. North M. D.

3/11 1922 (Address) American Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

American Falls March 12 1922

20. UNDERTAKER

ADDRESS

None

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

37793 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of *Power*

City of *American Falls*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Henry Clark*

Registration District No. *25*

Primary Registration District No. *2072*

File No. *3*

Registered No. *148*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male*

4. COLOR OR RACE *White*

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. *Single*
(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

(Year)

7. AGE *About 35 yrs*

yrs.

mos.

ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION *Don't know*

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *R. F. Noth*

(Address) *American Falls*

15.

Filed *1922 R. F. Noth*

1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH *March 24 1922*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *March 24 1922* to *March 24 1922*

that I last saw him alive on *March 24 1922*

and that death occurred on the date stated above, at *2 P.* M.

The CAUSE OF DEATH* was as follows:

Fracture of base of skull and dislocation of hip. Accidentally struck by train.
(Duration) yrs. mos. *5 hrs.*

Contributory (Secondary)

(Duration)

yrs.

mos.

ds.

(Signed) *Richard F. Noth M.D.*

1922

(Address) *American Falls*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days.

In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

191

20. UNDERTAKER *a. w. Davis*

ADDRESS *Am. Falls*

FORM V. S. No. 5-12 M. 6-15-17.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

District No.

Registration District No.

STATISTICAL

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No.Registered No. 147
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

6. DATE OF BIRTH.

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed 191

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from
Mar 12 1922 to Mar 4 1922that I last saw her alive on Mar 4 1922
and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage
(Duration) Yrs. mos. 3 ds.Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) M. D.

3-4-1922 (Address) American Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days, State yrs. mos. daysWhere was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

American Falls

Mar 12 1922

20. UNDERTAKER

ADDRESS

Arthur J. J. J.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Shoshone*
City of *Stelllogg*Registration District No. *123*

Primary Registration District No.

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Joseph C Rivett*File No. *37796*Registered No. *1*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

widower
(Write the word.)

6. DATE OF BIRTH

Sept. *9* *1836*
(Month) (Day) (Year)

7. AGE

85 Yrs. *4* Mos. *1* ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Montreal Canada

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

Canada

12. MAIDEN NAME OF MOTHER

Rose Stache

13. BIRTHPLACE OF MOTHER

(State or Country)

Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

James D. Orr

(Address)

Stelllogg Idaho

15.

Filed *Jan 28* 19*22**E E Hardy*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan *10* *22*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan *22* to *19*that I last saw him alive on *19*and that death occurred on the date stated above, at *2 P.* M.

The CAUSE OF DEATH* was as follows:

Cyelo-nephritis

(Duration) Yrs. mos. ds.

Contributory
(Secondary)*old age*

(Duration) yrs. mos. ds.

(Signed)

Georg Kenneth M. D.*19* (Address) *Stelllogg, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Jaylors Falls, Minn. *Jan 12, 1922*

20. UNDERTAKER

ADDRESS

W. H. Thumhies *Stelllogg, Idaho*

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Boone
City of KeelRegistration District No. 123

Primary Registration District No. _____

(No. _____) (St.) _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

H. HolmgrenFile No. 37797Registered No. 2

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDsingle
(Write the word.)

6. DATE OF BIRTH

No information

(Month) (Day) (Year)

7. AGE

35

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Miner

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Sweden

10. NAME OF FATHER

No information

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. B. Shanks

(Address)

Keel, Idaho

15.

Filed Jan 28 / 1932E. E. Hardy

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 13 1932
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

.....19....., to19.....

that I last saw h..... alive on.....19.....

and that death occurred on the date stated above, at.....M.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(Duration) Yrs. mos. ds.

Contributory
(Secondary)Chronic alcoholism

(Duration) yrs. mos. ds.

(Signed)

Geo. H. Kennest M. D.19..... (Address) Keel, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

GreenwoodJan 13, 1932

20. UNDERTAKER

ADDRESS

M. ShanksKeel, Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Shoshone
City of KelloggRegistration District No. 123

Primary Registration District No. _____

(No. _____) (St. _____)

File No. 37798Registered No. 3

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Frank B Gibson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

M

4. COLOR OR RACE

White5. SINGLE, MARRIED, WIDOWED OR DIVORCED
widowed
(Write the word.)

6. DATE OF BIRTH

Dec 15 1850
(Month) (Day) (Year)

7. AGE

71 Yrs. 1 Mos. 10 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Farmer

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

New York

10. NAME OF FATHER

B. Gibson

11. BIRTHPLACE OF FATHER

(State or Country)

Penn.

12. MAIDEN NAME OF MOTHER

Miss Howland

13. BIRTHPLACE OF MOTHER

(State or Country)

Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edward Gibson

(Address) _____

15.

Filed Jan 28 / 1922 E E Hardy
Local Registrar

16. DATE OF DEATH

Jan 15 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19that I last saw him alive on 19

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Carcinoma of throat(Duration) 2 Yrs. _____ mos. _____ ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Scott Kennet M. D.Jan 18, 1922 (Address) Kellogg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Greenwood Cemetery

DATE OF BURIAL

Jan 18, 1922

20. UNDERTAKER

McCharnick

ADDRESS

Kellogg, Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

Registration District No. 123

Primary Registration District No.

(No.

St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED
married
(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15. Filed

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw her alive on
and that death occurred on the date stated above, at 10:30 A.M.

The CAUSE OF DEATH* was as follows:

(Duration) Yrs. mos. 25 ds.

Contributory (Secondary) Placenta praevia & version of child.

(Duration) Yrs. mos. ds.

(Signed) M. D.

1/27/1922 (Address) Kellogg, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

FORM V. S. No. 5-25 M. 1917

CERTIFICATE OF DEATH

PLACE OF DEATH

Registration District No.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 37800

Registered No.

City of Kellogg

(No.

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Frances Le Bert

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

F white Married
(Write the word.)

6. DATE OF BIRTH

Oct 12 1886
(Month) (Day) (Year)

7. AGE

35 Yrs. 3 Mos. 15 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Virginia

10. NAME OF FATHER

M. B. White

11. BIRTHPLACE OF FATHER

(State or Country)

Va.

12. MAIDEN NAME OF MOTHER

Miss Eastep

13. BIRTHPLACE OF MOTHER

(State or Country)

Va.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Hector Le Bert

(Address)

Kellogg, Idaho

15.

Filed

Jan 27 1922 E. E. Hardy

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 27 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
Jan 20 1922 to Jan 26 1922
that I last saw him alive on Jan 26 1922
and that death occurred on the date stated above, at 5 A.M.
The CAUSE OF DEATH* was as follows:

Alcoholism

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. R. Mason M. D.

17 1922 (Address) Kellogg, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Colfax, Wash.

DATE OF BURIAL

Jan 29, 1922

20. UNDERTAKER

M. C. Thomber

ADDRESS

Kellogg, Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Shoshone*Registration District No. *123*City of *Healy*

Primary Registration District No. _____

File No. *37801*Registered No. *6*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John P. Perspich, Jr.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED *single*
(Write the word.)

6. DATE OF BIRTH

Jan 25 1920
(Month) (Day) (Year)

7. AGE

2 Yrs. — Mos. *2* ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)*at home*

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

John Perspich

11. BIRTHPLACE OF FATHER

(State or Country)

Croatian

12. MAIDEN NAME OF MOTHER

Eva Perspich

13. BIRTHPLACE OF MOTHER

(State or Country)

Croatian

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John Perspich

(Address)

15. *Mar 23 1922* *E. E. Hardy*
Filed _____ Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 27 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 27th 1922, to _____ 19____

that I last saw him _____ alive on _____ 19____

and that death occurred on the date stated above, at *11 A.* M.

The CAUSE OF DEATH* was as follows:

acute drug poisoning, accidental(Duration) _____ Yrs. _____ mos. *1* ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

H. Lindsay

M. D.

1/28 1922 (Address) *Healy, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Healy, Idaho

DATE OF BURIAL

Jan 29 1922

20. UNDERTAKER

M. C. Turnhues

ADDRESS

Healy, Idaho

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 123

Primary Registration District No.

(No. St.)

2. FULL NAME

Emil Klee

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 37802

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married

(Write the word.)

6. DATE OF BIRTH

No information

(Month)

(Day)

(Year)

7. AGE

42

Yrs.

Mos.

ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

Miner

9. BIRTHPLACE

(State or Country)

Finland

10. NAME OF FATHER

No information

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Finland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ed Klee

(Address)

Keelogg Idaho

15. Filed

March 23 1922

Ed Hardy

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan

(Month)

29

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 25 1922, to Jan 29 1922

that I last saw him alive on Jan 29 1922

and that death occurred on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) Yrs. mos. 7 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Geo H Kennest M. D.

19. (Address) Keelogg, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Greenwood Cemetery

DATE OF BURIAL

Feb 3 1922

20. UNDERTAKER

McMankin

ADDRESS

Keelogg Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 123

Primary Registration District No.

(No. St.)

2. FULL NAME

Issac SaloState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 37803

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

May 7 1888
(Month) (Day) (Year)

7. AGE

33 Yrs. 8 Mos. 29 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Miner

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Finland

10. NAME OF FATHER

John Salo

11. BIRTHPLACE OF FATHER

(State or Country)

Finland

12. MAIDEN NAME OF MOTHER

Ausie Rajala

13. BIRTHPLACE OF MOTHER

(State or Country)

Finland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Hill(Address) Kingston, Idaho

15. Filed

Mar 23 / 1912E. E. Hand

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 31 1912
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

..... 19....., to 19.....

that I last saw him..... alive on 19.....

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Miner's Consumption

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

..... 19..... (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Kingston

DATE OF BURIAL

Feb 1, 1912

20. UNDERTAKER

M. C. Hankins

ADDRESS

Keegs, Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 123County of ✓

Primary Registration District No. _____

City of _____

(No. _____ St.)

File No. 37804Registered No. 9

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Walee Kaski

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Feb
(Month)16
(Day)1881
(Year)

7. AGE

41 Yrs.

Mos.

ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Miner

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Finland

10. NAME OF FATHER

John Kaski

11. BIRTHPLACE OF FATHER

(State or Country)

Finland

12. MAIDEN NAME OF MOTHER

Mrs. Kate

13. BIRTHPLACE OF MOTHER

(State or Country)

Finland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. E. Hardy

(Address)

B. L. 6 - Grandville, Mich.

15. Filed

Mar 23 1922E. E. Hardy

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb
(Month)2
(Day)1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 19 _____, to _____ 19 _____

that I last saw him _____ alive on _____ 19 _____

and that death occurred on the date stated above, at 5:15 M.

The CAUSE OF DEATH* was as follows:

No. of Intercourse

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

_____ 19 _____ (Address) _____

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Hunt's Cemetery

DATE OF BURIAL

Feb 5 1922

20. UNDERTAKER

M. C. Shanker

ADDRESS

Keely, Mich.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 123

County of Shoshone

Primary Registration District No.

City of Kellogg

(No.)

(St.)

File No.

37805

Registered No. 18

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Henry F. Laer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

single
(Write the word.)

6. DATE OF BIRTH

Feb. 16, 1882
(Month) (Day) (Year)

7. AGE

39 Yrs. 2 Mos. 19 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Miner

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Minnesota

10. NAME OF FATHER

L. Henry Laer

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Lina Bruner

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Theo. A. Laer

(Address)

Hollister, Calif.

15.

Mar 23/22

E. E. Hardy

Filed

19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb. 15, 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY That I attended deceased from

Feb. 9, 1922, to Feb. 15, 1922

that I last saw him alive on Feb. 15, 1922

and that death occurred on the date stated above, at 11:40 P.M.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(Duration) Yrs. mos. 6 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Geo. V. Kennett M. D.

Feb. 20, 1922 (Address) Kellogg, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Ref. May. Minn. Feb. 20/22 19

20. UNDERTAKER

ADDRESS

McShannell Kellogg, Idaho

FORM 10-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of **Shoshone**
City of **Hellogg**Registration District No. **123**

Primary Registration District No. _____

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Cloye Fern BradleyState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **37806**

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **F** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Married**
(Write the word.)

6. DATE OF BIRTH

August 29 1898
(Month) (Day) (Year)

7. AGE

23 Yrs **5** Mos **19** ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

At Home

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

Orin Fast**Orin Fast**

11. BIRTHPLACE OF FATHER

(State or Country)

Illinois

12. MAIDEN NAME OF MOTHER

Frances Prizell

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Frank B. Bradley

(Address)

Hellogg, Idaho.

15. Filed

Mar 25 1922**E. C. Hardy**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb. 8 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from **Feb 1st** 1922 to **Feb 9th** 1922that I last saw her alive on **Feb 9th** 1922 and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Appendicitis followed by peritonitis

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory (Secondary)

Pregnancy(Duration) _____ yrs. _____ mos. **9** ds.

(Signed)

W. C. Lindsay

M. D.

3/17 1922 (Address) **Hellogg, Ida.**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL **Hellogg, Idaho.** DATE OF BURIAL **Feb 12/22**20. UNDERTAKER **M. C. Thornhill****Hellogg, Ida**

1. PLACE OF DEATH ✓

CERTIFICATE OF DEATH

County of ShoshoneRegistration District No. 123City of Keelogg

Primary Registration District No. _____

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Sand B. GordonState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 37807Registered No. 12

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-

OWED OR DIVORCED

unmarried
(Write the word)

6. DATE OF BIRTH

Mar. 17 1922
(Month) (Day) (Year)

7. AGE

76 Yrs.

Mos.

ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Carpenter

9. BIRTHPLACE

(State or Country)

Canada

10. NAME OF FATHER

No information

11. BIRTHPLACE OF FATHER

(State or Country)

Montreal

12. MAIDEN NAME OF MOTHER

No information

13. BIRTHPLACE OF MOTHER

(State or Country)

Montreal

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

R. B. Gordon

(Address)

Keelogg, Idaho

15.

Filed

3/25/22E. E. Hardy

Local Registrar

16. DATE OF DEATH

Feb. 24 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 21 1922 to Feb 24 1922that I last saw her alive on Feb 20 1922

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Influenza(Duration) _____ Yrs. _____ mos. 5 ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Scott & Tennet M. D.19. (Address) Keelogg, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Keelogg, IdahoFebr. 1922

20. UNDERTAKER

ADDRESS

M. C. ThornhillKeelogg, IdahoMARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

Registration District No. 153

Primary Registration District No.

(No.)

St.)

File No. 37808

Registered No. 13

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Howard Pecnick

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single (Write word.)

6. DATE OF BIRTH

Feb

(Month)

25

(Day)

1922

(Year)

7. AGE

2 yrs

Mos.

4 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

none

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Kellogg, Idaho

10. NAME OF FATHER

John Pecnick

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Miss Singer

13. BIRTHPLACE OF MOTHER

(State or Country)

Hungary

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John Pecnick

(Address)

Kellogg, Idaho

15.

Filed

3/5/22

1922

E. E. Hardy

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar

(Month)

1

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from
Feb 25 1922 to Mar 1 1922

that I last saw him alive on Feb 28 1922

and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Patent Foramen Ovale

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

E. E. Hardy

M. D.

1922 (Address) Kellogg, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Kellogg, Idaho

DATE OF BURIAL

Mar 2 1922

20. UNDERTAKER

M. C. Thornhill

ADDRESS

Kellogg, Idaho

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Shoshone*

City of *Seeley*

If death occurs away from usual residence, give facts called for under special information.

Registration District No. *123*

Primary Registration District No.

(No. St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. *37809*

Registered No. *14*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Jessie Agnes Bowen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

Aug *14* *1885*
(Month) (Day) (Year)

7. AGE

36 Yrs. *6* Mos. *14* ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Washington

10. NAME OF FATHER

David B. Gaudin

11. BIRTHPLACE OF FATHER

(State or Country)

Canada

12. MAIDEN NAME OF MOTHER

Miss Jessie Lee

13. BIRTHPLACE OF MOTHER

(State or Country)

Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

R. J. Brown
Seeley, Idaho

(Address)

15.

Filed

3/20/22 *E. E. Hardy*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March *1* *1922*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Feb 23* — *1922* to *Mar 1* *1922*

that I last saw him alive on *Mar 1* *1922*

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) Yrs. *3* mos. *3* ds.

Contributory (Secondary)

Influenza

(Duration) yrs. *5* mos. *5* ds.

(Signed)

Geor. H. Kennett M. D.

(Address) *Seeley, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Seeley, Idaho

DATE OF BURIAL

Mar 5, 1922

20. UNDERTAKER

M. P. Thornhill

ADDRESS

Seeley, Idaho

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Shoshone Registration District No. 123
 City of Kellogg Idaho Primary Registration District No. _____
 (No. _____) (St. _____)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Helia Agnes Boehm

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 37810Registered No. 15

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

December 23 1891
(Month) (Day) (Year)

7. AGE

30 Yrs. 7 Mos. 11 ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Kelkelly, County Mayo, Ireland

10. NAME OF FATHER

Thoinas Connors

11. BIRTHPLACE OF FATHER

(State or Country)

Kelkelly, County Mayo, Ireland

12. MAIDEN NAME OF MOTHER

Bridget Pendergast

13. BIRTHPLACE OF MOTHER

(State or Country)

Kelkelly, County Mayo, Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Henry H. Boehm

(Address)

Kellogg Idaho

15.

Filed

3/25/22 E. E. Hardy

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 3 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 24th 1922 to March 2nd 1922

that I last saw him alive on March 2nd 1922

and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Septicemia

Septicemia

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

Cholera

(Duration) _____ Yrs. _____ mos. 6 ds.

(Signed)

Dr. Lindsey

M. D.

3/27/22 (Address) Kellogg Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

at place of death _____ Yrs. _____ mos. _____ days. In the State _____ Yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Kellogg Idaho Mar 7 1922

20. UNDERTAKER

ADDRESS

Mr. Thornhill Kellogg

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Shoshone
City of SteeleRegistration District No. 123

Primary Registration District No.

(No. St.)

File No. 37811Registered No. 16

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Nora Hasboun

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F.

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WID-

OWED OR DIVORCED

married
(Write the word.)

6. DATE OF BIRTH

Feb 19
1877

(Month)

(Day)

(Year)

7. AGE

45 Yrs. 1 Mos. 13 ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

New York

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

New York

12. MAIDEN NAME OF MOTHER

no inf.

13. BIRTHPLACE OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Martin Hasboun(Address) Steele, Idaho15. 3/25/22 E. E. StandFiled 19 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 18
(Month) (Day)1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 18th 1922 to March 18 1922that I last saw him alive on Mar 18 1922and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Tuberculosis Peritonitis

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. L. Lindsay

M. D.

3/23 1922 (Address) Steele, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Steele, Idaho

DATE OF BURIAL

Mar 21, 1922

20. UNDERTAKER

M. E. Hornum, Steele, Idaho

ADDRESS

FORM V. S. No. 1-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH *Home*
 County of *Thurston* Registration District No. *123*
 City of *Steely* (No. *123*) St. *Wash.*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Hannah Victoria Pace

A. Mason
 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. *37813*
 Registered No. *18*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *F.* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *married*
 (Write the word.)

6. DATE OF BIRTH

May 1 1888
 (Month) (Day) (Year)

7. AGE

33 Yrs. *10* Mos. *29* ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

S. Dakota

10. NAME OF FATHER

John Nelson

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME OF MOTHER

Louise Larson

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Carl H. Rose

(Address)

Keelogg, Idaho

15.

Filed

3/31/22

19

E. E. Hardy

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 30 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *March 21 1922* to *March 30 1922* that I last saw her alive on *March 29 1922* and that death occurred on the date stated above, at *6 A.M.*

The CAUSE OF DEATH* was as follows:

Peritonitis

Impaction of bowels

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. P. Mason M. D.

3/31 1922 (Address) *Keelogg, Idaho*

*State the Disease Causing Death; or in death from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. 3 mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Provy, Idaho *April 1, 1922*

20. UNDERTAKER

ADDRESS

M. C. Thornhill *Keelogg, Idaho*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

McCluskey
State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37814

1. PLACE OF DEATH.

Registration District No.

County of Twin Falls

Primary Registration District No.

City of Buhl

(No.

St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

7. AGE

— yrs. — mos. — ds.

IF LESS than 1 day
how many 20 hrs. or
mins?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed 3-14

1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at P. M.

The CAUSE OF DEATH* was as follows: Premature

Baby born at
Twin Falls, Idaho
in mother

(Duration) yrs. mos. ds.

Contributory "flu" in mother.
(Secondary)

(Duration) yrs. mos. ds.

(Signed) A. J. McCluskey D.

3/13 1922 (Address) Buhl, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death... yrs. ... mos. ... days. In the State... yrs. ... mos. ... days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

Buhl Cemetery

20. UNDERTAKER

none called.

DATE OF BURIAL

3/15 1922

ADDRESS

P

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Laramie
City of BuhlRegistration District No. 39Primary Registration District No. 2087

(No.)

St.

File No. 37815

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Muriel Stombaugh

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married

6. DATE OF BIRTH

April 21 1882
(Month) (Day) (Year)

7. AGE

39 Yrs. 10 Mos. 12 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

Clayton Stombaugh

11. BIRTHPLACE OF FATHER

(State or Country)

Ind.

12. MAIDEN NAME OF MOTHER

Mrs. Schwetfeger

13. BIRTHPLACE OF MOTHER

(State or Country)

N.Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) R. E. Stombaugh

(Address)

15.

Filed 3-14 1922 J. H. Murphy

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 14 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 10 1922 to March 14 1922that I last saw him alive on March 12 1922and that death occurred on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

G. A. Marsh M. D.March 14 1922 (Address) Buhl Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

103rd St.1922

20. UNDERTAKER

ADDRESS

Howell DrugBuhl Ida

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Twin Falls ✓
City of CastlefordRegistration District No. 39
Primary Registration District No. 2087
(No. _____ St.)File No. 37816
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Rebecca Bulkeley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH

2 Sept 16 1923
(Month) (Day) (Year)

7. AGE

69 Yrs. 5 Mos. 1 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).House Wife

9. BIRTHPLACE

(State or Country)

Edwards Co Ill

10. NAME OF FATHER

John Oxman

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Woodman

13. BIRTHPLACE OF MOTHER

(State or Country)

Edwards Co Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

R. C. Bulkeley
Castleford Idaho

15.

Filed

3-171922J. H. Murphy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 17 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1922 to 3/17 1922
that I last saw him alive on 3/15 1922
and that death occurred on the date stated above, at 3 A. M.

The CAUSE OF DEATH* was as follows:

Suicidal
depression
(Duration) _____ yrs. _____ mos. _____ ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) A. H. Murphy M. D.3/17 1922 (Address) Buhl Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BIRTH OR REMOVAL

Hitchita Kan

DATE OF BURIAL

3/17 1922

20. UNDERTAKER

A. H. Johnson

ADDRESS

Buhl Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Swain Falls
City of BullRegistration District No. 39Primary Registration District No. 2087File No. 37817Registered No. 37817

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Joseph Edward Conrad

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

6. DATE OF BIRTH

Jan 2 1860
(Month) (Day) (Year)

7. AGE

62 Yrs. 2 Mos. 19 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Farmer

9. BIRTHPLACE

(State or Country)

W. Va.

10. NAME OF FATHER

Lorenza Dow

11. BIRTHPLACE OF FATHER

(State or Country)

Va.

12. MAIDEN NAME OF MOTHER

Adda Hess

13. BIRTHPLACE OF MOTHER

(State or Country)

Va.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

H. L. Boyd
Bull

15.

Filed

3-231922J. H. Murphy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 21 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

..... 19....., to 19.....
that I last saw h..... alive on..... 19.....
and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Died suddenly.Acute dilatation of heart.

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. H. Murphy M. D.
3-21 1922 (Address) Bull Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bull Cemetery Mar 23 1922

20. UNDERTAKER

ADDRESS

Lewitts & Co. Bull Ida

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Swain Falls
 City of Buhl

Registration District No. 39
 Primary Registration District No. 2087
 (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Frank Watt

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 37818
 Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married

6. DATE OF BIRTH

Feb. 20 1868
 (Month) (Day) (Year)

7. AGE

54 Yrs. 24 Mos. 6 da.

IF LESS than 1 day
 how many _____ hrs.
 or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

Ranch laborer

9. BIRTHPLACE

(State or Country)

Oregon

10. NAME OF FATHER

George Watt

11. BIRTHPLACE OF FATHER

(State or Country)

don't know

12. MAIDEN NAME OF MOTHER

Mahaley Johnson

13. BIRTHPLACE OF MOTHER

(State or Country)

Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

G. D. Johnson
Buhl R. F. D.

(Address)

15.

Filed 3-27 1922

J. H. Murphy
 Local Registrar

16. DATE OF DEATH

Mar 26 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar 21 1922 to Mar 26 1922
 that I last saw him alive on 3/26 1922
 and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) Yrs. mos. 7 ds.

Contributory
 (Secondary)

(Duration) Yrs. mos. 10 ds.

(Signed)

Dr. H. C. Hays
3/26 1922 (Address) Buhl R. F. D.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Swain Falls

Mar 29 1922

20. UNDERTAKER

ADDRESS

J. F. Grossman

Swain Falls

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Twin Falls
City of BuhlRegistration District No. 39
Primary Registration District No. 2087
(No. _____) (St. _____)File No. 37819
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Rella Lynn Wright

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDMale White Married
(Write the word.)

6. DATE OF BIRTH

Apr 12 1888
(Month) (Day) (Year)

7. AGE

34 Yrs. 11 Mos. 25 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Chicago

10. NAME OF FATHER

Walter S. Wright

11. BIRTHPLACE OF FATHER

(State or Country)

Mass.

12. MAIDEN NAME OF MOTHER

Eugene A. Lemmey

13. BIRTHPLACE OF MOTHER

(State or Country)

Mass

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs R. L. Wright

(Address)

Buhl Ida

15.

Filed

Mar. 27 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 27 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____ 19____, to _____ 19____,

that I last saw him _____ alive on _____ 19____,

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Peritonitis
by physician in attendance
Post-mortem held(Duration) Yrs. about mos. 2 ds.Contributory
(Secondary)ruptured appendix(Duration) Yrs. about mos. 10 ds.

(Signed)

J. H. Murphy
Ed. A. Marsh M. D.3-27-1922 (Address) Buhl & Twin Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Buhl 3/30 1922

20. UNDERTAKER

L. J. Johnson Buhl Ida

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED

APR 21 1922

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Registration District No. 37

Registration District No. 2085

(No.)

(St.)

File No. 37820

Registered No.

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Male

White

Single
(Write the word.)

6. DATE OF BIRTH

April 2

(Month)

(Day)

1922
(Year)

7. AGE

Yrs.

Mos.

3 ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF
FATHER11. BIRTHPLACE
OF FATHER

(State or Country)

12. MAIDEN NAME
OF MOTHER13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

April 7-1922

John T. Coughlin

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 5

(Month)

(Day)

1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 2nd 1922 to April 5 1922

that I last saw him alive on April 4 1922

and that death occurred on the date stated above, at 5 AM.

The CAUSE OF DEATH* was as follows:

Premature Birth about 7 mos.

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

4/5/22

(Address)

Twin Falls, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place

of death

Yrs.

mos.

In the

State

Yrs.

mos.

days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Twin Falls

April 5 1922

20. UNDERTAKER

ADDRESS

P. J. Grossman

Twin Falls

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Franklin* Registration District No. *37*
City of *Franklin* Registration District No. *1085*
City of *Franklin* County Hospital, St.)

If death occurs away from usual residence, give facts called for under special information.

BUREAU OF VITAL STATISTICS

2. FULL NAME

*Leah Garrett Selmer*File No. *37822*
Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female white *Married* (Write the word.)

6. DATE OF BIRTH

Jun 20 19*22*
(Month) (Day) (Year)

7. AGE

49 Yrs. *1* Mos. *15* ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

House wife

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Arkansas

10. NAME OF FATHER

J. Warren

11. BIRTHPLACE OF FATHER

(State or Country)

Arkansas

12. MAIDEN NAME OF MOTHER

Esther Hanner

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John F. Loughan

(Address)

Franklin, Idaho

15.

Filed *April 9 -* 19*22**John F. Loughan*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 8 19*22*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 1 19*21*, to *March 8th* 19*22*that I last saw him alive on *March 8th* 19*22*and that death occurred on the date stated above, at *10³⁰* P.M.

The CAUSE OF DEATH* was as follows:

Peritonitis(Duration) _____ Yrs. _____ mos. *4* ds.Contributory (Secondary) *Chronic Peritonitis Recurrent - Uterine Fibroid - infected.*(Duration) *1* yrs. _____ mos. _____ ds.(Signed) *James L. Anderson* M. D.*4/10/22* (Address) *Franklin, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Franklin

DATE OF BURIAL

Mar 12 1922

20. UNDERTAKER

J. E. H. H. H.

ADDRESS

Franklin

RECEIVED

APR 21 1922

CERTIFICATE OF DEATH

Registration District No. 37

BUREAU OF VITAL STATISTICS

Primary Registration District No. 1085

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 37823

Registered No.

1. PLACE OF DEATH

County of

City of

(No.

St.)

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Josephus Shidler

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDWidowed
(Write the word.)

6. DATE OF BIRTH

July 30 1832
(Month) (Day) (Year)

7. AGE

89 Yrs. 7 Mos. 18 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)Retired
Farmer

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF
FATHER

Joshia Shidler

11. BIRTHPLACE
OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME
OF MOTHER

Miss Merritt

13. BIRTHPLACE
OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs C. W. Drigler

(Address)

Twin Falls, Ida.

15.

Filed April 9 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 18 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19
that I last saw h. alive on 19
and that death occurred on the date stated above, at 8:30 AM.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) Yrs. mos. ds.
Contributory (Secondary) old age(Duration) yrs. mos. ds.
(Signed) J. J. Grossman

3/21/1922 (Address) Twin Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Twin Falls, Ida. 3/21 1922

20. UNDERTAKER

ADDRESS

J. J. Grossman Twin Falls

Ida.

1. PLACE OF DEATH

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsCounty of *Lincoln* Registration District No. *37*
Primary Registration District No. *1085*
City of *Idaho* STAT (No. _____ St.)File No. *37824*

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Paul Edward Henderson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED*male white* *Infant* (Write the word.)

6. DATE OF BIRTH

May 20 1921
(Month) (Day) (Year)

7. AGE

10 Yrs. *4* Mos. *4* ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)*Infant*

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Aubrey Henderson

11. BIRTHPLACE OF FATHER

(State or Country)

Maine

12. MAIDEN NAME OF MOTHER

Bertha Shaw

13. BIRTHPLACE OF MOTHER

(State or Country)

Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Aubrey E. Henderson

(Address)

15.

Filed

April 9 1922 *John T. Laughlin*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 24 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

3/23/1922 to *3/24/1922*
that I last saw him alive on *3/24/1922*
and that death occurred on the date stated above, at *8 P.M.*

The CAUSE OF DEATH* was as follows:

Non-communicable(Duration) Yrs. mos. *7* ds.Contributory
(Secondary)(Duration) yrs. mos. *17* ds.

(Signed)

W. G. C. M. D.(Address) *Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Idaho**3-26-1922*

20. UNDERTAKER

ADDRESS

*J. E. Edwards**Idaho*

FORM V. S. No. 5-A—25 M. 1-19.

1. PLACE OF DEATH

County of Twine Falls District No. 37
City of " Primary Registration District No. 1083
City of Twine Falls St. County Hospital

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harry M. Darling

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-OWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH July 23 1913
(Month) (Day) (Year)

7. AGE 8 Yrs 6 Mos 3 ds IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. School
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE Idaho
(State or Country)

10. NAME OF FATHER Frank M. Darling

11. BIRTHPLACE OF FATHER Ind.
(State or Country)

12. MAIDEN NAME OF MOTHER Vernonia Campbell

13. BIRTHPLACE OF MOTHER Wyoming
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mr. Fred E. Craig
(Address) Bozeman, Ida

15. Filed April 9 1922 John S. Koughlin
Local Registrar

RECEIVED CERTIFICATE OF DEATH

APR 9 1922

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 37825

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 26 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 26-1922 to Mar. 26-1922
that I last saw him alive on Mar. 26 1922
and that death occurred on the date stated above, at 3:45 PM
The CAUSE OF DEATH* was as follows:

Hemorrhage & Shock
(Duration) Yrs. mos. 20 hours
Contributory Abdominal gun shot
(Secondary) (Duration) Yrs. mos. 20 years
(Signed) Frank A. Dwight M. D.
Mar 26 1922 (Address) Twine Falls, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs mos days In the State yrs mos days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Twine Falls

DATE OF BURIAL 3/28 1922

20. UNDERTAKER J. F. Grossman

ADDRESS Twine Falls

1. PLACE OF DEATH

County of *San Joaquin*

City of _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED

APR 21 1922

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. *37*Primary Registration District No. *1085*

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *37826*

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED*M**white**Married*
(Write the word.)

6. DATE OF BIRTH

April 13

(Month)

(Day)

1920
(Year)

7. AGE

1 Yrs. *11* Mos. *14* ds.

IF LESS than 1 day

how many _____ hrs.

or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

Infant

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Rudolph E Lutz

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Bessie Hewitt

13. BIRTHPLACE OF MOTHER

(State or Country)

MO

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Rudolph E Lutz

(Address)

San Joaquin, Ida

15. April 9-22

Filed _____ 19 _____

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March

(Month)

25

(Day)

1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar. 22 - 1922 to *March 26th 1922*that I last saw him alive on *March 26th 1922*and that death occurred on the date stated above, at *6* P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) Yrs. mos. ds.

Contributory (Secondary) *Endocarditis*

(Duration) yrs. mos. ds.

(Signed) *Gilbert Jelford D.C.**Mar. 21 1922* (Address) *San Joaquin, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

San Joaquin

DATE OF BURIAL

Mar. 26 1922

20. UNDERTAKER

J. C. Venable

ADDRESS

San Joaquin

FORM V. S. No. 5-A-25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Duwin Falls Registration District No. 37
 City of " Registration District No. 1082 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Wiebe

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 37827
Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-OWED OR DIVORCED Single
 (Write the word.)

6. DATE OF BIRTH

Mar 26 1922
 (Month) (Day) (Year)

7. AGE

Yrs. 3 Mos. 3 ds. IF LESS than 1 day
 how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Duwin Falls, Ida.

10. NAME OF FATHER

Peter F. Wiebe

11. BIRTHPLACE OF FATHER

(State or Country)

Minn.

12. MAIDEN NAME OF MOTHER

Marta Hodel.

13. BIRTHPLACE OF MOTHER

(State or Country)

Kansas.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Peter F. Wiebe
Duwin Falls

15.

Filed

April 9 1922 James J. Loughrey
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 29 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 26 1922 to March 29 1922
 that I last saw her alive on March 29 1922
 and that death occurred on the date stated above, at 10 AM.

The CAUSE OF DEATH* was as follows:

Premature birth.

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Howelunchick M. D.19 (Address) Duwin Falls, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Duwin Falls

3 1922

20. UNDERTAKER

ADDRESS

FORM V. S. No. 5-A-25 M. 1-19.

RECEIVED

APR 21 1922

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *San Joaquin*City of *San Joaquin*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration No. *37*

BUREAU OF VITAL STATISTICS

San Joaquin District No. *1085*(No. *County Hospital*)

(St.)

Lilly J Rice

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *37828*Registered No. *37828*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *female* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *widow*

6. DATE OF BIRTH

Jan 3 1875
(Month) (Day) (Year)

7. AGE

49 Yrs. *2* Mos. *24* ds.
IF LESS than 1 day how many..... hrs. or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. *House maid*
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) *Utah*

10. NAME OF FATHER

Geo Groes

11. BIRTHPLACE OF FATHER

(State or Country) *nat. known*

12. MAIDEN NAME OF MOTHER

" "

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *George Rice*(Address) *San Joaquin, Idaho*15. Filed *April 9* 1922 *John J. Doughlin*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March *27* 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *Mar. 1* 1922, to *Mar. 27* 1922 that I last saw her alive on *Mar. 27* 1922 and that death occurred on the date stated above, at *11:30 AM*

The CAUSE OF DEATH* was as follows:

Surgical shock

(Duration) Yrs. mos. ds.

Contributory (Secondary) *Thyrotosis*

(Duration) 0 yrs. 6 mos. ds.

(Signed) *Edman Cott* M. D.3-27-1922 (Address) *Twinn Falls*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

*San Joaquin*20. UNDERTAKER *J E DeWitt*DATE OF BURIAL *3-29* 1922ADDRESS *San Joaquin*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M, 6-15-17.

1. PLACE OF DEATH

County of *Linn Falls*
City of *Filer*

If death occurs away from usual residence, give facts called for under special information.

RECEIVED

CERTIFICATE OF DEATH

Registration District No. *38*

Primary Registration District No. *2086*

BUREAU OF VITAL STATISTICS

2. FULL NAME

Melford H. Bonham

State of Idaho
BOARD OF HEALTH

Bureau of Vital Statistics

File No. *37829*

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single (Write the word.)

6. DATE OF BIRTH.

Sept 21 1921
(Month) (Day) (Year)

7. AGE

5 Yrs. *15* Mos. *15* ds.

IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

R. E. Bonham

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Lybelle Jones

13. BIRTHPLACE OF MOTHER

(State or Country)

Colo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

R. E. Bonham

(Address)

Filer

15.

3/14 *191*

G. A. Newberry
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 14 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to *Mar 14 191*
that I last saw h... alive on *Mar 14 191*

and that death occurred on the date stated above, at *11* P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed)

F. E. Drake

3/14 (Address) *Filer Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death ... yrs. ... mos. ... days, State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

West Cemetery

DATE OF BURIAL

Mar 14 1922

20. UNDERTAKER

F. E. Drake

ADDRESS

Filer

FORM V. S. No. 5-12 M, 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BUREAU OF HEALTH
Bureau of Vital Statistics
File No. 37830
Registered No. 37830
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH *N. Falls*
County of *Idaho*
City of *Filer*
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME *Bert Cameron*

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male*
4. COLOR OR RACE *white*
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. *Aug 2 1910*
(Month) (Day) (Year)

7. AGE *1 Yrs. 7 Mos. 7 ds.*
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE *Idaho*
(State or Country)

10. NAME OF FATHER *Irue Cameron*

11. BIRTHPLACE OF FATHER *Utah*
(State or Country)

12. MAIDEN NAME OF MOTHER *Edith Smith*

13. BIRTHPLACE OF MOTHER *Utah*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *Irue Cameron*
(Address) *Filer*

15. *Mar 8 1911* *a. a. Newberry*
Filed Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *Mar 8 1911*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *March 7 1911* to *Mar 8 1911*
that I last saw him alive on *Mar 7 1911*
and that death occurred on the date stated above, at *5 am* M.

The CAUSE OF DEATH* was as follows:

Pneumonia Influenza
(Duration) Yrs. mos. 7 ds.

Contributory (Secondary)
(Duration) Yrs. mos. ds.
(Signed) *a. a. Newberry* M. D.
Mar 8 1911 (Address) *Filer Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days, State yrs. mos. days

Where was disease contracted
if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *J. O. O. Campbell* DATE OF BURIAL *Mar 10 1911*

20. UNDERTAKER *J. E. Drake* ADDRESS *Filer*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 15-12 M. 6-15-17.

RECEIVED
MAY 3 1922
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

(No.

St.)

State of Idaho
BOARD OF HEALTH

Bureau of Vital Statistics

File No. 37831

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH.

7. AGE

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15. Filed

191

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 14 1922 to Mar. 14 1922 that I last saw him alive on 14 March 1922 and that death occurred on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration)

Yrs.

mos.

ds.

Contributory (Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

3/14

(Address)

M. D.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death yrs. mos. days, State yrs. mos. days

Where was disease contracted

if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

WHITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. N. 5-12 M. 6-15-17.

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH

Bureau of Vital Statistics

File No. 37832

Registered No. 37832
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of *Butte*

City of *Butte*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No. *286*

Primary Registration District No. *286*

(No. *1* St.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

Jan 12 1858
(Month) (Day) (Year)

7. AGE

64 Yrs. *3* Mos. *13* ds.

IF LESS than 1 day how many . . . hrs. or . . . min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Turner

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

J. S. Seldford

11. BIRTHPLACE OF FATHER

(State or Country)

N. Y.

12. MAIDEN NAME OF MOTHER

Alice Seldford

13. BIRTHPLACE OF MOTHER

(State or Country)

N. Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Cordelia Seldford
Butte

15.

Filed *3-23* 191*2*

Adm

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 23 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 11 1922 to March 23 1922

that I last saw him alive on *March 22 1922* and that death occurred on the date stated above, at *1 P. M.*

The CAUSE OF DEATH* was as follows:

Cerebral Lymphoma
(Duration) Yrs. mos. *12* ds.

Contributory (Secondary)

Cardiac paralysis
(Duration) Yrs. mos. *2* ds.

(Signed) *Frank A. Dwight* M. D.

April 10 1922 Address *Butte, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death . . . yrs. . . mos. . . days. In the State . . . yrs. . . mos. . . days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

200 Cemetery No. *25* 191*2*

20. UNDERTAKER

E. Drake Address *Butte*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

1. PLACE OF DEATH

County of *Idaho*

City of *Tiler*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No. *28*

Primary Registration District No. *2086*

(No. *28* St.)

Ralph B. Menger

State of Idaho
BOARD OF HEALTH

Bureau of Vital Statistics

File No. *37834*

Registered No. *37834*
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married

(Write the word.)

6. DATE OF BIRTH.

Aug 10 1888
(Month) (Day) (Year)

7. AGE

34 Yrs. *8* Mos. *12* ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Laborer

9. BIRTHPLACE

(State or Country)

Calo

10. NAME OF FATHER

Henry Menger

11. BIRTHPLACE OF FATHER

(State or Country)

Ill

12. MAIDEN NAME OF MOTHER

Lydial Merrill

13. BIRTHPLACE OF MOTHER

(State or Country)

Main

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ralph B. Menger

(Address)

Tiler

15.

Filed *Apr 24 1927*

aan

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Apr 22 1927
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 10 1927 to April 21 1927

that I last saw him alive on *April 21 1927*

and that death occurred on the date stated above, at *10 P. M.*

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) Yrs. mos. *14* ds.

Contributory *Myocarditis*
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) *Joseph Regal* M. D.

19 (Address) *Twin Falls*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days, State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Root Cemetery

DATE OF BURIAL

Apr 24 1927

20. UNDERTAKER

J E Drake

ADDRESS

Tiler

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH

Bureau of Vital Statistics

File No. 37835

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of *Shoshone*
City of *Tiler*

Registration District No.

Primary Registration District No.

City of *Tiler* MAY 3 (No. 122)

If death occurs away from usual residence, give facts called for under special information.

BUREAU OF VITAL STATISTICS

2. FULL NAME

Mary P. Pearson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH.

Aug 26 1893
(Month) (Day) (Year)

7. AGE

28 Yrs. *4* Mos. *3* ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Wife

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

Wendner

11. BIRTHPLACE OF FATHER

(State or Country)

Iowa

12. MAIDEN NAME OF MOTHER

Louise Robinson

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *M. P. Pearson*

(Address) *Tiler*

15.

Filed *Apr 18 21* 191...

aan

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Apr 28 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 24 1922 to April 28 1922

that I last saw him alive on *April 27 1922*

and that death occurred on the date stated above, at *2:45 P.M.*

The CAUSE OF DEATH* was as follows:

Intestinal, Abdominal hemorrhage.

(Duration) Yrs. mos. *4 Hours*

Contributory (Secondary)

Pregnant

(Duration) Yrs. *5* mos. ds.

(Signed) *H. A. Swigler* M. D.

April 29 1922 (Address) *Tiler, Iowa*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the of death yrs. mos. days, State yrs. mos. days

Where was disease contracted

If not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

100 Cemetery

DATE OF BURIAL

Apr 30 1922

20. UNDERTAKER

H. E. Drake

ADDRESS

Tiler

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37836
Registered No.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of *Shoshone*
City of *Filer*
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
St.

2. FULL NAME *John Kalbfleiser*

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED, *married*
(Write the word.)

6. DATE OF BIRTH, *Jan 7 1834*
(Month) (Day) (Year)

7. AGE *88* Yrs. *2* Mos. *21* ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) *Farmer*

9. BIRTHPLACE

(State or Country) *Germany*

10. NAME OF FATHER

Leander Kalbfleiser

11. BIRTHPLACE OF FATHER

(State or Country) *Germany*

12. MAIDEN NAME OF MOTHER

—

13. BIRTHPLACE OF MOTHER

(State or Country) *Germany*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mrs. Leander Kalbfleiser*
(Address) *Filer*

15. *Apr 28* Filed *1912* *A. A. Newberry* Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *Apr 27 1912*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *April 26 1912* to *April 27 1912*
that I last saw him alive on *April 26 1912*
and that death occurred on the date stated above, at *10 P.* M.
The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum
(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.
(Signed) *F. A. Wright* M. D.
Apr 28 1912 (Address) *Filer, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days, State yrs. mos. days
Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

100 S. Cemetery *Apr 30 1912*
20. UNDERTAKER *J. E. Drake* ADDRESS *Filer*

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Lincoln* Registration District No. *39*
City of *Buhl* Primary Registration District No. *2087*
St. *Idaho*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Gertha Bernettie Todd*File No. *37837*

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*
(Write the word.)6. DATE OF BIRTH *April 15 1911*
(Month) (Day) (Year)7. AGE *11* Yrs. *24* Mos. *24* ds.
IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)9. BIRTHPLACE *Buhl-Ida.*
(State or Country)10. NAME OF FATHER *W. L. Todd*11. BIRTHPLACE OF FATHER *Tennessee*
(State or Country)12. MAIDEN NAME OF MOTHER *Lucette Dobbs*13. BIRTHPLACE OF MOTHER *Kentucky*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *W. L. Todd*
(Address) *Buhl*15. Filed *4-9* 19*22* *J. H. Murphy*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *April 8 1922*
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *Apr. 6 1922* to *Apr. 8 1922*
that I last saw her alive on *April 7 1922*
and that death occurred on the date stated above, at *3 P.M.*
The CAUSE OF DEATH* was as follows: *Purpura.*

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory (Secondary) _____

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) *J. H. Murphy* M. D.
4-9 1922 (Address) *Buhl Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Buhl Ida *Apr. 9 1922*

20. UNDERTAKER ADDRESS

L. Johnson *Buhl Ida*

✓ RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 37838

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of *Blaine*City of *Blaine*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No. *39*Primary Registration District No. *2087*

(No. _____)

St. _____

Edua Lucile Smith

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed *4-27* 19*22*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

3-17-1922 to *3-22-1922*that I last saw him alive on *3-22-1922*and that death occurred on the date stated above, at *9 A. M.*

The CAUSE OF DEATH* was as follows:

acute indigestion

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

Geo. Jennings M. D.*3-22-1922*

(Address)

Blaine, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Linn*
City of *Burke*Registration District No. *39*
Primary Registration District No. *2087*
(No. St.)File No. *37839*
Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Joe Russell Dayley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

Oct 24 1915
(Month) (Day) (Year)

7. AGE

7 Yrs. *6* Mos. *1* ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)*School Boy*

9. BIRTHPLACE

(State or Country)

Oakley

10. NAME OF FATHER

J. L. Dayley

11. BIRTHPLACE OF FATHER

(State or Country)

Oakley

12. MAIDEN NAME OF MOTHER

Lucile Dayley

13. BIRTHPLACE OF MOTHER

(State or Country)

Oakley

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. L. Dayley
Burke

15.

Filed *4-25* 19*22*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Apr. 28 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

3/17/22 to *4/25/22*
that I last saw him alive on *4/25/22*
and that death occurred on the date stated above, at *1:30 PM*

The CAUSE OF DEATH* was as follows:

Croupyema(Duration) Yrs. mos. *6* ds.Contributory (Secondary) *Scarlet Fever*(Duration) yrs. mos. *38* ds.(Signed) *A. H. Murphy* M. D.*4/25/22* (Address) *Burke*

*State the Disease Causing Death; or in deaths from Violent Causes, state Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

*Oakley*DATE OF BURIAL *Apr 26 1922*

20. UNDERTAKER

D. J. Johnson

ADDRESS

Burke

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Valley

Registration District No.

Primary Registration District No.

City of

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

not namedFile No. 37840

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

fmwhitesingle
(Write the word.)

6. DATE OF BIRTH

2 12 1922
(Month) (Day) (Year)

7. AGE

Yrs. Mos. 1 ds.IF LESS than 1 day
how many hrs.
or min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

None

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Ida

10. NAME OF FATHER

Joe Crawford

11. BIRTHPLACE OF FATHER

(State or Country)

Ida

12. MAIDEN NAME OF MOTHER

Mable Hooker

13. BIRTHPLACE OF MOTHER

(State or Country)

W n

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

G E Hogg

(Address)

Cascade

15.

Filed 19W. H. Cain
Refy Local Registrar

16. DATE OF DEATH

2 13 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from 2-12 1922, to 2-13 1922that I last saw him alive on 2-12 1922and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Natural Cause(Duration) Yrs. mos. 1 ds.

Contributory (Secondary)

Granular Benth(Duration) yrs. mos. 1 ds.

(Signed)

G E Hogg

M. D.

19. (Address) Cascade

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Cascade

DATE OF BURIAL

2-15-1922

20. UNDERTAKER

none

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37841
Registered No. 20

1. PLACE OF DEATH
County of Washington
City of Weir

Registration District No. 86
Primary Registration District No. 1010
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alice May Black

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE whr
5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH Sept 9 1872
(Month) (Day) (Year)

7. AGE 49 Yrs. 6 Mos. 4 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION Capt Salazar army
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE Ohio
(State or Country)

10. NAME OF FATHER Fred Meyer

11. BIRTHPLACE OF FATHER Germany
(State or Country)

12. MAIDEN NAME OF MOTHER Erans

13. BIRTHPLACE OF MOTHER Florida
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas. Beck
(Address) 37 - W. J. Dahl

15. Filed 3/17 1922
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 13 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 3 1922 to March 13 1922 that I last saw her alive on March 13 1922 and that death occurred on the date stated above, at 2 A.M.

The CAUSE OF DEATH* was as follows:
Pneumonia & nephritis

(Duration) Yrs. mos. 10 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) W. H. Marshall M. D.
March 14 1922 (Address) Weir

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Wilcox Cemetery
DATE OF BURIAL 3/16 1922

20. UNDERTAKER Northam & M. Conn
ADDRESS Boise, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37842
Registered No. 21

1. PLACE OF DEATH

County of Washington
City of Weiser

Registration District No. 86
Primary Registration District No. 1010
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Warren Leslie Thatt

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WID-OWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

June 12 1920
(Month) (Day) (Year)

7. AGE

1 Yrs. 9 Mos. 6 ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

None

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ida

10. NAME OF FATHER

E. C. Thatt

11. BIRTHPLACE OF FATHER

(State or Country)

Iowa

12. MAIDEN NAME OF MOTHER

Martha Charlotte Jones

13. BIRTHPLACE OF MOTHER

(State or Country)

Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Frank Shaw

(Address)

Weiser Ida

15.

Filed 3/21 1922

W. P. Hamilton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 18 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 18 1922, to March 18 1922, that I last saw him alive on March 18 1922, and that death occurred on the date stated above, at 5:30 P. M.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

(Duration) Yrs. mos. 10 mos.

Contributory (Secondary)

Convulsions

(Duration) Yrs. mos. 1 mos.

(Signed) W. P. Hamilton M. D.

3/19/1922 (Address) Weiser Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Payette Ida

3-19 1922

20. UNDERTAKER

ADDRESS

Northam McEwan

Weiser Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH
 County of Washington
 City of Wenatchee
 If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME
Charles H. Redd

Registration District No. 86
 Primary Registration District No. 2112
 (No. _____ St.)

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 37843
 Registered No. 22
 If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
 (Write the word.)

6. DATE OF BIRTH Aug 14 1886
 (Month) (Day) (Year)

7. AGE 55 Yrs. 7 Mos. 13 ds.
 IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION Farmer
 (a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE Iowa
 (State or Country)

10. NAME OF FATHER Redd

11. BIRTHPLACE OF FATHER _____
 (State or Country)

12. MAIDEN NAME OF MOTHER M Martha Schobey

13. BIRTHPLACE OF MOTHER Ida.
 (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) J W Cooper
 (Address) Wenatchee, Ida.

15. Filled 3/31 1922
H P Smith
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar 27 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 24 1922 to Mar 27 1922
 that I last saw him alive on Mar 24 1922
 and that death occurred on the date stated above, at 8:00 A.M.
 The CAUSE OF DEATH* was as follows:
apoplexy & Cancer of Stomach
 (Duration) _____ Yrs. 6 mos. 10 ds.
 Contributory (Secondary) asthma & diabetes
 (Duration) 10 yrs. _____ mos. _____ ds.
 (Signed) W Marshall M. D.
Mar 27 19 22 (Address) Wenatchee

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
 At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.
 Where was disease contracted if not at place of death? _____
 Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Manno Creek DATE OF BURIAL 3/28 1922

20. UNDERTAKER Northman & Son ADDRESS Wenatchee, Ida.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Washington
City of Wenatchee

Registration District No. 86Primary Registration District No. 2112

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Carl F Fletcher

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 37844Registered No. 23

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

Wht

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

Dec 30 1879
(Month) (Day) (Year)

7. AGE

42 Yrs. 3 Mos. 28 ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Farmer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ind.

10. NAME OF FATHER

Edward Fletcher

11. BIRTHPLACE OF FATHER

(State or Country)

Canada

12. MAIDEN NAME OF MOTHER

Mortha Brantley

13. BIRTHPLACE OF MOTHER

(State or Country)

Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ed. F. Fletcher

(Address)

Wenatchee, Idaho

15.

Filed 4/1 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 28 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar 16 1922 to Mar 28 1922

that I last saw him alive on Mar 16 1922

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH was, as follows:

apoplexy

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory (Secondary)

arteriosclerosis(Duration) 10 yrs. _____ mos. _____ ds.

(Signed)

W. W. Marshall M. D.

Mar 16 1922 (Address) Wenatchee

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Hillcrest Cemetery

DATE OF BURIAL

3/30 1922

20. UNDERTAKER

Northrup McCombs

ADDRESS

Wenatchee, Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH **RECEIVED**
 Registration District No. 86
 County of Washington
 Primary Registration District No. 2112
 City of Wesley (No. _____) St. _____

File No. 37845
 Registered No. 24

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Stephen Graham

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
 (Write the word)

6. DATE OF BIRTH March 5 1847
 (Month) (Day) (Year)

7. AGE 75 Yrs. 1 Mos. 6 ds.
 IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Arkansas

10. NAME OF FATHER

Graham

11. BIRTHPLACE OF FATHER

(State or Country)

Arkansas

12. MAIDEN NAME OF MOTHER

Ellen Hartley

13. BIRTHPLACE OF MOTHER

(State or Country)

Arkansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Ollie Langer
 (Address) Wesley

15. Filled 4/18 1922
H. R. Hamilton
L.A. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 11 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 2nd 1922 to April 2nd 1922
 that I last saw him alive on April 2nd 1922
 and that death occurred on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Rocky Mountain Sisk Fever.

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
 (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) H. R. Hamilton M. D.

4/12 1922 (Address) Wesley, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Hillcrest Cemetery DATE OF BURIAL 4/13 1922

20. UNDERTAKER Northham McLean ADDRESS Wesley, Ida.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No.

Primary Registration District No.

(No.)

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

April 9th. 1922, to April, 13th. 1922

that I last saw her alive on April, 12th. 1922.

and that death occurred on the date stated above, at 3 A.M.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction.

(Duration) Yrs. mos. 6 ds.

Contributory Exhaustion.

(Duration) Yrs. mos. 6 ds.

(Signed) E. W. Weiser M. D.

4/13 1922 (Address) Weiser Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Washington Registration District No. 86
City of Paris Primary Registration District No. 2112
(No. 11 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Francis Xavier KrausFile No. 37847Registered No. 23

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

MaleWhiteMarried

(Write the word.)

6. DATE OF BIRTH

Jan111856

(Month)

(Day)

(Year)

7. AGE

77Yrs. 2Mos. 29

ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Farmers

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Austria

10. NAME OF FATHER

Antoine Kraus

11. BIRTHPLACE OF FATHER

(State or Country)

Austria

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Austria

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lydia Kraus Townley(Address) Weiser, Idaho

15.

Filed 4/181922J. H. Smith
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April101922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19..... to 19.....

that I last saw him alive on 10th 1922.and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Probably Heart trouble, Dropped dead
while feeding his Chickens,
No Indication of foul play

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Jas. J. McCann

Coroner

4/11 1922

(Address)

Weiser Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Weiser County

DATE OF BURIAL

4-12 1922

20. UNDERTAKER

W. H. McLean

ADDRESS

Weiser Idaho

PLACE OF DEATH

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28

Primary Registration District No. 3161

Registered No. 588

City of *Pocatello*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

James P. King

If death occurred in pital, institution or give its NAME ins street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WID-OWED OR DIVORCED *Married*

16. DATE OF DEATH

March 31st 19*22*
(Month) (Day) (Year)

6. DATE OF BIRTH *Jan 15th 1854*
(Month) (Day) (Year)

7. AGE *68* Yrs. *2* Mos. *16* ds. IF LESS than 1 day how many hrs. or min.?

I HEREBY CERTIFY, That I attended deceased from *Feb. 20th* 19*22*, to *March 31st* 19*22*, that I last saw him alive on *March 31st* 19*22*, and that death occurred on the date stated above, at *5:05 P.M.*

The CAUSE OF DEATH* was as follows:

Secondary carcinoma liver

8. OCCUPATION (a) Trade, profession or particular kind of work *Merchant*

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) *Conn*

10. NAME OF FATHER *James P. King*

11. BIRTHPLACE OF FATHER (State or Country) *Ireland*

12. MAIDEN NAME OF MOTHER *Mary Brady*

13. BIRTHPLACE OF MOTHER (State or Country) *Ireland*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *William P. King*
(Address) *Diggs Bldg*

(Duration) Yrs. *1* mos. *1* ds.
Contributor (Secondary) *Primary carcinoma sigmoid*

(Duration) *Unknown* Yrs. *0* mos. *0* ds.
(Signed) *W.A. Wright* M. D.
4/1 19*22* (Address) *Pocatello, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs mos days In the State yrs mos days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Mar 31st

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH. Exact statement of OCCUPATION is very important. See instructions on back of form, so that it may be properly classified.

1. PLACE OF DEATH

County of Kentucky
City of Nathaniel

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Amanda L. Sylvester

RECEIVED CERTIFICATE OF DEATH

Registered District No. 30Primary Registration District No. 1057BUREAU
STA.State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 37849Registered No. 1062

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widowed
(Write the word.)

6. DATE OF BIRTH

Nov 20 1856
(Month) (Day) (Year)

7. AGE

85 Yrs. 4 Mos. 16 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ill.

10. NAME OF FATHER

John Mitchell

11. BIRTHPLACE OF FATHER

(State or Country)

Kentucky

12. MAIDEN NAME OF MOTHER

Amanda

13. BIRTHPLACE OF MOTHER

(State or Country)

Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Rep. S. Sylvester
Nathaniel

(Address)

15.

Filed

May 22, 1922 h. W. Drennan
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 7 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 27, 1920 to April 7, 1922
that I last saw him alive on March 30, 1922
and that death occurred on the date stated above, at 1.30 M.

The CAUSE OF DEATH* was as follows:

General Paralysis following
stroke of apoplexy and
hemiplegia(Duration) 2 Yrs. 2 mos. 15 ds.Contributory General Atrophic Paralysis
(Secondary)(Duration) about 5 yrs. 0 mos. 0 ds.(Signed) Frank Stenzel, M. D.4/8, 1922 (Address) Nathaniel, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Nathaniel, Idaho

DATE OF BURIAL

4/9, 1922

20. UNDERTAKER

E. L. Cassidy

ADDRESS

Nathaniel

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **37850**
Registered No. **120**

1. PLACE OF DEATH

County of **Ada** Registration District No. **2**
City of **Boise** Primary Registration District No. **1004**
(No. **1114**, N. **13**, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

George Andrew Brown

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX **M** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Widower**
(Write the word.)

6. DATE OF BIRTH

July 29 18**44**
(Month) (Day) (Year)

7. AGE

77 Yrs. **9** Mos. **18** ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Retired

9. BIRTHPLACE

(State or Country)

Indiana

10. NAME OF FATHER

Brown

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

L. W. Thacker

(Address)

1114 A-13 Boise, Ida

15.

Filed **5-18** 19**22**

R. L. Chaff
Local Registrar

16. DATE OF DEATH

May 17 19**22**
(Month) (Day) (Year)

17. I HEREBY CERTIFY That I attended deceased from **Jan** 19**17**, to **May 17** 19**22**
that I last saw him alive on **May 15** 19**22**
and that death occurred on the date stated above, at **8:10** M.

The CAUSE OF DEATH* was as follows:

Multiple Spinal Sclerosis

(Duration) **10** Yrs. mos. ds.

Contributory (Secondary) **Respiratory Paralysis**

(Duration) yrs. mos. ds.

(Signed) **J. M. Brattan** M. D.

May 18 1922 (Address) **Empire B. Boise Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Memorial Trust Cemetery **May 18 1922**

20. UNDERTAKER

ADDRESS

Summers & Krb. **Boise Ida**

Bureau of Vital Statistics
CERTIFICATE OF DEATH

1. PLACE OF DEATH Adm BUREAU Registration District No. 1004
 County of Boise Primary Registration District No. 1004
 City of Boise (No. 1206 Lincoln Ave. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary Eva Roland.

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 37851
 Registered No. 122

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F. 4. COLOR OR RACE White. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married.

6. DATE OF BIRTH

Mar 3 1878
 (Month) (Day) (Year)

7. AGE

14 Yrs. 2 Mos. 15 ds.

IF LESS than 1 day
 how many..... hrs.
 or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

At Home.

9. BIRTHPLACE

(State or Country)

Idaho.

10. NAME OF FATHER

Samuel Irton.

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio.

12. MAIDEN NAME OF MOTHER

Mary Davis.

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Henry E. Roland

(Address)

15.

Filed 5-19 1922 R. H. Pratt
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 18 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 1908 to May 18th 1922
 that I last saw h. u. alive on May 15 1922
 and that death occurred on the date stated above, at 2:15 P. M.

The CAUSE OF DEATH* was as follows:

Obsecur of Liver - following
adhesive syngon of
gall bladder

(Duration) Yrs. mos. ds.

Contributory
 (Secondary)

Gall stones.

many years yrs. mos. ds.

(Signed)

W. H. Bank M. D.

May 18 1922 (Address) Boise Id.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Morris Hill Cem.

DATE OF BURIAL

May 14 1922

20. UNDERTAKER

Summers & Sells.

ADDRESS

Boise Id.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **37852**
Registered No. **129**

1. PLACE OF DEATH

County of **Ada** Registration District No. **2**
City of **Boise** Primary Registration District No. **1004**
(Not **S 110 East Broadway** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Alexander G. Stocker

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male White Married
(Write the word.)

6. DATE OF BIRTH

Aug 10 1865
(Month) (Day) (Year)

7. AGE

56 Yrs. **9** Mos. **20** ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

Miner

9. BIRTHPLACE

(State or Country)

Iud

10. NAME OF FATHER

John Stocker

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Jennet Graham

13. BIRTHPLACE OF MOTHER

(State or Country)

Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John Davidson

(Address)

Molokai Ida

15.

Filed **5-31** 19 **22**

T. H. Hart
Local Registrar

MEDICAL CERTIFICATE OF DEATH

19

16. DATE OF DEATH

May 30 1922
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from **May 23 1922** to **May 30 1922**

that I last saw him alive on **19**
and that death occurred on the date stated above, at **5 P.M.**

The CAUSE OF DEATH* was as follows:

Dilatation of heart following pneumonia and a respiratory condition from 2 or 3 pneumoniae.
(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

5-31 1922 (Address) **Boise Ida**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Davidson Rayd Glen 6/2 1922

20. UNDERTAKER **Green & Sons** ADDRESS **Schreiber & Vidensfaden Boise Ida**

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **37853**Registered No. **127**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Ada
City of BoiseRegistration District No. 2Primary Registration District No. 1004(No. Idaho Soldiers Home St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Richard L. Ball

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH

1846

(Month)

(Day)

(Year)

7. AGE

76 Yrs. — Mos. — ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

Liver War Veteran

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Wm. Bratney
Boise, Idaho.

15.

Filed 5-27 1922P. I. Ratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 26 - 1922
5/21 (Month) 26 (Day) 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

5/21 1922 to 5/26 1922that I last saw him alive on 5/26 1922and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Senility
(Duration) Yrs. mos. ds.Contributory
(Secondary)(Duration) yrs. mos. ds.

(Signed)

5/27/22 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery5/28/22

20. UNDERTAKER

ADDRESS

Wm. BratneyBoise Idaho.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **37854**
Registered No. **126**

1. PLACE OF DEATH

County of *Ada*
City of *Boise*

Registration District No. *2*Primary Registration District No. *1004*(No. *St. Alphonsus Hospital*)

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Burton W. Renfro.

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

*White.*5. SINGLE, MARRIED, WID-
OWED OR DIVORCED*Single* (write the word.)

6. DATE OF BIRTH

July 5 1902
(Month) (Day) (Year)

7. AGE

18 Yrs. 10 Mos. 20 ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)*Laborer*

9. BIRTHPLACE

(State or Country)

*Kansas.*10. NAME OF
FATHER*Unknown.*11. BIRTHPLACE
OF FATHER

(State or Country)

*Unknown.*12. MAIDEN NAME
OF MOTHER*Unknown*13. BIRTHPLACE
OF MOTHER

(State or Country)

Unknown.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Harry Stebb.

(Address)

Boise Idaho

15.

Filed *5-27* 19*22*

P. H. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

181

16. DATE OF DEATH

May 25 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 23 1922 to *May 25 1922*

that I last saw him alive on *May 25 1922*

and that death occurred on the date stated above, at *4:35 P.M.*

The CAUSE OF DEATH* was as follows:

*Burns by high power
electric wires (2200 volts)*

(Duration) Yrs. mos. *2* ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

L. P. McCalla M. D.

5/27/1922 (Address) *Boise Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Fort Morgan Colo.

DATE OF BURIAL

19

20. UNDERTAKER

Sumner Stebb.

ADDRESS

Boise, Ida.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

Registration District No. 2
 County of Ada Primary Registration District No. 1004
 City of Boise (No. 410 State State St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Virgil Grimaud

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 37855
 Registered No. 125

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male White Single

6. DATE OF BIRTH

(Month) (Day) (Year)

1848

7. AGE

74 Yrs. Mos. ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Tailor

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

France

10. NAME OF FATHER

Not obtainable

11. BIRTHPLACE OF FATHER

(State or Country)

France

12. MAIDEN NAME OF MOTHER

Not obtainable

13. BIRTHPLACE OF MOTHER

(State or Country)

France

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. O. Witte

(Address)

111 N. 8th

15.

Filed 5-26 1922

R. L. Pratt

Local Registrar

MEDICAL CERTIFICATE OF DEATH

113

16. DATE OF DEATH

May 21st 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 7th 1922 to May 20th 1922 that I last saw him alive on May 20th 1922 and that death occurred on the date stated above, at 2 A.M.

The CAUSE OF DEATH* was as follows:

Cirrhosis of liver -

(Duration) about 5 Yrs. mos. ds.

Contributory (Secondary)

senility -

(Duration) yrs. mos. ds.

(Signed)

B. W. Mather M. D.

5/23 1922 (Address) 310 - Garfield Bldg. Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

St. Johns Cemetery 5/27 1922

20. UNDERTAKER

ADDRESS

Schrieber Widenfaden

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH **RECEIVED**
 County of Ada JUN 2 - 1922
 City of Boise BUREAU OF VITAL STATISTICS
 Registration District No. 1004
 Primary Registration District No. 136
 (No. Boise St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Sinda Means

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 37856Registered No. 124

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widow
 (Write the word.)

6. DATE OF BIRTH

March 12 1845
 (Month) (Day) (Year)

7. AGE

77

Yrs. Mos. ds.

IF LESS than 1 day
 how many hrs.
 or min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

Retired
Homemaker

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

Jefferson Bixlar

11. BIRTHPLACE OF FATHER

(State or Country)

Am.

12. MAIDEN NAME OF MOTHER

Not attainable

13. BIRTHPLACE OF MOTHER

(State or Country)

Am.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Bert Means

(Address)

Boise Ida

15.

Filed 5-26 1922

R. H. Roth

Local Registrar

CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

120

16. DATE OF DEATH

May 26 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 2 1922 to May 26 1922

that I last saw h. alive on May 26 1922

and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Nephritis

(Duration) Yrs. mos. ds.

Contributory
 (Secondary)

(Duration) yrs. mos. ds.

(Signed) Geo. Menonay M. D.

1922 (Address) Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Morris Hill Cemetery 5/27 1922

20. UNDERTAKER

ADDRESS

Schubert & Sons Boise

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH *Adair*
 County of *Boise*
 City of *Boise*
 Registration District No. *776*
 Primary Registration District No. *1004*
 (No. *776* *Main* St.)

File No. **37857**
 Registered No. *127*

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Helen Alexander

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *F.* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*
(Write the word.)

6. DATE OF BIRTH

Apr 9 - 1922
 (Month) (Day) (Year)

7. AGE

1 Yrs. *51* Mos. *51* ds.

IF LESS than 1 day
 how many..... hrs.
 or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

none

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Nick Alexander

11. BIRTHPLACE OF FATHER

(State or Country)

Greece

12. MAIDEN NAME OF MOTHER

Joy Mastore

13. BIRTHPLACE OF MOTHER

(State or Country)

Greece

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Nick Alexander

(Address)

776 Main St.

15.

Filed *5-31* *1922**R. H. Rott*

Local Registrar

16. DATE OF DEATH

May 30 *1922*
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *May 28th 1922* to *May 30th 1922*
 that I last saw him alive on *May 29th 1922*
 and that death occurred on the date stated above, at *7 A. M.*

The CAUSE OF DEATH* was as follows:

Intussusception

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

5-31-22

(Address)

Boise Id.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Morris Hill Cem.

DATE OF BURIAL

May 30 1922

20. UNDERTAKER

Summers & Krebs

ADDRESS

Boise Id.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada Registration District No. 2
City of Boise Primary Registration District No. 1004
(No. St Luke Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Harvey PothoffFile No. 37858-1
Registered No. 37858-1

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male White Single
(Write the word.)

6. DATE OF BIRTH

Don't know 1856
(Month) (Day) (Year)

7. AGE

66 Yrs. — Mos. — ds.
IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Indiana

10. NAME OF FATHER

Don't know

11. BIRTHPLACE OF FATHER

(State or Country) Don't know

12. MAIDEN NAME OF MOTHER

Don't know

13. BIRTHPLACE OF MOTHER

(State or Country) Don't know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. P. Davies
(Address) Grandview Idaho

15.

Filed 5-19 1922 P. H. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 18 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 17 1922 to May 18 1922
that I last saw him alive on May 17 1922
and that death occurred on the date stated above, at 6:45 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Oesophagus(Duration) Yrs. mos. ds.
Contributory (Secondary) Respiratory failure(Duration) yrs. mos. ds.
(Signed) J. M. Braxton M. D.May 18 1922 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Morris Hill Cemetery

DATE OF BURIAL

May 18 1922

20. UNDERTAKER

Summers & Sons

ADDRESS

Boise Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada Registration District No. 2
City of Bosse Primary Registration District No. 1004
(No. 1712, W. 8 st St.)

If death occurs away from usual residence, give facts called for under special information.

File No. 37859
Registered No. 119

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Mary J. T. Berry

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widow
(Write the word.)6. DATE OF BIRTH Jan 24, 1862
(Month) (Day) (Year)7. AGE 39 Yrs. 3 Mos. 19 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)At Home

9. BIRTHPLACE

(State or Country)

Illinois

10. NAME OF FATHER

Geo. V. Lader

11. BIRTHPLACE OF FATHER

(State or Country)

Illinois New York

12. MAIDEN NAME OF MOTHER

Aline Brunson

13. BIRTHPLACE OF MOTHER

(State or Country)

New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

1712 W. 8th St. Boise

15.

Filed 5-15 1922 P. H. Rath

Local Registrar

16. DATE OF DEATH

May 13, 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Apr 27, 1922 to May 13, 1922 that I last saw him alive on 12th 1922 and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

Myocarditis(Duration) Yrs. mos. ds.
Contributory (Secondary) Influenza

(Duration) yrs. mos. ds.

(Signed) J. B. Smith M.D.(Address) Boise, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hagerman Idaho

19

20. UNDERTAKER

ADDRESS

Sumner & Co.Boise Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada Registration District No. 2
City of Boise Primary Registration District No. 1004
City of Boise (310 East Bannock, St.)

If death occurs away from usual residence, give facts called for under special information.

BUREAU OF VITAL

STATISTICS

2. FULL NAME

Margaret W. Anderson.File No. 37860
Registered No. 118

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widow

6. DATE OF BIRTH

Aug 29 1851
(Month) (Day) (Year)

7. AGE

70 Yrs. 8 Mos. 10 ds.IF LESS than 1 day
how many..... hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)at home

9. BIRTHPLACE

(State or Country)

Sweden

10. NAME OF FATHER

Johnson

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Thos C. E. Johnson

(Address)

1310 E Bannock

15.

Filed 5-11 1922O. H. Rath
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 9 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from May 1 1922 to May 8 1922that I last saw him alive on May 8 1922
and that death occurred on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:

Coronary Arteriosclerosis

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Chas. V. Gurney M. D.5/10 1922 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Morris Hill Cemetery

DATE OF BURIAL

May 12 1922

20. UNDERTAKER

Summers & Sons

ADDRESS

Boise Idaho

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Ada
City of Boise

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED
JUN 2 1922

CERTIFICATE OF DEATH

Registration District No. 2
Primary Registration District No. 1004
(No. 110 E 3rd St.)State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 37864
Registered No. 117

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)6. DATE OF BIRTH July 18 1887
(Month) (Day) (Year)7. AGE 34 Yrs. 9 Mos. 22 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).at Home

9. BIRTHPLACE

(State or Country)

Boise Idaho

10. NAME OF FATHER

William A Roice

11. BIRTHPLACE OF FATHER

(State or Country)

Kansas

12. MAIDEN NAME OF MOTHER

Matthi Epperson

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Albert Slater
(Address) 2018 N 16 St Boise Ids15. Filed 5-11 1922 R. L. Pratt
Local Registrar

16. DATE OF DEATH

5 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from 5/7 1922 to 5/10 1922 that I last saw her alive on 5/9 1922 and that death occurred on the date stated above, at 3:00 AM.
The CAUSE OF DEATH* was as follows:Acute Yellow Atrophy Liver
cholelithiasis

(Duration) Yrs. mos. ds.

Contributory (Secondary) Influenza

(Duration) yrs. mos. ds.

(Signed) Fred A. Tuttle M. D.5/10 1922 (Address) Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Morris Hill Cemetery DATE OF BURIAL May 12 192220. UNDERTAKER Quinn & Thorne ADDRESS Boise Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
37862
File No.
Registered No. 115

1. PLACE OF DEATH

County of Ada Registration District No. 7
City of Boise Primary Registration District No. 1004
(No. 410 State St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Julia Bilboa

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female White Single
(Write the name)

6. DATE OF BIRTH

Mar 17 - 1917
(Month) (Day) (Year)

7. AGE

5 Yrs. 2 Mos. 10 ds.
IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

none

9. BIRTHPLACE

(State or Country)

Boise, Idaho

10. NAME OF FATHER

Besento Bilboa

11. BIRTHPLACE OF FATHER

(State or Country)

Spain

12. MAIDEN NAME OF MOTHER

Ursula Arguinaga

13. BIRTHPLACE OF MOTHER

(State or Country)

Spain,

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Besento Bilboa
(Address) Barber, Idaho.

15.

Filed 5-8 1922 R. H. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 7 - 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 5 - 1922 to May 7 - 1922
that I last saw her alive on May 7 - 1922
and that death occurred on the date stated above, at 5 P.M.
The CAUSE OF DEATH* was as follows:

First degree burn

(Duration) Yrs. mos. 2 ds.
Contributory (Secondary) Toxemia

(Duration) yrs. mos. 1 ds.
(Signed) R. L. McCalla M. D.

5-8-1922 (Address) Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.
Where was disease contracted if not at place of death?
Former or usual residence Barber, Idaho.

19. PLACE OF BURIAL OR REMOVAL

St Johns Cemetery

DATE OF BURIAL

5/9 1922

20. UNDERTAKER

Schreiber & Hidenfaden

ADDRESS

Boise, Ida

Dr. McCalla

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 2
County of Ada
City of Baise
Primary Registration District No. 1004
(No. St. Alphonsus Hospital St.)File No. 37863
Registered No. 176

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Hattie E. Rayment

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Married
(Write the word.)6. DATE OF BIRTH May 18-1857
(Month) (Day) (Year)7. AGE 64 Yrs. 11 Mos. 20 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Housewife

9. BIRTHPLACE

(State or Country)

Canada

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

Stephen FergusonCanada

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Lydia ColeNew York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

W. McBratney
Baise Idaho

15.

Filed 5-10-1922 R. H. Pratt
Local Registrar

16. DATE OF DEATH

May 8-1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 8th 1922 to 19
that I last saw h. or alive on May 8th 1922
and that death occurred on the date stated above, at 5:50 P. M.

The CAUSE OF DEATH* was as follows:

Burns - 2nd & 3rd degrees - covering the whole of body & kept face -
(Duration) Yrs. mos. ds.Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

5/10/22 Brown M. D.
(Address) Baise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery 5/10 1922

20. UNDERTAKER

ADDRESS

W. McBratney Baise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED
JUN 2 - 1922

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **37864**

1. PLACE OF DEATH
County of Ada Registration District No. 1004
City of Boise (No. 110 & Baincock St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Ettles

Registered No. 114
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH April 11th 1893
(Month) (Day) (Year)

7. AGE 29 Yrs. 19 Mos. 19 ds.
IF LESS than 1 day how many..... hrs. or..... min.?

8. OCCUPATION Rancher
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE Scotland.
(State or Country)

10. NAME OF FATHER Alexander Ettles.

11. BIRTHPLACE OF FATHER Scotland
(State or Country)

12. MAIDEN NAME OF MOTHER Georgine Brown

13. BIRTHPLACE OF MOTHER Scotland.
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jas B Thomson
(Address) Boise

15. Filled 5-2-22 19 22 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 1st 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 24 1922 to May 1st 1922
that I last saw him alive on May 1st 1922
and that death occurred on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:
Intestinal Glanders following Tuberculosis.

(Duration) Yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Hubert M. D.
5-2-22 (Address) Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence Mayfield, Idaho

19. PLACE OF BURIAL OR REMOVAL Mountain Hill Cemetery DATE OF BURIAL May 4 1922

20. UNDERTAKER Schubert & Son ADDRESS Boise

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics1. PLACE OF DEATH **RECEIVED**

Registration District No. 7
 County of Ada JUN 2 - 1922
 Primary Registration District No. 1004
 City of Boise BUREAU OF VITAL STATISTICS 410 State Idaho St.)

 File No. 37865
 Registered No. 123

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Lawery

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH 62
 3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED single
 (Write the word.)

 6. DATE OF BIRTH Nov 10 1890
 (Month) (Day) (Year)

 7. AGE 31 Yrs. 5 Mos. 12 ds. IF LESS than 1 day
 how many hrs. or min.?

8. OCCUPATION

 (a) Trade, profession or particular kind of work. Salesman
 (b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

 (State or Country) Leadville Colo

10. NAME OF FATHER

John Lawery

11. BIRTHPLACE OF FATHER

 (State or Country) Ireland

12. MAIDEN NAME OF MOTHER

Mary Kehoe

13. BIRTHPLACE OF MOTHER

 (State or Country) Kennville Ky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

 (Informant) Q. T. Cuyler
 (Address) Boise

 15. Filed 5-22-1922 Q. H. Pratt
 Local Registrar

16. DATE OF DEATH

May 22 1922
 (Month) (Day) (Year)

 17. I HEREBY CERTIFY, That I attended deceased from Oct 1st 1921 to May 22 1922
 that I last saw him alive on May 22 1922
 and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Recomotor stopped

 (Duration) 5 yrs. 5 mos. 5 ds.
 Contributory (Secondary) Syphilis

 (Duration) 15 yrs. 5 mos. 5 ds.
 (Signed) M. H. Tellman M. D.

5/23/22 (Address) Boise, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

 19. PLACE OF BURIAL OR REMOVAL St John's Cemetery DATE OF BURIAL 5/23/1922

 20. UNDERTAKER Schmidt & Widengrad ADDRESS Boise

FORM V. S. No. 5-A—25 M. 1-19.

1. PLACE OF DEATH

County of Ada Registration District No. _____
 City of Meridian Registration District No. 11
 (No. _____) (St. _____)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lura Fessie Hudson

CERTIFICATE OF DEATH

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 37866

Registered No. 11

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Divorced
 (Write the word.)

6. DATE OF BIRTH

September - 29 - 1897
 (Month) (Day) (Year)

7. AGE

24 Yrs. 6 Mos. 12 ds. IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

Housekeeper

9. BIRTHPLACE

(State or Country) Grane, Stone Co. Mo.

10. NAME OF FATHER

James Oliver Hudson

11. BIRTHPLACE OF FATHER

(State or Country) Bonne Co. Ark.

12. MAIDEN NAME OF MOTHER

Dovie Thomas

13. BIRTHPLACE OF MOTHER

(State or Country) Bonne Co. Ark.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dovie Thomas
 (Address) Meridian Idaho

15.

Filed _____ 19 _____

H.F. Neal
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 10 - 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan - 20 - 1922 to April - 10 - 1922
 that I last saw her alive on Jan - 20 - 1922
 and that death occurred on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:

General Tuberculosis and Pulmonary Cavities

(Duration) 1 Yrs. 10 mos. 10 ds.

Contributory Yes
 (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) C. L. Dutton M. D.

4/10 1922 (Address) Overland Bld Bldg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Meridian

DATE OF BURIAL

April 12 - 1922

20. UNDERTAKER

W. M. Mutton Meridian Idaho

ADDRESS

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Ada Registration District No.
 City of Meridian Primary Registration District No.
 St.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William L. Day

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 37867
 Registered No. 37867

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widower
 (Write the word.)

6. DATE OF BIRTH

Nov 17 1940
 (Month) (Day) (Year)

7. AGE

81 Yrs. 5 Mos. 15 ds.

IF LESS than 1 day
 how many..... hrs.
 or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

None

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Halifax - Nova Scotia

10. NAME OF FATHER

George Day

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Mary E. Hughes

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Leona Beach

(Address)

Meridian Idaho

15.

Filed

19

H. F. Neal

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 15 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Apr. 12 1922, to Apr. 15 1922

that I last saw him alive on Apr. 15 1922

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Bronchitis Pneumonia
& Scurvy

(Duration) Yrs. mos. 3 ds.

Contributory
 (Secondary)

(Duration) yrs. mos. ds.

(Signed)

H. F. Neal

M. D.

4-16-1922

(Address) Meridian Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Meridian Cemetery

DATE OF BURIAL

Apr 16 1922

20. UNDERTAKER

W. B. Smith

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada
City of BoiseRegistration District No. 8
Primary Registration District No. 2908
(No. near Kinder Station St.)File No. 37868
Registered No. 78

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lena Wise Heffner.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F. 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH

Aug 17th 1879
(Month) (Day) (Year)

7. AGE

42 Yrs. 9 Mos. 28 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Housekeeper

9. BIRTHPLACE

(State or Country)

Wyatt Co., Illinois

10. NAME OF FATHER

J. N. Overley

11. BIRTHPLACE OF FATHER

(State or Country)

Ind

12. MAIDEN NAME OF MOTHER

Sabra Warfield

13. BIRTHPLACE OF MOTHER

(State or Country)

Ills.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Albert Heffner

(Address)

Boise, Idaho

15.

Filed 5-15 1922R. H. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 14th 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from May 13 1922 to May 14 1922
that I last saw her alive on May 13 1922
and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(Duration) 5 Yrs. mos. ds.

Contributory (Secondary)

Influenza

(Duration) yrs. mos. ds.

(Signed)

Albert F. Neal

M. D.

5-14-1922 (Address) Murdan, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Idaho Falls, Idaho

DATE OF BURIAL

5/16 1922

20. UNDERTAKER

Schreiber & Sidenfaden

ADDRESS

Boise, IdahoDr. H. F. Neal Murdan, Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada
City of _____

Registration District No. _____

Primary Registration District No. _____

(No. 3 1/2 mile West of Boise)

File No. _____

Registered No. 37869

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Thomas G. Maxwell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

M white married
(Write the word.)

6. DATE OF BIRTH

Dec 29 - 1869
(Month) (Day) (Year)

7. AGE

32 Yrs. 4 Mos. 19 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Farmer

9. BIRTHPLACE

(State or Country)

Indiana

10. NAME OF FATHER

A. Cyrus M. Maxwell

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Sarah Crockett

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE ARE TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wm. Ray Maxwell

(Address)

Boise R #1

15.

Filed 5-20 1922R. H. Paul
Local Registrar

MEDICAL CERTIFICATE OF DEATH

120

16. DATE OF DEATH

May 18 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 9 1922 to May 18 1922that I last saw him alive on May 18 1922and that death occurred on the date stated above, at 11:35 A.M.

The CAUSE OF DEATH* was as follows:

Bright's disease(Duration) 1 Yrs. mos. ds.Contributory
(Secondary)(Duration) yrs. mos. ds.

(Signed) _____ M. D.

19 (Address) W. L. Frazier

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Morris Tree Cemetery May 1922

20. UNDERTAKER

ADDRESS

Summers & Tuck Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada
City of Registration District No. 8-2018
Primary Registration District No. 3/4 mi east of Ustie
(No. St.)If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Columbus P. HaworthFile No.
Registered No. 37870If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m. 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Single (use word.)

6. DATE OF BIRTH

May 1 1887
(Month) (Day) (Year)

7. AGE

65 Yrs. - 27 Mos. 27 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work Merchant.
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country) Lower10. NAME OF
FATHER11. BIRTHPLACE
OF FATHER(State or Country) Indiana12. MAIDEN NAME
OF MOTHER13. BIRTHPLACE
OF MOTHER(State or Country) Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harry Scribs(Address) Boise Idaho.

15.

Filed 5-29 1922R. R. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 28 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
May 15 1922 to May 28 1922
that I last saw him alive on May 20 1922
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Rogers Yert
Spotted Fever
(Duration) Yrs. 12 mos. 12 ds.Contributory
(Secondary)(Duration) yrs. mos. ds.(Signed) E. L. Outton M. D.(Address) Cleveland Bldg. BoiseState the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)At place of death yrs. mos. days. In the State yrs. mos. days.Where was disease contracted
if not at place of death? Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Morris Hill Cemetery

DATE OF BURIAL

May 30 1922

20. UNDERTAKER

Sumner Scribs

ADDRESS

Boise Idaho.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada
City of PrimaRegistration District No. 8
Primary Registration District No. 2008
(No. 2 E of Prima St.)File No. 37871
Registered No. 46

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Albert Franklin King

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widower
(write the word.)

6. DATE OF BIRTH

Mar 20th 1853
(Month) (Day) (Year)

7. AGE

69 Yrs. 1 Mos. 18 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Farmer

9. BIRTHPLACE

(State or Country)

Beaver Co, Penn

10. NAME OF FATHER

Saml King.

11. BIRTHPLACE OF FATHER

(State or Country)

Penn

12. MAIDEN NAME OF MOTHER

Eliza Savers

13. BIRTHPLACE OF MOTHER

(State or Country)

Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Geo F Nelson

(Address)

Prima Idaho

15.

Filed

5-91922R. H. Pratt

Local Registrar

MEDICAL CERTIFICATE OF DEATH

79

16. DATE OF DEATH

May 8th 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

2-18 1922, to 5-8 1922,
that I last saw him alive on 5-7 1922,
and that death occurred on the date stated above, at 6:18 M.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) - Yrs. - mos. - ds.

Contributory
(Secondary)

(Duration) - yrs. - mos. - ds.

(Signed)

F J Coleman M. D.5-9-1922

(Address)

Prima Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

Prima Ada Co Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hall Cemetery5/11 1922

20. UNDERTAKER

ADDRESS

Schuster & HidenfeldPrima

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada
City of BoiseRegistration District No. 8
Primary Registration District No. 2058
(No. 4x Garden St.)File No. 37873
Registered No. 43

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Bell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

✓ 57a

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male White Single
(Write the word.)

6. DATE OF BIRTH

May 2nd 1922
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day
how many 4 hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).none

9. BIRTHPLACE

(State or Country)

Boise, Idaho

10. NAME OF FATHER

Oliver K. Bell

11. BIRTHPLACE OF FATHER

(State or Country)

Mo.

12. MAIDEN NAME OF MOTHER

Mabel E. Allen

13. BIRTHPLACE OF MOTHER

(State or Country)

Mont

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

O. K. Bell
Fol - 7th Ave So Tampa

15.

Filed

19 2

Local Registrar

16. DATE OF DEATH

May 2nd 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 2 1922 to May 2nd 1922
that I last saw him alive on May 2nd 1922
and that death occurred on the date stated above, at 11:30 M.

The CAUSE OF DEATH* was as follows:

Heart lesion due to premature birth - 7 1/2 months

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

May 2 1922 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Joplin Cemetery5/3 1922

20. UNDERTAKER

ADDRESS

Schreiber & Shidenfaden Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of AdaCity of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. Ada County Hospital St.)File No. 37873Registered No. 44

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Mrs Lavina Purcell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F.

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widow
(Write the word.)

6. DATE OF BIRTH

1838

(Month)

(Day)

(Year)

7. AGE

84

Yrs.

Mos.

ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).None.

9. BIRTHPLACE

(State or Country)

Tenn

10. NAME OF FATHER

Don't know

11. BIRTHPLACE OF FATHER

(State or Country)

?

12. MAIDEN NAME OF MOTHER

?

13. BIRTHPLACE OF MOTHER

(State or Country)

?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. McBratney

(Address)

Boise Idaho.

15.

Filed

5-61922R. H. Rath

Local Registrar

MEDICAL CERTIFICATE OF DEATH

81

16. DATE OF DEATH

May - 5 - 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan. 1920, to May 5 1922
that I last saw her alive on May 4 1922
and that death occurred on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis(Duration) 5 Yrs. mos. ds.Contributory
(Secondary)Cerebral Thrombosis

(Duration) yrs. mos. ds.

(Signed)

J. M. Braxton

M. D.

5/5 1922

(Address)

Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Baker One.

DATE OF BURIAL

5-7 1922

20. UNDERTAKER

W. McBratney

ADDRESS

Boise Idaho

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 8County of DouglasPrimary Registration District No. 2008File No. 37874near
City of Jordan ValleyCornman, Ralph Pleasant ValleyRegistered No. 45

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Alice Teresa Cornman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

July
(Month)3
(Day)1873
(Year)

7. AGE

48 yrs. 10 mos. 4 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Silver City

10. NAME OF FATHER

Patrick McMahon

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Jane Cochran

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Jos Cornman

(Address)

Jordan Valley

15.

May 9, 1922P. H. Pratt

Filed

May 7 1922W. J. Jones

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May 7 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 15 1921, to May 7 1922that I last saw her alive on May 7 1922and that death occurred on the date stated above, at 9:30 M.

The CAUSE OF DEATH* was as follows:

Heart disease. Mitral regurgitation with dropsy
(Duration) 5 yrs. mos. ds.Contributory
(Secondary)(Duration) yrs. mos. ds.(Signed) W. J. Jones M. D.19 (Address) Jordan Valley, Or

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence Pleasant Valley Oregon

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. John Cemetery5/10 1922

20. UNDERTAKER

W. J. Jones

ADDRESS

Home

RECEIVED
MAY 23 1922

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 37875

Registered No.

If death occurred in a hospital institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Bannock

City of Lund

Registration District No. 2161

BUREAU OF VITAL STATISTICS
Primary Registration District No. 84

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eric Magnus Heger

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widower

(Write the word.)

6. DATE OF BIRTH

Aug 19 1844

(Month)

(Day)

(Year)

7. AGE

77

Yrs.

Mos.

ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Farmer

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Sweden

10. NAME OF FATHER

Eric Andersen Heger

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME OF MOTHER

Anna Selberg

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed 5-1-22 19

W. J. Bach
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

4-30-22

(Month)

(Day)

19

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19

that I last saw him alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) Yrs. mos. ds.

Contributory age
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

19 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 37876
Registered No. 3832

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Bannock Registration District No. 28
City of Pocatello Primary Registration District No. 3161
(No. Lynn Bro Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Joe Monfredo

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male Italian Single
(Write the word.)

6. DATE OF BIRTH

March 1 1886
(Month) (Day) (Year)

7. AGE

36 Yrs. 1 Mos. 22 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)Laborer
Comptroller

9. BIRTHPLACE

(State or Country)

Italy

10. NAME OF FATHER

Dominio Monfredo

11. BIRTHPLACE OF FATHER

(State or Country)

Italy

12. MAIDEN NAME OF MOTHER

Christina Magina

13. BIRTHPLACE OF MOTHER

(State or Country)

Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Jack Monfredo
529 - 9th St

15.

Filed

4/25 1922

Local Registrar

16. DATE OF DEATH

April 23 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

ap 1st 1922 to ap 23 1922
that I last saw him alive on ap 23 - 1922
and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

intercoster of left
Kidney & Syphilis

(Duration) 2 Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Dr. Lynn M. D.

(Address) Pocatello Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mountain View Cem

4/26 1922

20. UNDERTAKER

ADDRESS

Shumaker Hall

Pocatello

RECEIVED
CERTIFICATE OF DEATH.State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Bannock
City of PocatelloIf death occurs away from
usual residence, give facts
called for under special
information.

2. FULL NAME

Buhichi KayamaFile No. 37897Registered No. 3830If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

6. DATE OF BIRTH.

7. AGE

8. OCCUPATION

(a) Trade, profession or
particular kind of work...
(b) General nature of in-
dustry, business, or estab-
lishment in which employ-
ed (or employer).....

9. BIRTHPLACE

(State or Country)

10. NAME OF
FATHER11. BIRTHPLACE
OF FATHER

(State or Country)

12. MAIDEN NAME
OF MOTHER13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15.

Filed

Apr 22 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) M. D.

(Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death.....yrs.....mos. 14 days In the State.....yrs.....mos. 14 days

Where was disease contracted
if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS
should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement
of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock
City of PocatelloRegistration District No. 28Primary Registration District No. 3161(No. 31. M. 4th ave St.)File No. 50Registered No. 38879

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Renaldo Oreguiza

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Male Mexican

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

April 14 1922
(Month) (Day) (Year)

7. AGE

5 Yrs. 5 Mos. 5 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)none

9. BIRTHPLACE

(State or Country)

Pocatello, Idaho

10. NAME OF FATHER

John Oreguiza

11. BIRTHPLACE OF FATHER

(State or Country)

Mexico

12. MAIDEN NAME OF MOTHER

Janie Strodo

13. BIRTHPLACE OF MOTHER

(State or Country)

Mexico

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John Oreguiza

(Address)

Pocatello, Idaho

15.

Filed April 20 1922

Local Registrar

16. DATE OF DEATH

April 20 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

4-18 1922 to 4-19 1922that I last saw him alive on 4-19 1922and that death occurred on the date stated above, at 2 M.

The CAUSE OF DEATH* was as follows:

Septic infection liver and gall bladder resulting in infection due to infection cord.(Duration) Yrs. mos. 4 ds.Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

D. L. Ray

M. D.

4/20 1922 (Address) Pocatello, Id.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Life in Pocat.

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mt. View Cem. Pocatello Apr 21 1922

20. UNDERTAKER

ADDRESS

McKhan Undertaking Co. H. L. McKhan

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No.

Registration District No.

(No.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

to

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bannock Registration District No. 28
 City of Pocatello Primary Registration District No. 21617
General Hospital (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant Roan (Em)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 37880
Registered No. 5806

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
 (Write the word.)

6. DATE OF BIRTH

Mar 31 1922
 (Month) (Day) (Year)

7. AGE

Premature Birth IF LESS than 1 day
 how many 9 hrs.
 Yrs. Mos. ds. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Thomas B Roan

11. BIRTHPLACE OF FATHER

(State or Country)

Ala

12. MAIDEN NAME OF MOTHER

Minella Logan

13. BIRTHPLACE OF MOTHER

(State or Country)

Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thomas B Roan
 (Address) 310 S. Arthur

15.

Filed 4/1 1922

J. Young
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 31 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 31 1922 to March 31 1922
 that I last saw him alive on Mar 31 1922
 and that death occurred on the date stated above, at 11:30 M.
 The CAUSE OF DEATH* was as follows:
Premature birth.

(Duration) Yrs. mos. ds.

Contributory
 (Secondary)

(Duration) yrs. mos. ds.

(Signed) Carl W Clark M. D.

Mar 31 1922 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mountain View Apr 2 1922

20. UNDERTAKER

ADDRESS

Chunnam Gray City

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bannock Registration District No. 28
 City of Pocatello Primary Registration District No. A161
 (No. 318 M. 4th St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Leon Jules Rabail

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 49,3007
Registered No. 33007

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male white Single (Write the word)

6. DATE OF BIRTH

Mar 31 1922
(Month) (Day) (Year)

7. AGE

Yrs. 4 Mos. 2 ds. IF LESS than 1 day
how many 4 hrs.
or 4 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

none

9. BIRTHPLACE

(State or Country)

Pocatello Id

10. NAME OF FATHER

August Rabail

11. BIRTHPLACE OF FATHER

(State or Country)

France

12. MAIDEN NAME OF MOTHER

Agathe Blanchard

13. BIRTHPLACE OF MOTHER

(State or Country)

France

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) August Rabail
(Address) Pocatello, Idaho

15.

Filed Apr 1 1922 Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH

151-8

16. DATE OF DEATH

Mar 31 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 31 1922 to Mar 31 1922
that I last saw him alive on Mar 31 1922
and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Patulous Foramen Ovale

(Duration) Yrs. 1 mos. 1 ds.

Contributory (Secondary)

None

(Duration) yrs. 1 mos. 1 ds.

(Signed)

W. N. Madden M. D.

4/1 1922 (Address) Pocatello Id

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. 1 mos. 1 days. In the State yrs. 1 mos. 1 days

Where was disease contracted if not at place of death?

Former or usual residence Born in Pocatello

19. PLACE OF BURIAL OR REMOVAL

Mt View Cem.

DATE OF BURIAL

Apr 1 1922

20. UNDERTAKER

McHann and Co.

ADDRESS

Pocatello Idaho

H. L. McHann

CERTIFICATE OF DEATH

1. PLACE OF DEATH

Registration District No. 28
 County of Bannock Primary Registration District No. 2161
 City of Pocatello (No. 1016 - No. 8th) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

George Holmes

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 587883

Registered No. 5810

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
 (Write the word.)

6. DATE OF BIRTH

October 6 1927
 (Month) (Day) (Year)

7. AGE

64 Yrs. 5 Mos. 24 ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

Retired

9. BIRTHPLACE

(State or Country)

Louth England

10. NAME OF FATHER

Geo Richard Holmes

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Sarah Scott

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Louis D Holmes
 (Address) 1016 - 7th St

15.

Filed

4/1 1927

J. Young
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 30 1927
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 10, 1919 to Mar 30, 1927
 that I last saw him alive on Mar 30, 1927
 and that death occurred on the date stated above, at 11 a.m.
 The CAUSE OF DEATH* was as follows:
Diabetes mellitus.

(Duration) 5 Yrs. mos. ds.

Contributory
 (Secondary)

(Duration) Yrs. mos. ds.

(Signed) J. Young M. D.

4/1, 1927 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Mountain View Cem Apr 2, 1927

20. UNDERTAKER

ADDRESS

Schumacher's Hall Pocatello

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **37884**
Registered No. **3811**

1. PLACE OF DEATH **Hamock** Registration District No. **28**
County of **Pocatello** Primary Registration District No. **2101**
City of **Pocatello** (No. **128** No. **14** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Elizabeth D. Bair

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Widow**
(Write the word)

6. DATE OF BIRTH **April 21 1856**
(Month) (Day) (Year)

7. AGE **65** Yrs. **11** Mos. **10** ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

None

9. BIRTHPLACE **Detroit Ohio**
(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) **Albessa Bair**
(Address) **Pocatello**

15. Filed **4/3** 19 **22**
Local Registrar

16. DATE OF DEATH **April 2** 19 **22**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Mar 15 1922** to **Mar 26 1922** that I last saw her alive on **Mar 26 1922** and that death occurred on the date stated above, at **5:30** P. M.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) Yrs. mos. **18** ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) **W. W. Brothers** M. D.

4/3 1922 (Address) **Pocatello, Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

St. Lawrence Cemetery **4/5** 19 **22**

20. UNDERTAKER ADDRESS

W. W. Brothers **Pocatello**

RECEIVED
MAY 28 1922

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County

City

Registration District No.

Bureau of Vital Statistics

(No.)

Registration District No.

28

File No.

Registered No.

If death occurred in a hospital, institution or camp, give name instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

4/3 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 1 1922

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb. 18 1922 to April 1 1922

that I last saw him alive on Apr 1 1922

and that death occurred on the date stated above, at 10¹⁰ M.

The CAUSE OF DEATH* was as follows:

Rabies

(Duration) Yrs 1 mos 9 ds.

Contributory (Secondary)

(Duration) mos ds.

(Signed)

4/3 1922 (Address) J. P. Bocala

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs mos days In the State yrs mos days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mountain View

Apr 4 1922

20. UNDERTAKER

ADDRESS

Schumacher & Son

JAMES R. YOUNG, M.D., F.A.C.S.
POCATELLO, IDAHO

September 12, 1934

To Whom It May Concern:

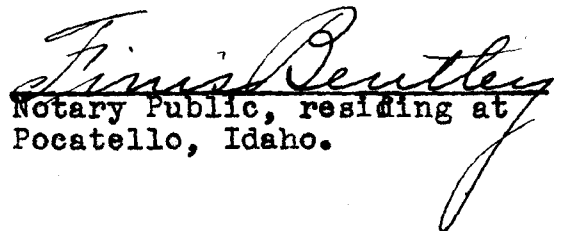
This is to certify that I was acquainted with Mr. Giuseppe Nicola Busco and his wife Mrs. Teresa Busco and that they were my patients for many years and that I attended Mr. Busco at the time of his death. On examining the death certificate I find a mistake in the name of the informant, which should be Mrs. Teresa Busco instead of Mrs. Luisa Busco, and this mistake should be rectified.

Signed:



JRY:EM

Subscribed and sworn to before me the undersigned
Notary Public this 12th day of September, 1934.



Notary Public, residing at
Pocatello, Idaho.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bannock
City of PocatelloRegistration District No. 28Primary Registration District No. 2461
(No. Lynn Bros Hospital St.)State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 37886Registered No. 3813

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lavonne Royal Ruff

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Infant
(Write the word.)

6. DATE OF BIRTH

June 16 1921
(Month) (Day) (Year)

7. AGE

9 Yrs. 17 Mos. 17 ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Infant

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Pocatello Ida.

10. NAME OF FATHER

Roy A Ruff

11. BIRTHPLACE OF FATHER

(State or Country)

Granville Utah

12. MAIDEN NAME OF MOTHER

Lavonne Warren

13. BIRTHPLACE OF MOTHER

(State or Country)

Mapleton Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Roy A Ruff

(Address)

Pocatello Ida

15.

Filed

7/41922J. Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 2 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar 31 1922 to Apr 2 1922that I last saw him alive on Apr 2 1922and that death occurred on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:

appendicitis
intussusception(Duration) Yrs. mos. 3 ds.

Contributory operation

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Dr. Lynn M. D.(Address) Pocatello Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mountain View Cem Apr 4 1922

20. UNDERTAKER

ADDRESS

Schumacher & Hall Pocatello

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **37887**
Registered No. **3814**

1. PLACE OF DEATH

Registration District No. **28**
County of **Bannock** Primary Registration District No. **2141**
City of **Pocatello** (No. **549, So. Main** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Laisadell Williams

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female white (Write the word.)

6. DATE OF BIRTH

March 19 1921
(Month) (Day) (Year)

7. AGE

1 Yrs. **23** Mos. **23** ds.
IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

none

9. BIRTHPLACE

(State or Country) **Pocatello, Idaho.**

10. NAME OF FATHER

William W. Williams

11. BIRTHPLACE OF FATHER

(State or Country) **Mosco, Idaho.**

12. MAIDEN NAME OF MOTHER

Beulah L. Carr

13. BIRTHPLACE OF MOTHER

(State or Country) **New Mexico**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Wm. W. Williams**
(Address) **Pocatello, Idaho.**

15.

Filed **April 5 1922**, **W. W. Williams**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 5 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Apr 5 1922 to **Apr 5 1922**
that I last saw him alive on **Apr 5 1922**
and that death occurred on the date stated above, at **3:30 P. M.**

The CAUSE OF DEATH* was as follows:

meningitis

(Duration) Yrs. mos. ds.
Contributory (Secondary) **mastoiditis Refused operation**

(Duration) yrs. mos. ds.
(Signed) **W. W. Williams** M. D.

4/5 1922 (Address) **Pocatello, Idaho.**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death? **Life in Pocatello.**
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Mt View Cem.

DATE OF BURIAL

4/6 1922

20. UNDERTAKER

McHann Undertaking Co. Pocatello, Idaho.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 58-37888
Registered No. 58791. PLACE OF DEATH Barre, IdahoCounty of BenewahCity of BarreRegistration District No. 28Primary Registration District No. 2141(No. 558 - No Grant St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John E Gladwin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH 92

3. SEX

Male

4. COLOR OR RACE

white5. SINGLE, MARRIED, WIDOWED OR DIVORCED
married
(Write the word.)

6. DATE OF BIRTH

November 4 1851
(Month) (Day) (Year)

7. AGE

70 Yrs. 5 Mos. - ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Janitor Idaho Furniture.

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

Thomas Gladwin

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Emma Bausor

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John E Gladwin

(Address)

Barre, Idaho

15.

Filed

4/61922

Local Registrar

16. DATE OF DEATH

April 4 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from March 31 1922 to April 4 1922 that I last saw him alive on Apr. 4 1922 and that death occurred on the date stated above, at 7:00 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia (Lobular both lungs)(Duration) 0 Yrs. 0 mos. 5 ds.

Contributory (Secondary)

Chronic Asthma(Duration) 1 1/2 yrs. 0 mos. 0 ds.

(Signed)

James F. Miller

M. D.

April 22 1922 (Address) 503 N. Myers Barre, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Mountain View Bur.

DATE OF BURIAL

April 7 1922

20. UNDERTAKER

Schumacher & Hall

ADDRESS

Barre, Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

Registration District No.

Primary Registration District No.

(No.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many.....hrs.
or.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from
to
that I last saw him alive on
and that death occurred on the date stated above, at P. M.

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Signed)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **30 37890**
Registered No. **3817**

1. PLACE OF DEATH

County of **Damoc**City of **Pocatello**Registration District No. **28**Primary Registration District No. **2161**(No. **936** **P. Main** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ernie Jannette Armstrong

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female**White****Single**
(Write the word.)

6. DATE OF BIRTH

April 6
(Month) (Day) (Year)

7. AGE

4
Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Pocatello

10. NAME OF FATHER

John A. Armstrong

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Ernie Jannette

13. BIRTHPLACE OF MOTHER

(State or Country)

Oakdale, Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John A. Armstrong
Pocatello

(Address)

15.

Filed

4/10 1922**J. H. Young**
Local Registrar

16. DATE OF DEATH

April 9
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **April 6 1922** to **April 9 1922**

that I last saw him or alive on **April 9 1922** and that death occurred on the date stated above, at **11:30** M.

The CAUSE OF DEATH* was as follows:

Inanition(Duration) Yrs. mos. **4** ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

H. L. Lynn M. D.**ap. 9 1922** (Address) **Pocatello, Ida**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Louis Cemetery**7/10 1922**

20. UNDERTAKER

ADDRESS

J. M. Vacker
Pocatello

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Bannock* Registration District No. *28*
City of *Pocatello* Primary Registration District No. *2161*
(*St. Mary's Hospital* St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Marion J. Crump*File No. *137891*Registered No. *3818*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Child*
(Write the word.)

6. DATE OF BIRTH

July 12 19*16*
(Month) (Day) (Year)

7. AGE

5 Yrs. *8* Mos. *27* ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)*Child*

9. BIRTHPLACE

(State or Country)

Robin Idaho

10. NAME OF FATHER

Marion J. Crump

11. BIRTHPLACE OF FATHER

(State or Country)

Robin Idaho

12. MAIDEN NAME OF MOTHER

Ora Matilda Lopez

13. BIRTHPLACE OF MOTHER

(State or Country)

Mississippi

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Marion J. Crump

(Address)

Pocatello, Ida.

15.

Filed *7/10* 19*22**J. Young*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

170

16. DATE OF DEATH

April 9 19*22*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

ap 2 19*22* to *ap 9th* 19*22*
that I last saw him alive on *ap 9th* 19*22*
and that death occurred on the date stated above, at *4 A.* M.

The CAUSE OF DEATH* was as follows:

rephritis(Duration) Yrs. *1* mos. ds.Contributory (Secondary) *none except*(Duration) yrs. mos. *2* ds.(Signed) *Dr. Young* M. D.Date *ap 10* 19*22* (Address) *Pocatello, Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death... yrs... mos... days. In the State... yrs... mos... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Robin Idaho

DATE OF BURIAL

Apr 11 19*22*

20. UNDERTAKER

Schumacher's Hall

ADDRESS

*Pocatello*WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B. - Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **27892**
Registered No. **3819**

1. PLACE OF DEATH

County of **Bannock**
City of **Pocatello**

Registration District No. **28**

Primary Registration District No. **2161**

(No. **827 M. Grant St** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William Vochel Lee

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

married

6. DATE OF BIRTH

April 2 1868
(Month) (Day) (Year)

7. AGE

52 Yrs. **8** Mos. **8** ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) **Indiana**

10. NAME OF FATHER

Jahn W. Lee

11. BIRTHPLACE OF FATHER

(State or Country) **Ind.**

12. MAIDEN NAME OF MOTHER

Samantha J. Stoggett

13. BIRTHPLACE OF MOTHER

(State or Country) **Ind**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Jahn W. Lee**

(Address) **827 M. Grant St**

15.

Filed **Apr 11 1922**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 10 1922
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from **Jan 1921** to **Feb 1922**
that I last saw him alive on **Feb 22 1922**
and that death occurred on the date stated above, at **10:25 A.M.**

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

L. Ray

M. D.

411 1922 (Address) **Pocatello, Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death **3** yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence **Blackfoot, Idaho**

19. PLACE OF BURIAL OR REMOVAL

Mt View Cem

DATE OF BURIAL

Apr 11 1922

20. UNDERTAKER

McKee Undertaking Co. Pocatello, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
37893

1. PLACE OF DEATH May 23 1922
Registration District No. 28
County of Bannock Bureau of Vital Statistics
Primary Registration District No. 2161
City of Pocatello (No. 1043 M. Main St.)

File No. 38
Registered No. 38201

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Bella Benson Goodwin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED widowed

6. DATE OF BIRTH March 9 1846
(Month) (Day) (Year)

7. AGE 76 Yrs. 1 Mos. 1 ds.
IF LESS than 1 day
how many. hrs.
or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work house keeper
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Iowa

10. NAME OF FATHER Ezra T. Benson

11. BIRTHPLACE OF FATHER
(State or Country) England

12. MAIDEN NAME OF MOTHER not known

13. BIRTHPLACE OF MOTHER
(State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Miss Strong Shields
1043 M. Main Pocatello Idaho

15. Filed Apr 12 1922 J. P. Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 10 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1922 to Apr 10 1922
that I last saw her alive on Apr 10 1922
and that death occurred on the date stated above, at 11 30 a M.

The CAUSE OF DEATH* was as follows:
chronic mitral insufficiency

(Duration) 4 Yrs. 4 mos. 4 ds.
Contributory (Secondary) nephritis

(Duration) 4 Yrs. 4 mos. 4 ds.
(Signed) L. Ray M. D.
4/12 1922 (Address) Pocatello, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 22 yrs. in Pocatello days. State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence Ligon, Utah

19. PLACE OF BURIAL OR REMOVAL Mt View Cem Pocatello DATE OF BURIAL 4/13 1922

20. UNDERTAKER McHann Und. Co ADDRESS Pocatello

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bannock
City of PocatelloRegistration District No. 28Primary Registration District No. 2161(No. General Hosp St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

W. Alan E. RocheState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 34894Registered No. 34894

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-OWED OR DIVORCED

male white married (Write the word.)

6. DATE OF BIRTH

March 11 1871
(Month) (Day) (Year)

7. AGE

52 yrs. 1 Mos. 3 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

Credit man Idaho Hamilton
Thomas Equity
Vice Pres & Secy

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

W. E. Roach

11. BIRTHPLACE OF FATHER

(State or Country)

France

12. MAIDEN NAME OF MOTHER

Elizabeth Record

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Walter L. Roache
856 E. Cedar Pocatello Ida.
(Address)

15.

Filed Apr 14 1922W. H. Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 14 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
Apr. 11 1922 to Apr. 14 1922that I last saw him alive on Apr. 13 1922and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Carotid body tumor left
Carotid area - operation
(Duration) Yrs. _____ mos. _____ ds.Contributory
(Secondary)anaemia of brain
(Duration) yrs. _____ mos. _____ ds.

(Signed)

Harner C. Swin M. D.4/14/1922 (Address) Pocatello Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 8 yrs. _____ mos. _____ days. In the State 8 yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence Tremonton, Utah

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mt View Cem Pocatello Apr 16 1922

20. UNDERTAKER

ADDRESS

McHaw Undertaking Pocatello Ida.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
MAY 23 1922

CERTIFICATE OF DEATH

1. PLACE OF DEATH

Registration District No. 28

County of

Primary Registration District No. 2161

City of

(No. 754 No. Arthur St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Law T. Barnes

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No. 378852

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF
FATHER11. BIRTHPLACE
OF FATHER

(State or Country)

12. MAIDEN NAME
OF MOTHER13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

19 22

Local Registrar

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from
for post several months
that I last saw h. alive on April 13 1922
and that death occurred on the date stated above, at 6:20 A.M.

The CAUSE OF DEATH* was as follows:

Endocarditis, chronic,
chronic nephritis.Good Compensation 3 months
age (Duration) Yrs. mos. ds.Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

4/4 1922 (Address) Pocatello, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Bannock
City of Pocatello R.F.D. #1
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 28
Primary Registration District No. 2161
(No. Jyhee — St.)

2. FULL NAME William Forse Richardson

File No. 537896
Registered No. 5826
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH April 11 1922
(Month) (Day) (Year)

7. AGE 0 Yrs. 0 Mos. 5 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE Pocatello Idaho R.F.D. #1
(State or Country)

10. NAME OF FATHER William Richardson

11. BIRTHPLACE OF FATHER Utah
(State or Country)

12. MAIDEN NAME OF MOTHER Jessie Landry

13. BIRTHPLACE OF MOTHER Mont.
(State or Country)

16. DATE OF DEATH April 16 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 11 1922, to Apr. 16 1922
that I last saw him alive on Apr 16 1922
and that death occurred on the date stated above, at 8 P.M.
The CAUSE OF DEATH* was as follows:
Hemorrhage - 7 bowel + Pul. tract

(Duration) 0 Yrs. 0 mos. 5 ds.
Contributory (Secondary) none

(Duration) — yrs. — mos. — ds.
(Signed) J. F. Miller M.D. M. D.
4-18-22 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
None
At place of death — yrs. — mos. — days. In the State — yrs. — mos. — days.
Where was disease contracted if not at place of death?
Former or usual residence

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) William Richardson
(Address) Jyhee

15. Filed 4/17 1922
J. F. Miller
Local Registrar

19. PLACE OF BURIAL OR REMOVAL Pocatello Idaho R.F.D. #1
20. UNDERTAKER Wm. Richardson

DATE OF BURIAL Apr. 18 1922
ADDRESS Jyhee

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **378996**
Registered No. **38**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of **Bannock**
City of **Porterville**Registration District No. **28**Primary Registration District No. **761**(No. **C. S. L. bar shops** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Isaac William Parker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White5. SINGLE, MARRIED, WIDOWED OR DIVORCED
(Write the word.)
Married

6. DATE OF BIRTH

August 22, 1871
(Month) (Day) (Year)

7. AGE

50 Yrs. **7** Mos. **27** ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)**Carpenter**
C. S. L. bar shops

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

James Parker

11. BIRTHPLACE OF FATHER

(State or Country)

Missouri

12. MAIDEN NAME OF MOTHER

Sarah Jane Yates

13. BIRTHPLACE OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mr. I. W. Parker

(Address)

521 - 8th Main

15.

Filed

4/20 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 19, 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19..... to **19**.....
that I last saw him alive on **19**.....
and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

My corditisContributory
(Secondary)

(Signed)

4-20-22

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Billings Montana

DATE OF BURIAL

4/20 1922

20. UNDERTAKER

Schumacher & Hall

ADDRESS

Porterville

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock
City of PocatelloRegistration District No. 28Primary Registration District No. 161(No. Pocatello Gen. Hospital)File No. 32900Registered No. 3828

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Eliza Marie Lamb

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married

6. DATE OF BIRTH

May 27 1856
(Month) (Day) (Year)

7. AGE

65 Yrs. 10 Mos. 24 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)house wife

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

Mathew Coombs

11. BIRTHPLACE OF FATHER

(State or Country)

Kentucky

12. MAIDEN NAME OF MOTHER

Martha McDonald

13. BIRTHPLACE OF MOTHER

(State or Country)

Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Grace Helen Hall

(Address)

Pocatello, Idaho

15.

Filed

April 20 1922

Local Registrar

16. DATE OF DEATH

April 19 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 10 1922 to April 18 1922that I last saw h. er alive on April 18 1922and that death occurred on the date stated above, at 59' M'

The CAUSE OF DEATH* was as follows:

Pneumonia(Duration) Yrs. mos. 9 ds.Contributory
(Secondary)(Duration) Obstruction of bowel yrs. mos. ds.

(Signed)

J. J. Ruff

M. D.

4/20 1922 (Address) Pocatello, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 19 yrs. 10 mos. 24 days. In the Pocatello State Ida. yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

Pocatello, Ida.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mt View Cem.Apr 21 1922

20. UNDERTAKER

ADDRESS

Mc Han Undertaking Co. Pocatello
Ida.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **37901**
Registered No. **3829**

1. PLACE OF DEATH

County of **Bannock**
City of **POCATELLO, IDAHO**

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Registration District No. **28**
Primary Registration District No. **2161**
(No. **Pocatello Gen Hosp** St.)

Anna Laura Barrett

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Female white married

6. DATE OF BIRTH

Dec. 19 1873
(Month) (Day) (Year)

7. AGE

48 Yrs. 4 Mos. 2 ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

- (a) Trade, profession or
particular kind of work.
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer).

House wife

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Jacob Snyder

11. BIRTHPLACE OF FATHER

(State or Country)

Pennsylvania

12. MAIDEN NAME OF MOTHER

Adelaide Andrews

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **William M. Barrett**
(Address) **Hailey Idaho**

15.

Filed **Apr. 21 1932**

J. H. H. H.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH POCATELLO, IDAHO

April 21 1932
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
April 20 1932 to **April 22 1932**

that I last saw him alive on **April 20 1932**

and that death occurred on the date stated above, at **5 A.M.**

The CAUSE OF DEATH* was as follows:

**Progress of form
causing shock**

(Duration) Yrs. mos. ds.
Contributory (Secondary) **General debility**

(Duration) yrs. mos. ds.

(Signed) **J. J. Rao** M. D.

4/21 1932 (Address) **POCATELLO, IDAHO**

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. **6 hours** In the State yrs. mos. days

Where was disease contracted
if not at place of death?

Former or usual residence **Hailey Idaho**

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Hailey Idaho April 23 1932

20. UNDERTAKER ADDRESS
H. L. McHAN POCATELLO, IDAHO

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **36903**
Registered No. **3833**

1. PLACE OF DEATH.
County of **Cannock** Registration District No. **28**
City of **Pocatillo** (No. **2161** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Robert Elynn**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **male** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WID-OWED OR DIVORCED **married**
(Write the word.)
6. DATE OF BIRTH **Sept 22 1876**
(Month) (Day) (Year)

7. AGE **45** Yrs. **7** Mos. **7** ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION **Shepherd and stock man**

9. BIRTHPLACE **Salt Lake City, Ut.**
(State or Country)

10. NAME OF FATHER **Andrew Elynn**

11. BIRTHPLACE OF FATHER **Scotland**
(State or Country)

12. MAIDEN NAME OF MOTHER **Ann Craig**

13. BIRTHPLACE OF MOTHER **Scotland**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) **W. Elynn**
(Address) **Pocatillo**

15. Filed **4/30- 1922**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **April 29 1922**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Apr 22 1922** to **Apr 29 1922**, that I last saw him alive on **4-29 1922**, and that death occurred on the date stated above, at **10 A.M.**

The CAUSE OF DEATH* was as follows:
Mountain Fever

(Duration) Yrs. mos. **14** ds.
Contributory (Secondary)
(Duration) Yrs. mos. ds.
(Signed) **R. Ray** M. D.
430 1922 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **Elba, Ida.** DATE OF BURIAL **3/2 1922**

20. UNDERTAKER **V. F. McMan** ADDRESS **Pocatillo Idaho.**

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **37904**

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH **RECEIVED**Registration District No. **53**County of **Bear Lake** **JUN 6 1922**

Primary Registration District No. _____

City of **Paris** **BUREAU OF VITAL STATISTICS**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Emith Grimmitt Hoge**

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

M

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH.

July
(Month)**7th**
(Day)**1912**
(Year)

7. AGE

11 Yrs. **10** Mos. **24** ds.IF LESS than 1 day
how many.....hrs. or
.....min.

8. OCCUPATION

(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....**Student**

9. BIRTHPLACE

(State or Country)

Paris, Idaho

10. NAME OF FATHER

M. Emith Hoge

11. BIRTHPLACE OF FATHER

(State or Country)

Paris, Idaho

12. MAIDEN NAME OF MOTHER

Bertha M. Grimmitt

13. BIRTHPLACE OF MOTHER

(State or Country)

Paris, Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

M. Emith Hoge

(Address)

Paris, Idaho

15.

Filed

June 2 1922**Mrs. J. S. Hainey**
Local Registrar

16. DATE OF DEATH

June
(Month)**1**
(Day)**1912**
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 29, 1922, to June 1, 1922.that I last saw him alive on **June 1, 1922.**and that death occurred on the date stated above, at **1 P.M.**

The CAUSE OF DEATH* was as follows:

**Peritonitis following
Ruptured appendix.**

(Duration)Yrs.....mos.....ds.

Contributory
(Secondary)

(Duration)Yrs.....mos.....ds.

(Signed)

6/2/22 **Paris, Ida.**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....Yrs.....mos.....days In the State.....Yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Paris, Idaho**June 3, 1922**

20. UNDERTAKER

ADDRESS

Dr. M. D. Low**Paris**

RECEIVED CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bear Lake Registration District No. 53
City of Paris Primary Registration District No. 53
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Genevieve S. HumphreyFile No. 2 37905

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

79

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH

8 - 31 1922
(Month) (Day) (Year)

7. AGE

22 Yrs. 8 Mos. 18 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).House wife

9. BIRTHPLACE

(State or Country)

Paris Ida.

10. NAME OF FATHER

Mark H. Sutton

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Marion Hibbert

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

P. V. Sutton
Paris Ida.

(Address)

15.

Filed May 20 1922 Mrs. J. S. Skinner
Local Registrar

16. DATE OF DEATH

May 18 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY That I attended deceased from

Jan 1 1922 to May 18 1922
that I last saw her alive on May 18 1922
and that death occurred on the date stated above, at 2:40 P.M.

The CAUSE OF DEATH* was as follows:

Metral Regurgitation
which was aggravated
by Pregnancy
(Duration) Yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) P. V. Sutton M. D.5/19/22 (Address) Paris, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Paris

DATE OF BURIAL

5 - 21 1922

20. UNDERTAKER

Morris Low

ADDRESS

Paris, Ida.MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bear Lake District No. 63
City of Paris, Ida. Registration District No. _____
BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

George H. HumphreysFile No. 37906

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

19

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH

April 19th 1862
(Month) (Day) (Year)

7. AGE

80 Yrs. 1 Mos. ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)retired

9. BIRTHPLACE

(State or Country)

Nottingham England

10. NAME OF FATHER

Thomas Humphreys

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Mary Sudbroy

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mary E. Davis

(Address)

Paris Idaho

15.

Filed

May 20 1922Mrs. J. Skinner
Local Registrar

16. DATE OF DEATH

May 19 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 18 1922 to May 19 1922
that I last saw him alive on May 18 1922
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

R. R. Rutton M. D.
5/19/22 (Address) Paris Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Paris Idaho5-22-1922

20. UNDERTAKER

ADDRESS

Bishop LowParis Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **237907**

Registered No.

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

1. PLACE OF DEATH

County of *Beau Lake* Registration District No. *53*
City of *Paris, Idaho* Registration District No.
St.)If death occurs away from
usual residence, give facts
called for under special in-
formation.2. FULL NAME *No Name*

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED *Single*
(Write the word.)

6. DATE OF BIRTH

May *30* *1922*
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day
how many *11* hrs.
or *30* min. ?
Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or
particular kind of work *baby.*
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country) *Paris Idaho*10. NAME OF
FATHER*Simpson Lyman Collins*11. BIRTHPLACE
OF FATHER(State or Country) *Paris Idaho*12. MAIDEN NAME
OF MOTHER*Oliver Pearl DeRenz*13. BIRTHPLACE
OF MOTHER(State or Country) *Momoth Id*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *J. L. Collins*(Address) *Paris.*

15.

Filed *May 31* *1922* *May 31* *1922*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May *30* *1922*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 30 *1922* to *May 30* *1922*
that I last saw him alive on *May 30* *1922*
and that death occurred on the date stated above, at *12 P.M.*

The CAUSE OF DEATH* was as follows:

Premature (7 mo.)

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *J. P. Dutton**5/31* *1922* (Address) *Paris Ida.**State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Paris Ida.

DATE OF BURIAL

5/31 *1922*

20. UNDERTAKER

Bothrop & Co

ADDRESS

Paris Ida

MARGIN RESERVING FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH
in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Bear Lake Registration District No. _____
City of St. Charles Registration District No. 57 St.)
BUREAU OF VITAL STATISTICS

File No. 37908
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Orina angelie Wilhelmson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH.

June 14 1857
(Month) (Day) (Year)

7. AGE

64 Yrs. Mos. ds.

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

House wife

9. BIRTHPLACE

(State or Country)

Grantsville Utah

10. NAME OF FATHER

William M. Allred

11. BIRTHPLACE OF FATHER

(State or Country)

Dont Know

12. MAIDEN NAME OF MOTHER

Orina Angelia Bates

13. BIRTHPLACE OF MOTHER

(State or Country)

Dont Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Willhelmsen-Willhelmsen

(Address)

St. Charles Id.

15.

Filed June 1 1922

John Mattison
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 14 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to 191
that I last saw h. alive on 191
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

after a
lingering illness
No Doctor in attendance

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days State yrs. mos. days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

St. Charles Id. May 14 1922
20. UNDERTAKER ADDRESS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **37909**

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of **Bear Lake** Primary Registration District No. **53**
City of **Bloomington** (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Peter Thompson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

widowed
(Write the word.)

6. DATE OF BIRTH.

June 22 18**64**
(Month) (Day) (Year)

7. AGE

57 Yrs. **10** Mos. **19** ds.IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).**Farmer**

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Peter L Thompson

11. BIRTHPLACE OF FATHER

(State or Country)

Denmark

12. MAIDEN NAME OF MOTHER

Mary Jensen

13. BIRTHPLACE OF MOTHER

(State or Country)

Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. C. E. Briscoe

(Address)

Bloomington Idaho

15.

Filed

May 4 191**22**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

20

16. DATE OF DEATH

May **2** 19**22**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

3/18/22 191 to **4/2/22** 191that I last saw him alive on **4/1/22** 191and that death occurred on the date stated above, at **4:30 AM**.

The CAUSE OF DEATH* was as follows:

Myocardial Pyemia.

(Duration) Yrs. mos. ds.

Contributory (Secondary) **Blood Poison from Striking Thumb - Wound**

(Duration) Yrs. mos. ds.

(Signed) **R. J. Fulton** M. D.**4/2/22** (Address) **Paris.**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bloomington **4/5** 191**22**

20. UNDERTAKER

ADDRESS

Bishop C. C. Hart **Bloomington**

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Bear Lake
City of Paris
Registration District No. 62
Primary Registration District No. _____
(No.) _____ St.) _____

File No. 237910
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Thomas Humphreys

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

142

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH.

April 21 1866
(Month) (Day) (Year)

7. AGE

56 Yrs. 4 Mos. 4 ds.

IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

Carpenter

9. BIRTHPLACE

(State or Country)

Paris, Ida.

10. NAME OF FATHER

John James Humphreys

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Mary Smith

13. BIRTHPLACE OF MOTHER

(State or Country)

St. Louis, Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Geo A Parry

(Address)

Paris Idaho

15.

Filed

April 25 1922

Mrs J S Hume
Local Registrar

16. DATE OF DEATH

April 25 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 22 1922 to April 25 1922

that I last saw him alive on April 23 1922 and that death occurred on the date stated above, at 4:55 A.M.

The CAUSE OF DEATH* was as follows:

Gangrene

(Duration) Yrs. mos. ds.

Contributory (Secondary)

Thrombosis of Artery

(Duration) yrs. mos. ds.

(Signed)

J. D. Dutton M. D.

4/25/22 (Address) Paris, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Paris Ida.

April 27 1922

20. UNDERTAKER

ADDRESS

Bishop Law

Paris Ida.

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **37911**Registered No. **2**If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

1. PLACE OF DEATH.

County of Benedict District No. 31
City of Benedict Primary Registration District No. 1000
St. IdahoIf death occurs away from
usual residence, give facts
called for under special
information.

2. FULL NAME

Josephine Larose Kalin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.FIndian

(Write the word.)

6. DATE OF BIRTH.

June 13 1918
(Month) (Day) (Year)

7. AGE

3 Yrs. 10 Mos. 24 ds.IF LESS than 1 day
how many.....hrs. or
.....min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work...
(b) General nature of in-
dustry, business, or estab-
lishment in which employ-
ed (or employer).....

9. BIRTHPLACE

(State or Country)

Idaho10. NAME OF
FATHERJoe Pierre Kalin11. BIRTHPLACE
OF FATHER

(State or Country)

Mont.12. MAIDEN NAME
OF MOTHERLouisa Larose13. BIRTHPLACE
OF MOTHER

(State or Country)

Wn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Louisa Larose

(Address)

Benedict

15.

Filed May 8 1922G. L. B. Jones
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 7 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
Feb. 15 1922, to April 17 1922,
that I last saw her alive on April 17 1922
and that death occurred on the date stated above, at 3 A. M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Fred Bartman M. D.19 (Address) Benedict, Idaho*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted
if not at place of death? not knownFormer or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Benedict Idaho5/8 1922

20. UNDERTAKER

ADDRESS

J. TalonBenedict, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A-25 M. 1-19.

RECEIVED
JUN 1922

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH Julesburg
 County of Bennett
 City of Julesburg
 Registration District No. 21
 Primary Registration District No. _____
 (No. _____) (St.) _____

File No. 2
 Registered No. 37912

If death occurs away from
 usual residence, give facts
 called for under special in-
 formation.

2. FULL NAME Robert Eugene Backman

If death occurred in a hos-
 pital, institution or camp,
 give its NAME instead of
 street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED
 (Write the word.)

6. DATE OF BIRTH

May 9 1922
 (Month) (Day) (Year)

7. AGE

Yrs. 8 Mos. _____ ds. _____

IF LESS than 1 day
 how many _____ hrs.
 or _____ min.?

8. OCCUPATION

(a) Trade, profession or
 particular kind of work _____
 (b) General nature of in-
 dustry, business or estab-
 lishment in which employ-
 ed (or employer) _____

9. BIRTHPLACE

(State or Country)

Julesburg Idaho

10. NAME OF FATHER

Theodore Backman

11. BIRTHPLACE OF FATHER

(State or Country)

Illinois

12. MAIDEN NAME OF MOTHER

Jella Walker

13. BIRTHPLACE OF MOTHER

(State or Country)

Washington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Theodore Backman

(Address)

Julesburg Idaho

15.

Filed May 18 1922

E. L. Backman
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 17 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 9 1922, to May 17 1922
 that I last saw him alive on May 17 1922,
 and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Congenital Heart Disease

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

William B. Riley M. D.

19 _____

(Address) Idaho Wash

*State the Disease Causing Death; or in deaths from Violent Causes, state
 (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted
 if not at place of death? _____

Former or
 usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Wainbury

DATE OF BURIAL

5/20 1922

20. UNDERTAKER

E. L. Schuler

ADDRESS

Idaho Wash

1. PLACE OF DEATH **RECEIVED**

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsCounty of Bennett **JU**
City of Bennett **BU**Registration District No. 31
Primary Registration District No. _____
(No. _____ St.)File No. **37913**
Registered No. 5

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Virginia Moses

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7. 4. COLOR OR RACE Indian 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH.

April 24 1921
(Month) (Day) (Year)

7. AGE

1 Yrs. 1 Mos. 7 ds.IF LESS than 1 day
how many _____ hrs. or
_____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Libson Moses

11. BIRTHPLACE OF FATHER

(State or Country) Washington

12. MAIDEN NAME OF MOTHER

Ellen Abel

13. BIRTHPLACE OF MOTHER

(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ellen Abel(Address) Lowell Idaho

15.

Filed June 2 1922Y. L. Braham
Local RegistrarMEDICAL CERTIFICATE OF DEATH **91**

16. DATE OF DEATH

May 31 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to 191that I last saw h. alive on 191

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed) Y. Braham M. D.19 (Address) Bennett Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bennett6/2 1922

20. UNDERTAKER

ADDRESS

J. FalconBennett

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bennett District No. 32
City of St. Maries District No. 2049
STATISTICS (St.)

File No. 37914
Registered No. 23

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

A. A. Darknell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male White Married
(Write the word.)

6. DATE OF BIRTH

Oct. 16 1859
(Month) (Day) (Year)

7. AGE

62 Yrs. 6 Mos. 20 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Farmer

9. BIRTHPLACE

(State or Country) Watertown Wis.

10. NAME OF FATHER

Henry Samuel Darknell

11. BIRTHPLACE OF FATHER

(State or Country) England

12. MAIDEN NAME OF MOTHER

Jane Alexander

13. BIRTHPLACE OF MOTHER

(State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Edna A. Williams
St. Maries Idaho
(Address)

15.

Filed May 6 1922 H. E. Hunt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

5 6 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 1 1920, to May 6 1922
that I last saw him alive on May 5 1922
and that death occurred on the date stated above, at 1030 M.

The CAUSE OF DEATH* was as follows

Hypertrophy of heart
& General anasarca

(Duration) 3 Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

C. O. Platt

M. D.

May 6 1922 (Address) St. Maries Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Woodlawn

DATE OF BURIAL

5/8 1922

20. UNDERTAKER

H. E. Hunt Co

ADDRESS

St. Maries

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

BUREAU OF VITAL STATISTICS

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

May 11 1922

J. E. Spunt

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Signed)

5/11/1922 (Address) St. Marie's, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death life mos. days In the State life mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

FORM V. S. No. 5-25 M. 1-19.

RECEIVED CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bennett District No. 32
City of St. Maries Primary Registration District No. 2049
St.)

If death occurs away from usual residence, give facts called for under special information.

File No. 37916
Registered No. 26

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Georgia L. Sather

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

March 14 1902
(Month) (Day) (Year)

7. AGE

20 yrs. 2 mos. 4 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Kansas

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Kilmar Sather

(Address)

Spokane

15.

Filed

May 18 1922H. E. Hunt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 18 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 11 1922 to May 18 1922
that I last saw him alive on May 17 1922
and that death occurred on the date stated above, at 11:30 A.M.
The CAUSE OF DEATH* was as follows:General Peritonitis(Duration) Yrs. mos. 3 ds.Contributory
(Secondary)Chick fever(Duration) yrs. mos. 7 ds.

(Signed)

O. O. Platt

M. D.

May 18 1922 (Address) St. Maries, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

Spokane Wash

19. PLACE OF BURIAL OR REMOVAL

Woodlawn

DATE OF BURIAL

5/21/1922

20. UNDERTAKER

H. E. Hunt & Co

ADDRESS

St. Maries

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

BUREAU OF VITAL STATISTICS

Registration District No.

Primary Registration District No.

(No.

St.)

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed June 1 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from May 28 1922 to May 28 1922

that I last saw him alive on May 27 1922 and that death occurred on the date stated above, at 49 M.

The CAUSE OF DEATH* was as follows:

Contributory (Secondary)

(Signed)

M. D.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Benedict
City of St. MariesRegistration District No. 32
Primary Registration District No. 2049
St.)File No. 37918
Registered No. 25

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Nick Nelson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

June 30 1886
(Month) (Day) (Year)

7. AGE

35 Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Labourer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Norway

10. NAME OF FATHER

Antons Nelson

11. BIRTHPLACE OF FATHER

(State or Country)

Norway

12. MAIDEN NAME OF MOTHER

Ingrid Thronson

13. BIRTHPLACE OF MOTHER

(State or Country)

Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Ingrid Nelson
Caern & Alve

15.

Filed May 16 1922 A. E. Hunt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 15 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Feb 3 1922 to May 15 1922that I last saw him alive on May 15 1922and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Aortic Regurgitation(Duration) 4 Yrs. mos. ds.Contributory (Secondary) Rheumatic fever(Duration) 6 years ago yrs. mos. ds.(Signed) E. A. Collins M. D.5/15/22 (Address) St. Maries, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. 3 mos. 12 days. In the State 12 yrs. mos. daysWhere was disease contracted if not at place of death? St. Joe, IdahoFormer or usual residence St. Joe, Idaho

19. PLACE OF BURIAL OR REMOVAL

Woodlawn

DATE OF BURIAL

5/17 1922

20. UNDERTAKER

A. E. Hunt Co

ADDRESS

St Maries

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bingham
City of ShelleyReceivd District No. 116
JUN 5 1922
Principal Registrar District No. 2193
BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Theodora ToewsFile No. 37919
Registered No. 71

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Female white Single (Write the word.)

6. DATE OF BIRTH

April 15 1910
(Month) (Day) (Year)

7. AGE

12 Yrs. 1 Mos. 2 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

School girl

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Jacob D Toews

11. BIRTHPLACE OF FATHER

(State or Country)

Kansas

12. MAIDEN NAME OF MOTHER

Louise Wiebe

13. BIRTHPLACE OF MOTHER

(State or Country)

Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J Toews
Shelley Idaho

15. Filed

May 18 22 McCreath
19 Local Registrar

MEDICAL CERTIFICATE OF DEATH

92

16. DATE OF DEATH

May 17 22
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
May 12 22 to May 17 22that I last saw her alive on May 17 1922
and that death occurred on the date stated above, at 3:10 A.M.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) McCreath M. D.

May 18 22 (Address) Shelley Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Memorial Cemetery May 20 1922
Shelley Idaho

20. UNDERTAKER

ADDRESS

R.N. Leuchtwhite Shelley Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B. - Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED CERTIFICATE OF DEATH

MAY 23 1922

1. PLACE OF DEATH

County of

Bingham

City of

Blackfoot

District No. 131

BUREAU OF VITAL STATISTICS

BUREAU OF VITAL STATISTICS

Registration Dist No. 2194

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

37920

Registered No.

388

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary Liljenquist

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

March 31

1922

(Month)

(Day)

(Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day:
how many hrs
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Blackfoot, Ida

10. NAME OF FATHER

O. Eugene Liljenquist

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Lilly May England

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Eugene Liljenquist

(Address)

Moreland, Ida

15.

Filed

April 15 1922

Mrs. Helen E. Palmer

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March Friday 1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar 31 1922, to Mar 31 1922

that I last saw her alive on Mar 31 1922

and that death occurred on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:

Premature birth

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. W. Beck

M. D.

3/31 1922 (Address) Blackfoot, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Moreland, Ida

DATE OF BURIAL

4-10-1922

20. UNDERTAKER

E. J. Ogli

ADDRESS

Blackfoot

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **37921**
Registered No. **37921**1. PLACE OF DEATH **RECEIVED**
Registration District No. **121**
County of **Bingham** MAY 23 1922
Primary Registration District No. **2194**
City of **Blackfoot** St. **Idaho**
BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Elizabeth Killion**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Married**
(Write the word.)

6. DATE OF BIRTH

Sept 2 1878
(Month) (Day) (Year)

7. AGE

43 Yrs. **7** Mos. **4** ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)**Housewife**

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Christin Olsen

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

E. Killion
Blackfoot Idaho

15.

Filed

April 8 1922 Mrs. Helen E. Palmer

Local Registrar

16. DATE OF DEATH

April 6 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 1 1922 to April 6 1922
that I last saw her alive on **April 6 1922**and that death occurred on the date stated above, at **7:20 P.M.**

The CAUSE OF DEATH* was as follows:

Cancer of Stomach(Duration) Yrs. **8** mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) **F. W. Metcalf** M. D.**1922** (Address) **Blackfoot, Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Graveland Idaho April 9 1922

20. UNDERTAKER

ADDRESS

E. F. Rank Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

RECEIVED

Registration District No. 121

County of

Bingham

Primary Registration District No. 1207

File No.

37922

City of

Blanchfort

No. 189

San Antonio St.

Registered No.

68

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Arnold Dennis Quantrell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male

White

Married
(Write the word.)

6. DATE OF BIRTH

March 4

(Month)

1852
(Year)

7. AGE

70 Yrs.

1 Mos.

2 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Retired

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

Thomas Quantrell

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Lydia

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. H. Hinger

(Address)

Blanchfort, Idaho

15.

Filed

Apr. 8 1922

M. H. Hinger & Co.

Local Registrar

MEDICAL CERTIFICATE OF DEATH

79

16. DATE OF DEATH

April 6

(Month)

(Day)

1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 6 1922, to April 6 1922

that I last saw him alive on April 6 1922

and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Mental sufficiency

(Duration) 5 Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) F. W. Mitchell M. D.

19. (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Luna City Cemetery

7-9-22

20. UNDERTAKER

ADDRESS

E. J. Turk Blanchfort

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bingham Registration District No. 121
City of Blackfoot Primary Registration District No. 1097
BUREAU STAT 169 East Judicial St.

File No. 37923
Registered No. 37923

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Hammett Berry Arrin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-OWED OR DIVORCED Widow
(Write the word.)

6. DATE OF BIRTH

May 9 1838
(Month) (Day) (Year)

7. AGE

83 Yrs. 11 Mos. 28 ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

Retired

9. BIRTHPLACE

(State or Country)

Ill

10. NAME OF FATHER

Henry B Berry

11. BIRTHPLACE OF FATHER

(State or Country)

Kentucky

12. MAIDEN NAME OF MOTHER

Louisa Hammett

13. BIRTHPLACE OF MOTHER

(State or Country)

Vermont

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Louise E. Spalding

(Address)

169 E. Judicial Blackfoot

15.

Filed

April 8 1922 Mrs. Thelma E. Spalding
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 7 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 6 1922 to April 7 1922
that I last saw him alive on April 7 1922
and that death occurred on the date stated above, at 5 a.m.

The CAUSE OF DEATH* was as follows:

Paratyphoemia

(Duration) Yrs. mos. 2 ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

W E Patie

M. D.

April 8 1922 (Address) Blackfoot Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Macomb, Ill

19

20. UNDERTAKER

ADDRESS

Edrick Blackfoot

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bingham Registration District No. 121
City of near Tabor Primary Registration District No. 2194
(No. of St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Uman DelzerFile No. 37924
Registered No. 37924

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

April 5 1922
(Month) (Day) (Year)

7. AGE

3 days
Yrs. Mos.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

near Tabor Idaho

10. NAME OF FATHER

William Delzer

11. BIRTHPLACE OF FATHER

(State or Country)

South Dakota

12. MAIDEN NAME OF MOTHER

Alma Guenther

13. BIRTHPLACE OF MOTHER

(State or Country)

N. Dakota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

William Delzer
Tabor, Idaho

15.

Filed

April 8 1922
Mr Walter E. Pattee

Local Registrar

16. DATE OF DEATH

April 8 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19that I last saw h. alive on 19and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Failure of closing transverse
3 day ves suff. ab.

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. Davis

M. D.

(Address)

Blackfoot Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

William Delzer

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bingham District No. 131
City of Blackfoot Registration District No. 2194
St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Milfred R. GivensFile No. 37925
Registered No. 65

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

MaleCaucasianDivorced
(Write the word.)

6. DATE OF BIRTH

March 17, 1850
(Month) (Day) (Year)

7. AGE

72 Yrs. 22 Mos. 22 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Farmer

9. BIRTHPLACE

(State or Country)

Indiana

10. NAME OF FATHER

John B. Givens

11. BIRTHPLACE OF FATHER

(State or Country)

Indiana

12. MAIDEN NAME OF MOTHER

Martha Hazelwood

13. BIRTHPLACE OF MOTHER

(State or Country)

Indiana14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE and according to Arizona, Arizona(Informant) Martha E. High - Bookkeeper(Address) Blackfoot, Idaho

15.

Filed Apr 10 1922 Mrs. Kate E. Patten

Local Registrar

16. DATE OF DEATH

April 8, 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from April 1, 1920, to April 8, 1922 that I last saw him alive on April 7, 1922 and that death occurred on the date stated above, at 1-9 A.M. The CAUSE OF DEATH* was as follows:Exhaustion due to General Paralysis
(Duration) Yrs. mos. ds.Contributory (Secondary) General Paralysis

(Duration) Yrs. mos. ds.

(Signed) W. H. Long M. D.4-8 1922 (Address) Blackfoot, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 2 yrs. 7 mos. 7 days. In the State 30 yrs. 0 mos. 0 daysWhere was disease contracted if not at place of death? UnknownFormer or usual residence 74 Nampa, Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Grove City Cemetery 4-10 1922UNDER-TAKER E. E. EgliADDRESS Blackfoot,

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **37926**
Registered No. **64**

1. PLACE OF DEATH

Registration District No. **121**
County of **Bingham** Primary Registration District No. **2194**
City of **Blackfoot** (No. **1**) St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
MAY 23 1922
BUREAU OF
STATISTICS

2. FULL NAME

Lucy Brathworth

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **Caucasian** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Widow**
(Write the word.)

6. DATE OF BIRTH

April 20 1875
(Month) (Day) (Year)

7. AGE

46 Yrs. **11** Mos. **19** ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE and according to **deputy records**

(Informant) **Martha E. High - Bookkeeper**
(Address) **Blackfoot, Idaho**

15. **April 9 1922** **Martha E. High**
Filed Local Registrar

MEDICAL CERTIFICATE OF DEATH

69

16. DATE OF DEATH

April 8 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **March 12 1919** to **April 8 1922** that I last saw her alive on **April 7 1922** and that death occurred on the date stated above, at **7:50 A.M.** The CAUSE OF DEATH* was as follows:

Status Epilepticus

(Duration) Yrs. mos. **3** ds.
Contributory (Secondary) **Chronic Epilepsy**

(Duration) **32** yrs. mos. ds.
(Signed) **C. J. Hooper** M. D.

4.8 1922 (Address) **Blackfoot, Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death **7** yrs **7** mos **13** days. In the same infancy State yrs. mos. days

Where was disease contracted if not at place of death? **Unknown**

Former or usual residence **Peyton, Idaho**

19. PLACE OF BURIAL OR REMOVAL **Mt. Comm. Id.** DATE OF BURIAL **4 10 1922**

20. UNDERTAKER **E. L. Egli** ADDRESS **Blackfoot**

FORM V, S. No. 5-25 M, 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **37927**
Registered No. **68**

1. PLACE OF DEATH

Registration District No. **121**
County of **Bingham** Primary Registration District No. **2194**
City of **Blackfoot** (City or Town) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

George Boche

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male **White** **Married**
(Write the word.)

6. DATE OF BIRTH

Can't say
(Month) (Day) (Year)

7. AGE

42 Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

U. S.

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Lightfoot Records

(Address)

Blackfoot, Ida

15.

Filed

Apr 9 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

31

16. DATE OF DEATH

4 (Month) **9** (Day) **1922** (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 18 1921 to **Apr 9 1922**that I last saw him alive on **Apr 8 1922**and that death occurred on the date stated above, at **5:30 AM**.

The CAUSE OF DEATH* was as follows:

Exhaustion of Paresis**Gradual failing since admission Sept 21 - '22**
(Duration) (Days) (Mos.) (Yrs.) (ds.)

Contributory (Secondary)

Specific(Duration) **2** yrs. mos. ds.

(Signed)

Dr. J. H. Haines, D. M.**4.9 1922** (Address) **Blackfoot, Ida**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. **6** mos. **22** In the State **4** yrs. mos. daysWhere was disease contracted if not at place of death? **Can't say**Former or usual residence **Brake Idaho**

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Brake Ida **19**

20. UNDERTAKER

ADDRESS

E. Hick

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bingham
City of BlackfootRECEIVED
MAY 23 1922
BUREAU OF VITAL STATISTICSRegistration District No. 121Primary Registration District No. 1007Name of Funeral Sonny

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Laona Heaps MurdockFile No. 37928Registered No. 66

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married (word.)

6. DATE OF BIRTH

Nov. 22 1899
(Month) (Day) (Year)

7. AGE

22 4 18
Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Housewife
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Pleasant Grove Utah

10. NAME OF FATHER

Benjamin Heaps

11. BIRTHPLACE OF FATHER

(State or Country) Utah

12. MAIDEN NAME OF MOTHER

Eva Dittmore

13. BIRTHPLACE OF MOTHER

(State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank H. Murdock(Address) Blackfoot

15.

Filed April 14 1922 Mr. Haines E. Patten
Local Registrar

MEDICAL CERTIFICATE OF DEATH

10

16. DATE OF DEATH

April10th 1922

(Month)

(Day)

19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 4 1922, to March 11 1922
that I last saw him alive on March 11 1922
and that death occurred on the date stated above, at 10:45 AM.

The CAUSE OF DEATH* was as follows:

Suffering w. fallow child birth(Duration) Yrs. mos. 7 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) C. O. Hampton M. D.4/12 1922 (Address) Blackfoot Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Ogden Utah

DATE OF BURIAL

4/14 1922

20. UNDERTAKER

G. L. Ogden

ADDRESS

Blackfoot

1. PLACE OF DEATH

County of Bingham
City of Blackfoot

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lillie May Liljenquist

RECEIVED

CERTIFICATE OF DEATH

Registration District No. 127BUREAU OF VITAL STATISTICS
Primary Registration District No. 2194State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 37929Registered No. 67

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married (word.)

6. DATE OF BIRTH

November 27 1886
(Month) (Day) (Year)

7. AGE

35 Yrs. 4 Mos. 17 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Housewife

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

John England

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Laura Thuesen

13. BIRTHPLACE OF MOTHER

(State or Country)

Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. Liljenquist
(Address) Moreland, Idaho

15.

Filed

April 16 1922 Mrs. Hattie E. Paton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 14th 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 15 1922 to April 14 1922
that I last saw her alive on April 12 1922
and that death occurred on the date stated above, at 5:20 A.M.

The CAUSE OF DEATH* was as follows:

Cardiac insufficiency(Duration) Yrs. 1 mos. 1 ds.

Contributory (Secondary)

Mitral insufficiency with sclerosis(Duration) 15 yrs. 1 mos. 1 ds.

(Signed)

W. E. Beck M. D.4/16/22 (Address) Blackfoot, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Moreland, Idaho

DATE OF BURIAL

4/16 1922

20. UNDERTAKER

ADDRESS

Blackfoot.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Bonham
City of Blackfoot

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
MAY 23 1922
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 121
Registration District No. 2194
(No. _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 37930
Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Maggie Miles

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widow
(Write the word.)

6. DATE OF BIRTH December 24 873
(Month) (Day) (Year)

7. AGE 48 Yrs. 3 Mos. 23 ds. IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION Housewife
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE Utah
(State or Country)

10. NAME OF FATHER Lewis Robbins

11. BIRTHPLACE OF FATHER Scotland
(State or Country)

12. MAIDEN NAME OF MOTHER Maggie Hayman

13. BIRTHPLACE OF MOTHER Scotland
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Louise Miles
(Address) Blackfoot.

15. April 20 1922 Mrs. Hattie E. Palmer
Filed _____ Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 17 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1921 to April 15th 1922
that I last saw her alive on April 15 1922
and that death occurred on the date stated above, at 9:20 M.

The CAUSE OF DEATH* was as follows:

Brain aneurysm

(Duration) 3 Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Joseph B. Davis M. D.

4/19 1922 (Address) Blaine, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL M oreland Cemetery DATE OF BURIAL 4-20 1922

20. UNDERTAKER Blackfoot ADDRESS _____

1. PLACE OF DEATH

County of *Lincoln*City of *Blackfoot*

If death occurs away from usual residence, give facts called for under special information.

RECEIVED

MAY 23 1922

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. *121*Registration District No. *2194*

2. FULL NAME

*Elvira Roper*State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *37931*Registered No. *67*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

Caucasian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

December 12 1893
(Month) (Day) (Year)

7. AGE

27 Yrs. *4* Mos. *9* ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Fayette, Utah

10. NAME OF FATHER

C. H. Roper

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Hope W. Dack

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

according to death records.
(Informant) *My: Martha E. High - Bookkeeper*
(Address) *Blackfoot, Idaho*

15.

Filed *April 22 1922* *Mrs. Helen E. Roper*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

103

16. DATE OF DEATH

April 21 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 24 1922, to April 21 1922
that I last saw her alive on *April 21 1922*
and that death occurred on the date stated above, at *1:30 P.M.*
The CAUSE OF DEATH* was as follows:*Acute Gastritis*(Duration) Yrs. mos. *3* ds.

Contributory (Secondary)

Arteriosclerosis

(Duration) Yrs. mos. ds.

(Signed) *C. H. Roper* M.D.*4/21/1922* (Address) *Blackfoot, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. *11* mos. *27* days. In the State Yrs. mos. daysWhere was disease contracted if not at place of death? *Unknown*Former or usual residence *Burley, Idaho*

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Burley, Idaho**19*

20. UNDERTAKER

ADDRESS

E. J. Roper *Blackfoot, Idaho*

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH **MA**
 County of **Bingham**
 City of **Blackfoot**
 Registration District No. **121**
 Primary Registration District No. **2194**
 (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Etta Woods**

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. **37932**
 Registered No. **70**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Widow** (the word.)
 6. DATE OF BIRTH **March 17 1879**
 (Month) (Day) (Year)
 7. AGE **43** Yrs. **1** Mos. **4** ds.
 IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. **Housewife**
 (b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) **Utah**

10. NAME OF FATHER

Joseph Merrell

11. BIRTHPLACE OF FATHER

(State or Country) **Iowa**

12. MAIDEN NAME OF MOTHER

Martha Camkin

13. BIRTHPLACE OF MOTHER

(State or Country) **England**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **George Merrell**
 (Address) **Blackfoot, Idaho**

15. Filed **April 22 1922** **Mrs. Walter E. Fair**
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 21 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **July 10 1921**, to **April 21 1922** that I last saw her alive on **April 19 1922** and that death occurred on the date stated above, at **10:45 P.M.**

The CAUSE OF DEATH* was as follows:

Carcinoma of both breasts
 (Duration) Yrs. **11** mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) **W. W. Beck** M. D.

Apr 22 1922 (Address) **Blackfoot, Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Grove City Cemetery

DATE OF BURIAL

4-24 1922

20. ADDRESS

Blackfoot.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH **RECEIVED**
 Registration District No. **131**
 County of **Bingham** MAY 23 1922
 Primary Registration District No. **217H**
 City of **Kimball** BUREAU OF VITAL STATISTICS St.)

 File No. _____
 Registered No. **37933**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Leroy Tayler

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

 3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED

Male White Single (Write the word.)

6. DATE OF BIRTH

 August 3, 1920
 (Month) (Day) (Year)

7. AGE

1 Yrs. 18 Mos. 18 ds.

 IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

None

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Kimball, Idaho

10. NAME OF FATHER

James B. Tayler

11. BIRTHPLACE OF FATHER

Utah

(State or Country)

12. MAIDEN NAME OF MOTHER

Luella Davis

13. BIRTHPLACE OF MOTHER

Idaho

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

 April 25, 1922 Mrs. Thelma E. Palmer
 Local Registrar

16. DATE OF DEATH

 April 22, 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I have deceased from

19 to 19

that I last saw him alive on 19

and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

 Strychning poisoning
 Homicidal
 (Duration) Yrs. mos. ds.
Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

424 22 (Address) Blackfoot

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Firth Cemetery

4-25-1922

20. UNDERTAKER

ADDRESS

Blackfoot.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bingham
 City of Kimball

If death occurs away from usual residence, give facts called for under special information.

RECEIVED

Registration District No. 121

MAY 1922

Primary Registration District No. 2194BUREAU (No. ST)

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 37934Registered No. 72

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edward Taylor

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single (the word.)

6. DATE OF BIRTH

October (Month) 3 (Day) 1914 (Year)

7. AGE

7 Yrs. 6 Mos. 20 ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

At school

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

Kimball

(State or Country)

Idaho

10. NAME OF FATHER

James B. Taylor

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Luella Davis

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. B. Taylor(Address) Fifth Route 1

15.

Filed April 25 1922by Mrs. Hester E. Taylor

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April (Month) 23 (Day) 1922 (Year)

17. I HEREBY CERTIFY, That I investigated attended deceased from

19 to 19

that I last saw him alive on 19

and that death occurred on the date stated above, at 8:30 A.M.

The CAUSE OF DEATH* was as follows:

Strychnine poisoning
homicidal

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) E. R. Egle

Coroner

4-24-22(Address) Blackfoot Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Fifth Cemetery

DATE OF BURIAL

4-25 1922

ADDRESS

Blackfoot.

1. PLACE OF DEATH

County of Bingham
City of Blackfoot

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
MAY 23 1922

CERTIFICATE OF DEATH

Registration District No. 421BUREAU OF VITAL STATISTICS
Registration District No. 1007
Station South Broadway St.)

2. FULL NAME

Jesse Butler AstleState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 32926Registered No. 74

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Divorced word.)

6. DATE OF BIRTH

Sept. 22 1922
(Month) (Day) (Year)

7. AGE

49 Yrs. 7 Mos. 7 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Painter

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) England

10. NAME OF FATHER

Humphry Astle

11. BIRTHPLACE OF FATHER

(State or Country) England

12. MAIDEN NAME OF MOTHER

Ann Butler

13. BIRTHPLACE OF MOTHER

(State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Harold Astle,
Blackfoot.

(Address)

15. Filled

May 1 1922 Mr. H. E. Patten
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 29 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

4/19 1922 to 4/29 1922
that I last saw him alive on 4/25 1922
and that death occurred on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:

Pneumonia following
influenza the
bronchial type
(Duration) yrs. mos. 10 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

H. C. Hamplair M. D.
4/29/22 (Address) Blackfoot

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Grove City Cemetery 5/1 1922

20. UNDERTAKER

ADDRESS

E. H. Egli, Blackfoot, Ida.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of CusterCity of Goldburg

If death occurs away from usual residence, give facts called for under special information.

RECEIVED

MAY 23 1922

BUREAU

CERTIFICATE OF DEATH

Registration District No. 1-21Primary Registration District No. 2194(No. 1)

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 37937Registered No. 37937

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Martha Elizabeth

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Married)

6. DATE OF BIRTH

December

(Month)

2

(Day)

1898

(Year)

7. AGE

23413

Yrs.

Mos.

ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

At home

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Sylvester M. Jackman

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Mary A. Hiatt

13. BIRTHPLACE OF MOTHER

(State or Country)

North Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Blackfoot, B. D. 1

15. FILED

April 17, 1922Mr. J. E. Palmer

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April

(Month)

15

(Day)

22

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19

to

19

that I last saw h..... alive on..... 19.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

19..... (Address).....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Grove City Cemetery

DATE OF BURIAL

April 18/22

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Custer
City of Goldburg

Registration District No.

Primary Registration District No.

(No. St.)

File No.

Registered No.

If death occurs away from
usual residence, give facts
called for under special in-
formation.If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.2. FULL NAME Martha Elizabeth Ziegler

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Female White Married (word.)

6. DATE OF BIRTH

December 2 1898
(Month) (Day) (Year)

7. AGE

23 4 13
Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work. Housewife
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer).

9. BIRTHPLACE

Utah
(State or Country)10. NAME OF
FATHERSylvester M Jackman11. BIRTHPLACE
OF FATHERUtah
(State or Country)12. MAIDEN NAME
OF MOTHERMary A. Hiatt13. BIRTHPLACE
OF MOTHERNorth Carolina
(State or Country)14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
S. M. Jackman(Informant) Route 1, Blackfoot.

(Address)

15.

Filed 19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 15 22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 10 1922, to April 15 1922
that I last saw her alive on April 15 1922
and that death occurred on the date stated above, at 5:00 A.M.
The CAUSE OF DEATH* was as follows:Bronchial Pneumonia(Duration) Yrs. mos. 7 ds.Contributory Chronic Nephritis
(Secondary)(Duration) 3 yrs. mos. ds.(Signed) G. E. Gilman M. D.6/14 1922 (Address) MAY Volante*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted
if not at place of death?Former or
usual residence19. PLACE OF BURIAL OR REMOVAL
BlackfootDATE OF BURIAL
4-18 192220. UNDERTAKER
E. E. EgliADDRESS
Blackfoot

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
.. BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Custer
City of Goldburg

Registration District No.
Primary Registration District No.
(No. St.)

File No.
Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Martha Elizabeth Ziegler

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Female White (Married)

6. DATE OF BIRTH

December 2 1898
(Month) (Day) (Year)

7. AGE

23 4 13
Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Utah

10. NAME OF FATHER

Sylvester M. Jackman

11. BIRTHPLACE OF FATHER

(State or Country) Utah

12. MAIDEN NAME OF MOTHER

Mary A. Hiatt

13. BIRTHPLACE OF MOTHER

(State or Country) North Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

S M Jackman
(Address) Blackfoot R. D. 1.

15.

Filed 19

Local Registrar

16. DATE OF DEATH

April 15th 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

.....19....., to19.....
that I last saw h..... alive on19.....
and that death occurred on the date stated above, atM.
The CAUSE OF DEATH* was as follows:

(Duration)Yrs.....mos.....ds.

Contributory
(Secondary)

(Duration)yrs.....mos.....ds.

(Signed)M. D.

.....19..... (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Grave City Cemetery

DATE OF BURIAL

4-18 1922

20. UNDERTAKER

ADDRESS

Blackfoot.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **37938**
Registered No. **87**

1. PLACE OF DEATH

Registration District No. **121**
County of **Bingham** JUN 1922, Primary Registration District No. **2174**
City of **Wapello** BUREAU OF VITAL STATISTICS St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Neils Homer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Single**
(Write one word.)

6. DATE OF BIRTH

May 20 1922
(Month) (Day) (Year)

7. AGE

1 hr IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work **None**
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) **Wapello Idaho**

10. NAME OF FATHER

Wellard E Homer

11. BIRTHPLACE OF FATHER

(State or Country) **Utah**

12. MAIDEN NAME OF MOTHER

Louisa J Pearson

13. BIRTHPLACE OF MOTHER

(State or Country) **Denmark**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W E Homer
(Address) **Wapello Idaho**

15. Filed

May 21 1922 **Mr Thelma E. Peltier**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 20 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **May 10 1922**, to **May 20 1922** that I last saw him alive on **May 20 1922** and that death occurred on the date stated above, at **8 P.M.** The CAUSE OF DEATH* was as follows:

Cardiac insufficiency and general weakness
(Duration) yrs. mos. ds.
Contributory (Secondary) **congenital**
(Duration) yrs. mos. ds.
(Signed) **W W Beck** M. D.
5/21 1922 (Address) **Blackfoot, Ida**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Broue City Cemetery **5/22 1922**

20. UNDERTAKER

E. D. Egli **Blackfoot**

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Bingham Registration District No. 121
 City of Shelly Primary Registration District No. 2194
 State of Idaho St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Phillip Rausch

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 37939
Registered No. 37939

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH

4 / 24 - 1847
(Month) (Day) (Year)

7. AGE

75 Yrs. 22 Mos. 22 ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

Don't know

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Elizabeth Rall

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mr. Rausch

(Address)

R-2 - Shelly

15.

Filed

May 17 1922 Mr. Walter S. F.

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

5 - 16 - 22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

5-11-1922 to 5-16-1922

that I last saw him alive on 5-16-1922

and that death occurred on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Toxemia accompanying reduction of urine

(Duration) _____ Yrs. 1 mos. _____ ds.

Contributory (Secondary)

Chronic Prostatitis

(Duration) _____ Yrs. unknown mos. _____ ds.

(Signed)

Edwin C. Butler M. D.

5/17/1922

(Address) Shelly Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Fashen, Cemetery

5/19 1922

20. UNDERTAKER

ADDRESS

none employed

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **37940**Registered No. **87**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH **RECEIVED**
Registration District No. **121**
County of **Bingham** JUN 7
Primary Registration District No. **2194**
City of **Blackfoot** No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary E. Minias

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX **Female** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **widowed**
(Write the word.)

6. DATE OF BIRTH

1864
9 (Month) **6** (Day) **4** (Year)

7. AGE

58 Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)**Housewife**

9. BIRTHPLACE

(State or Country)

Scotland

10. NAME OF FATHER

Can't say

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Can't say

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

according to **Asylum Records**
(Informant) **By: Martha C. High - Bookkeeper**

(Address)

Blackfoot, Idaho

15. Filed

May 13 1922 **Mr. Helen E. Pat.**
Local Registrar

16. DATE OF DEATH

5 (Month) **13** (Day) **1922** (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar 12 1919 to **May 12 1922**that I last saw him alive on **May 12 1922**and that death occurred on the date stated above, at **5 A.M.**

The CAUSE OF DEATH* was as follows:

**Sudden
found dead in bed at 5 A.M.
Valvular Heart trouble**

(Duration) Yrs. mos. ds.

Contributory (Secondary) **Paranoid Dementia**

(Duration) Yrs. mos. ds.

(Signed) **E. J. Pusk** M. D.**151922** (Address) **Blackfoot, Idaho**

*State the Disease Causing Death; or in deaths from violent causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death **17** yrs. **10** mos. **10** days. In the State **17** yrs. **10** mos. **10** daysWhere was disease contracted if not at place of death? **Unknown**Former or usual residence **Boise**

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Boise Idaho **19**

20. UNDERTAKER

ADDRESS

E. J. Pusk Blackfoot Idaho

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH JUN 7 1922
 County of Bonneville Registration District No. 121
 City of Woodville Primary Registration District No. 2194
 (No. St.)

File No. 37941
 Registered No. 76

If death occurs away from
 usual residence, give facts
 called for under special in-
 formation.

2. FULL NAME

Dora Ludine Hammer

If death occurred in a hos-
 pital, institution or camp,
 give its NAME instead of
 street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

78

3. SEX 7 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED Single
 (Write the word)

6. DATE OF BIRTH

May - 28 - 1911
 (Month) (Day) (Year)

7. AGE

10 Yrs. 11 Mos. 24 ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or
 particular kind of work.
 (b) General nature of in-
 dustry, business or estab-
 lishment in which employ-
 ed (or employer)

At home

9. BIRTHPLACE

(State or Country)

Carey, Blaine Co. Ida

10. NAME OF FATHER

Geo. R. Hammer

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Eleanor Tappan

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

George R. Hammer

(Address)

R. 4 - Idaho Falls

15.

Filed

H - 23

1922

Mrs. Mabel E. Palmer

Local Registrar

16. DATE OF DEATH

4 - 22 - 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

4/20 - 1922 to 4 - 22 - 1922

that I last saw her alive on 4 - 21 - 1922,
 and that death occurred on the date stated above, at 8 A.M.,

The CAUSE OF DEATH* was as follows:

Acute Myo + Endo-
 Carditis

(Duration) Yrs. mos. 10 ds.

Contributory
 (Secondary)

Acute Muscular
 Rheumatism

(Duration) yrs. 1 mos. ds.

(Signed)

Edwin Cutler M. D.

4/22/1922 (Address) Shelley, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state
 (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
 if not at place of death?

Former or
 usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Woodville Cemetery

4/23/1922

20. UNDERTAKER

ADDRESS

None employed

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 121
County of Bingham Primary Registration District No. 2194
City of Groveland (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John H. YanceyFile No. 37942
Registered No. 77

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH

March. 26 1886
(Month) (Day) (Year)

7. AGE

66 Yrs. 1 Mos. 11 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Miner
Coal Mining

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Hyrum Yancey

11. BIRTHPLACE OF FATHER

(State or Country)

Illinois

12. MAIDEN NAME OF MOTHER

Harriet Wood

13. BIRTHPLACE OF MOTHER

(State or Country)

Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Alice Yancey

(Address)

Route 1 Blackfoot

15.

Filed May 1922Mrs. Helen E. Palmer

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 3 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from May 1 1922, to May 3 1922, that I last saw him alive on May 3 1922, and that death occurred on the date stated above, at 1:30 P.M. The CAUSE OF DEATH* was as follows:Consumption(Duration) 7 Yrs. _____ mos. _____ ds.Contributory
(Secondary)(Duration) 7 yrs. _____ mos. _____ ds.

(Signed)

H. W. Mitchell

M. D.

5/4 1922 (Address) Blackfoot Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted
if not at place of death?Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Groveland Cemetery 5-5 1922

20. UNDERTAKER

ADDRESS

E. L. Egli Blackfoot

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Bingham Registration District No. 121
 City of Moreland Primary Registration District No. 2194 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Edith Hacc

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 37943Registered No. 78

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single (write the word.)

6. DATE OF BIRTH

May 5 1922
(Month) (Day) (Year)

7. AGE

4 Yrs. 4 Mos. 4 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Jack Hacc

11. BIRTHPLACE OF FATHER

(State or Country) Kentucky

12. MAIDEN NAME OF MOTHER

Betty Akers

13. BIRTHPLACE OF MOTHER

(State or Country) Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Jack Hall
Moreland - Idaho

15. Filed

May-10-22

Mr. Hacc
Edith Hacc

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 9 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 5 1922 to May 8 1922
that I last saw her alive on May 8 1922
and that death occurred on the date stated above, at.....M.

The CAUSE OF DEATH* was as follows:

Premature Birth 7 1/2 mos.

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. B. Davis M. D.

5/10/1922 (Address) Blackfoot, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Moreland, Ida May 10 1922

20. UNDERTAKER

ADDRESS

Jack Hall

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

JUN 7 1922

Registration District No. 121

BUREAU OF

STATISTICS

Primary Registration District No. 2194

File No.

37944

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Baby Kimball

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many hrs.

Yrs.

Mos.

ds.

6 hours

or

min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15. Filed

May 9 1922

1922

Mrs. Helen E. Patton

Local Registrar

16. DATE OF DEATH

(Month)

(Day)

1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

8-17 1922 to 6-8 1922

that I last saw h. alive on 19

and that death occurred on the date stated above, at 2:10 P.M.

The CAUSE OF DEATH* was as follows:

Premature birth

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

Edwin Cuthler

M. D.

6-8 1922 (Address) Shelley, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs mos days In the State yrs mos days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

ADDRESS

20. UNDERTAKER

CERTIFICATE OF DEATH

1. PLACE OF DEATH JUNI Registration District No. 121
 County of Bingham Primary Registration District No. 2194
 City of Groveland (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Luella E. Fullmer

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 37945
 Registered No. 50

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
 (Write the word.)

6. DATE OF BIRTH September 10th 1863
 (Month) (Day) (Year)

7. AGE 58 Yrs. 8 Mos. 10 ds. IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION Housewife

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE Springville, Utah
 (State or Country)

10. NAME OF FATHER Stephan A. Perry

11. BIRTHPLACE OF FATHER U. S.
 (State or Country)

12. MAIDEN NAME OF MOTHER Mary Boggs

13. BIRTHPLACE OF MOTHER Illinois
 (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Alonzo S. Fullmer
 (Address) Route 1 Blackfoot

15. Filed May 11 1922 Mr. Walter E. Tabor
 Local Registrar

16. DATE OF DEATH May 10th 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 3 1922 to May 10 1922 that I last saw her alive on May 7 1922 and that death occurred on the date stated above, at 11:45 M. The CAUSE OF DEATH* was as follows:

Internal injuries from being run over by wagon
 (Duration) _____ Yrs. _____ mos. 7 ds.

Contributory (Secondary) _____
 (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W. W. Beck M. D.

5/11 1922 (Address) Blackfoot, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Groveland Cemetery DATE OF BURIAL 5-12 1922

20. UNDERTAKER E. L. Egli ADDRESS Blackfoot

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **37948**
Registered No. **86**

1. PLACE OF DEATH **Blackfoot**
County of **Bingham** JUN 7 1922
City of **Blackfoot** Registration District No. **2194**
If death occurs away from usual residence, give facts called for under special information.
BUREAU OF VITAL STATISTICS

2. FULL NAME **Leland W. Jensen**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Single**

6. DATE OF BIRTH **Feb 8 1910**
(Month) (Day) (Year)

7. AGE **12 Yrs. 3 Mos. 17 ds.** IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION **At school**
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE **Moore Idaho**
(State or Country)

10. NAME OF FATHER **Andrew S. Jensen**

11. BIRTHPLACE OF FATHER **Utah**
(State or Country)

12. MAIDEN NAME OF MOTHER **Lola W. Wilson**

13. BIRTHPLACE OF MOTHER **Utah**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) **A. S. Jensen**
(Address) **White, Blackfoot**

15. Filled **19** **Mr. Helen E. Pattee**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **May 25 1922**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **May 20 1922** to **May 21 1922** that I last saw him alive on **May 21 1922** and that death occurred on the date stated above, at **1 P. M.**
The CAUSE OF DEATH* was as follows:

Gangrenous Appendicitis
(Duration) Yrs. mos. **5** ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) **F. W. Mitchell** M. D.
26 1922 (Address) **Blackfoot, Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death **X** yrs. **X** mos. **5** days. In the State **X** yrs. **3** mos. **17** days
Where was disease contracted if not at place of death? **Groveland, Ida**
Former or usual residence **Groveland, Ida**

19. PLACE OF BURIAL OR REMOVAL **Groveland, Ida** DATE OF BURIAL **5/26 1922**

20. UNDERTAKER **E. L. Egli** ADDRESS **Blackfoot**

RECEIVED CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bingham Registration District No. 121
City of Thomas Registration District No. 2194
STATISTICS St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Unnamed DaytonFile No. 37949
Registered No. 151-a

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-OWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH

May 24 1922
(Month) (Day) (Year)

7. AGE

Yrs. Mos. 1 day
IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Rockford Idaho

10. NAME OF FATHER

George Dayton

11. BIRTHPLACE OF FATHER

(State or Country) Wyo

12. MAIDEN NAME OF MOTHER

Viola Martino

13. BIRTHPLACE OF MOTHER

(State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Robert H. Walters
(Address) Blackfoot Idaho Route 215. May 26 1922 Mrs. Thelma E. Faber
Filed Local Registrar

16. DATE OF DEATH

3 - 25 - 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
5/24 1922 to 19that I last saw him alive on 5/24 1922
and that death occurred on the date stated above, at 10:10 AM.

The CAUSE OF DEATH* was as follows:

Premature 8 mo.

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) G. H. Humphreys M. D.5/24/22 (Address) Blackfoot Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Thomas - Brown May 27, 1922

20. UNDERTAKER

ADDRESS

Robert H. Walters

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH

County of *Bingham*
City of *Blackfoot*

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
JUN 1 1922Registration District No. *121*Primary Registration District No. *2194*(No. *8*)

St.)

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *37959*Registered No. *88*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

William C Denton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

Caucasian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widower
(Write the word.)

6. DATE OF BIRTH

1843
(Month) (Day) (Year)

7. AGE

79 Yrs. — Mos. — ds.IF LESS than 1 day
how many — hrs.
or — min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).*Preacher*

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

Cary Denton

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Sarah M. Learen

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

according to Bingham Records
(Informant) *Margaret E. High, Bookkeeper*
(Address) *Blackfoot Idaho*

15.

Filed *May 31 1922* *Mrs. Thelma E. Denton*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

126

16. DATE OF DEATH

May 31 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan. 29 1922 to May 31, 1922
that I last saw him alive on *May 30 1922*
and that death occurred on the date stated above, at *4 P. M.*

The CAUSE OF DEATH* was as follows:

Auto Infection(Duration) Yrs. *4* mos. ds.Contributory *Cancer of Prostate Gland*
(Secondary)(Duration) Yrs. *1* mos. ds.(Signed) *Chas. J. Cory* M. D.*5-31-1922* (Address) *Blackfoot*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. *4* mos. *1* days. In the State *33* yrs. mos. daysWhere was disease contracted if not at place of death? *Unknown*Former or usual residence *Boise Idaho*

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bingham County *5/9* 19 *22*

20. UNDERTAKER

ADDRESS

E. J. Pink *Blackfoot*

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many.....hrs.
or.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15. Filed

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

St.)

File No.

Registered No.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from
May 20 1922 to May 22 1922
that I last saw him alive on May 20 1922
and that death occurred on the date stated above, at 3:30 A.M.

The CAUSE OF DEATH* was as follows:

Premature
(8 months)
(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

1922

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted
if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Registration District No.

Primary Registration District No.

(No.)

File No.

Registered No.

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF
FATHER11. BIRTHPLACE
OF FATHER

(State or Country)

12. MAIDEN NAME
OF MOTHER13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15. Filed

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

..... 19....., to 19.....

that I last saw h..... alive on..... 19.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Signed)..... M. D.

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted
if not at place of death?.....Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Boise
City of PioneervilleRegistration District No. 12Primary Registration District No. 12

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

George StuckFile No. 37953Registered No. 25

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDMaleWhiteSingle
(Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

80

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Pharmacist

9. BIRTHPLACE

(State or Country)

New York

10. NAME OF FATHER

Wm Brown

11. BIRTHPLACE OF FATHER

(State or Country)

" "

12. MAIDEN NAME OF MOTHER

" "

13. BIRTHPLACE OF MOTHER

(State or Country)

" "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

March 30, 1922Mrs E S Ropson
Local Registrar

16. DATE OF DEATH

March (Month) 27 (Day) 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

..... 19....., to 19.....

that I last saw him alive on 19.....

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

..... 19..... (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Pioneerville 19.....

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH ✓

County of *Basin*
City of *Horse Shoe Bend*Registration District No. *12*Primary Registration District No. *12*

(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*William Burchett*File No. *37954*
Registered No. *22*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

*White*5. SINGLE, MARRIED, WID-
OWED OR DIVORCED*Single*
(Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

67

Mos. _____ ds.

IF LESS than 1 day

how many _____ hrs.

or _____ min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Illinois

10. NAME OF FATHER

not known

11. BIRTHPLACE OF FATHER

(State or Country)

''

12. MAIDEN NAME OF MOTHER

''

13. BIRTHPLACE OF MOTHER

(State or Country)

''

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(Address) _____

15.

Filed

*March 19, 1922**Mrs E. R. Johnson*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

64

16. DATE OF DEATH

March 16
(Month) (Day) (Year)*1922*

17. I HEREBY CERTIFY, That I attended deceased from

_____ 19 _____, to _____ 19 _____

that I last saw him _____ alive on _____ 19 _____

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Paralysis

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

_____ 19 _____ (Address) _____

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Horse Shoe Bend

DATE OF BURIAL

March 18, 1922

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 12County of BoisePrimary Registration District No. 12City of Idaho

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Joseph Buck CulverFile No. 37955Registered No. 2

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX _____ 4. COLOR OR RACE _____ 5. SINGLE, MARRIED, WIDOWED OR DIVORCED _____

(Write the word.)

6. DATE OF BIRTH

(Month) _____ (Day) _____ (Year) _____

7. AGE

86IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

miner.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Maryland

10. NAME OF FATHER

not known

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(Address) _____

15.

Filed Feb 5 1922 Mrs. E. S. Robison
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 80 th 19_____
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____ 19_____, to _____ 19_____,

that I last saw him alive on _____ 19_____,

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

found dead.

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

_____ 19_____. (Address) _____

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho CityFeb 1 1922

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Boise
City of IdahoRegistration District No. 12
Primary Registration District No. 12
(No. _____ St.)File No. 37956
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Joseph Hill

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

MaleMarried
(Write the word.)

6. DATE OF BIRTH

Feb 1 1896
(Month) (Day) (Year)

7. AGE

86
Yrs. Mos. ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

minor

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

unknown

11. BIRTHPLACE OF FATHER

(State or Country)

11

12. MAIDEN NAME OF MOTHER

11

13. BIRTHPLACE OF MOTHER

(State or Country)

11

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(Address) _____

15.

Filed

Feb 27 1922 Mrs E. J. Rohsin
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 1st 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 19____, to _____ 19____,

that I last saw h_____ alive on _____ 19____,

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Old age

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

_____ 19____ (Address) _____

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho CityFeb 3 1922

20. UNDERTAKER

ADDRESS

RECEIVED
MAY 12
CERTIFICATE OF DEATHState of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bain Registration District No. 12
Idaho City (No. Idaho City Road St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William Hill CasnerFile No. _____
Registered No. 37960

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

malewhite

(Write the word.)

6. DATE OF BIRTH

March181822

(Month)

(Day)

(Year)

7. AGE

95

Yrs.

1

Mos.

7

ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)Retired farmer

9. BIRTHPLACE

(State or Country)

Beverly, Randolph Co. Va.

10. NAME OF FATHER

George Casner

11. BIRTHPLACE OF FATHER

(State or Country)

America

12. MAIDEN NAME OF MOTHER

Susan Yagge

13. BIRTHPLACE OF MOTHER

(State or Country)

America

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Ada Casner(Address) Idaho City Road Boise Ida.

15.

Filed

May 7 1922Mrs E S Rohon

Local Registrar

MEDICAL CERTIFICATE OF DEATH

120

16. DATE OF DEATH

April251922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from April 15 1922 to April 25 1922
that I last saw him alive on April 22 1922
and that death occurred on the date stated above, at 12:30 AM.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)Old Age

(Duration)

Yrs.

mos.

ds.

(Signed)

R E S Hunt

M. D.

19.

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Casner Road Boise Ida 4/28/22

20. UNDERTAKER

ADDRESS

Schubert & Tidensfader Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of *Ada* Registration District No. *12*
City of *Boise* Primary Registration District No. *12* File No. *37961*
(No. *Holcomb* *Boise*)
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME *Clinton M. Gardner*
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*
(Write the word.)
6. DATE OF BIRTH *Oct 18th 1853*
(Month) (Day) (Year)
7. AGE *68* Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. *Rancher*
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE *Humboldt Co. Calif*
(State or Country)

10. NAME OF FATHER *Dont Know*

11. BIRTHPLACE OF FATHER *American*
(State or Country)

12. MAIDEN NAME OF MOTHER *Dont Know*

13. BIRTHPLACE OF MOTHER *American*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *Clifford M Gardner*
(Address) *Holcomb, Y19 Barber*

15. Filed *May 9 1922*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *May 5th 1922*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *May 5 1922* to *May 5 1922*
that I last saw him alive on *May 5 1922*
and that death occurred on the date stated above, at *6 A.M.*

The CAUSE OF DEATH* was as follows:
Cancer of bladder

(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) *Clinton M. D.*
19 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Home Ranch Elmer, Idaho 5/7/1922
20. UNDERTAKER *Schneider & Sidenfaden* ADDRESS *Boise*

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bonner Registration District No. 78
City of Sandpoint Primary Registration District No. 2155
St. N. Depot on G. N. R. R.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

H. A. MacDonaldFile No. 37962

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Single
(Write the word.)6. DATE OF BIRTH Unknown 1873
(Month) (Day) (Year)7. AGE 49 Yrs. Mos. ds. IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Cook

9. BIRTHPLACE

(State or Country)

Scotland

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

"

12. MAIDEN NAME OF MOTHER

"

13. BIRTHPLACE OF MOTHER

(State or Country)

"

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John Braswell
(Address) Sandpoint, Idaho

15.

Filed June 2 1922Viola Allen
Deputy Local Registrar

MEDICAL CERTIFICATE OF DEATH

175-a

16. DATE OF DEATH

Jan. 9 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

.....19..... to19.....
that I last saw h..... alive on19.....
and that death occurred on the date stated above, atM.

The CAUSE OF DEATH* was as follows:

Run over by G. Northern
Freight Train

(Duration) Yrs. mos. ds.

Contributory Yes
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) L. M. Moore Waller5/16 1922 (Address) Sandpoint, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Sandpoint, Ida. Jan. 14 1922

20. UNDERTAKER ADDRESS

B. H. Pugh, Sandpoint, Idaho.

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH

JUN 5 1922

Registration District No. 78

County of

Bonneville

BUREAU OF VITAL STATISTICS

Registration District No. 2155

City of

Sandpoint City Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Bert C. Partridge

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

37963

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

married
(Write the word.)

6. DATE OF BIRTH

March 23 1899
(Month) (Day) (Year)

7. AGE

32 Yrs. 11 Mos. 20 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

R. R. Agent

(b) General nature of industry, business or establishment in which employed (or employer)

N. P. R. R.

9. BIRTHPLACE

(State or Country)

Mo.

10. NAME OF FATHER

H. J. Partridge

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Nancy Riley

13. BIRTHPLACE OF MOTHER

(State or Country)

Ind.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Bert C. Partridge
Kootenai, Idaho.

(Address)

15.

Filed June 2 1922

Viola Allen
Deputy Local Registrar

MEDICAL CERTIFICATE OF DEATH

183

16. DATE OF DEATH

March 13 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19, to 19,

that I last saw him alive on 19,

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

From knife wound in heart, administered from the hands of Samuel Clark.

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

L. M. Moore
5/16/1922 (Address) Sandpoint, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Spokane, Wash.

DATE OF BURIAL

3/16 1922

20. UNDERTAKER

B. H. Partridge, Sandpoint, Ida.

1. PLACE OF DEATH

County of Bonner Registration District No. 2155
 City of Clarksfork Clarksfork, Idaho. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Pete Gabrielson

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 37964

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED Unknown
 (Write the word.)

6. DATE OF BIRTH

Unknown
 (Month) (Day) (Year)

7. AGE

about 40
Unknown ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer)

Laborer

9. BIRTHPLACE

(State or Country)

Norway

10. NAME OF FATHER

Gabriel Peterson

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Grant Smith Co.
Spokane Wash

15. Filed

May 16 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 21 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

..... 19....., to 19.....
 that I last saw h..... alive on 19.....
 and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

By Car in Quarry road
rolled over him

(Duration) Yrs..... mos..... ds.

Contributory
 (Secondary)

Yes

(Duration) yrs..... mos..... ds.

(Signed)

J. M. Moore Coroner

5/16 1922 (Address) Sandpoint Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sandpoint Ida 3/31 1922

20. UNDERTAKER

ADDRESS

B. H. Pugh, Sandpoint Ida

Anderson

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **37965**

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

Registration District No. _____
County of **Bonner** Primary Registration District No. _____
City of **Sandpoint** (State) _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Gustave A. Thomas.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Married**
(Write the word.)

6. DATE OF BIRTH

July 8 1850
(Month) (Day) (Year)

7. AGE

71 Yrs. **9** Mos. **23** ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)**Farmer**

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

Thomas

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

n

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Dorothy Thomas

(Address)

Coeville, Idaho

15.

Filed

June 2 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 1, 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY That I attended deceased from **died not attend** **May 1 1922**
to **May 1 1922**
that I last saw him alive on **Apr 19 1922**
and that death occurred on the date stated above, at **7 AM**.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

E. T. Anderson M. D.19. (Address) **Sandpoint Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Shawano, Wisconsin.

DATE OF BURIAL

19. _____

20. UNDERTAKER

Moon & Dals

ADDRESS

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

RECEIVED

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

37966

1. PLACE OF DEATH Burns Registration District No. 78
 County of Burns BUREAU OF VITAL Primary Registration District No. 2455
 City of Sandpoint (No. Central Hospital) St.)

File No. _____

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME (Baby) Pierce

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH.

5 10 1922
(Month) (Day) (Year)

7. AGE

Yrs. Mos. 3 ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

infant

9. BIRTHPLACE

(State or Country)

Sandpoint Ida

10. NAME OF FATHER

Harold Pierce

11. BIRTHPLACE OF FATHER

(State or Country)

Iowa

12. MAIDEN NAME OF MOTHER

Lena McCaughey

13. BIRTHPLACE OF MOTHER

(State or Country)

Or.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

E. J. Anderson
Sandpoint Ida

15.

Filed

June 2 1922

Local Registrar

16. DATE OF DEATH

May 13 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

5-10 1922 to 113 1922

that I last saw him alive on 5-13 1922

and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Valvular insufficiency.(1- Blue Baby.)(Duration) Yrs. mos. 3 ds.Contributory (Secondary) Blue baby.(Duration) yrs. mos. 3 ds.(Signed) E. J. Anderson M. D.5/13/1922 (Address) Sandpoint Ida

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sandpoint Idaho May 14 1922

20. UNDERTAKER

ADDRESS

B. H. Ingels Sandpoint, Ida.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

JUN 5 1922

Registration District No. 78

County of

BUREAU OF VITAL STATISTICS

Primary Registration District No. 2155

File No.

37967

City of Sandpoint

(Name of Place) On Ranch, near Dover, St. Idaho

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Helen Fox Clapham

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

79

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

F.

White

Widowed
(Write the word.)

6. DATE OF BIRTH

Oct.

10

1833

(Month)

(Day)

(Year)

7. AGE

88 Yrs.

7 Mos.

2 ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

At Home

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Scotland

10. NAME OF FATHER

Robert Fox

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Mary Owen

13. BIRTHPLACE OF MOTHER

(State or Country)

Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. C. L. B. Lantz

(Address)

Dover, Idaho.

15.

Filed

June 2 1922

Vivian Allen
Deputy Local Registrar

16. DATE OF DEATH

May 12 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 19 18 to May 19 22

that I last saw her alive on May 6 19 22

and that death occurred on the date stated above, at 10:30 A.M.

The CAUSE OF DEATH* was as follows:

myocarditis chronic

(Duration) 4 Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

O. F. Page

M. D.

5/16/19 22 (Address) Sandpoint, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Buffalo New York 5/22/19 22

20. UNDERTAKER

ADDRESS

B. H. Pugh, Sandpoint, Ida.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bonneville
City of ColtmanRegistration District No.
Primary Registration District No. 1-1-5
(No. St.)File No. 37970
Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Martha E. Williams

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH

January 17 1860
(Month) (Day) (Year)

7. AGE

67 Yrs. 1 Mos. 28 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).at home

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

Charles Smith

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Ann Diller

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Gary Wilson
Rt 5 Ida Falls

15.

Filed Mar 13 1922 Coltman
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 11 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Jan 1922 to Feb 26 1922
that I last saw her alive on Feb 26 1922
and that death occurred on the date stated above, at 4 P M.
The CAUSE OF DEATH* was as follows:
General Debility(Duration) Yrs. 2 mos. ds.
Contributory (Secondary) Smile Dementia(Duration) 8 yrs. mos. ds.
(Signed) Jabez West M. D.
7/3 1922 (Address) Idaho Falls, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Idaho Falls, IdaDATE OF BURIAL 3/14 1922

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 37971

Registered No. 47

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Bonneville Registration District No. 73
City of Idaho Falls Primary Registration District No. 21 V 70
(No.) (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Abbie Colver

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH

Nov 6 1862
(Month) (Day) (Year)

7. AGE

58 Yrs. 5 Mos. 6 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

at Home

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

Benj. F. Palmer

11. BIRTHPLACE OF FATHER

(State or Country)

Mich.

12. MAIDEN NAME OF MOTHER

Kegiah Kirkland

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. M. Colver
Idaho Falls

15.

Filed

Apr. 24 1922

W. M. Munn

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 12 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 8 1922, to Apr 17 1922, that I last saw her alive on 17 Apr 1922 and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Acute Dilatation Heart
(Hyperthyroidism)Contributory
(Secondary)

(Duration) 1 Yrs. 1 Mos. 1 Ds.

(Duration) 1 Yrs. 1 Mos. 1 Ds.

(Signed)

M. D.

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho Falls

4/16 1922

20. UNDERTAKER

ADDRESS

C. C. Woodward

Idaho Falls

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 37972
Registered No. 679721. PLACE OF DEATH RECEIVED
County of Bannock Registration District No. 73
City of Idaho Falls Primary Registration District No. 2100
City of Idaho Falls (State)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Maria Ann Park

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)6. DATE OF BIRTH Sep ? 1963
(Month) (Day) (Year)7. AGE 58 6 ? Yrs 6 Mos ? ds
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)at home

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Wm. H. Carson

11. BIRTHPLACE OF FATHER

(State or Country)

Ill

12. MAIDEN NAME OF MOTHER

Ann McMain

13. BIRTHPLACE OF MOTHER

(State or Country)

?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

James F. Park
Rexburg, Ida

15.

Filed

Apr 11 1922W. H. Woodley
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 28 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Mar 22 1922 to Mar 28 1922
that I last saw him alive on Mar 27 1922
and that death occurred on the date stated above, at 29 M.

The CAUSE OF DEATH* was as follows:

Following a operation for
chronic cholecystitis(Duration) Yrs. mos. ds. 2 1 2
Contributory (Secondary) Chronic cholecystitis(Duration) Yrs. mos. ds. 4 0 0(Signed) H. F. Hatch M. D.(Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rexburg, IdaApr 11 1922

20. UNDERTAKER

ADDRESS

W. H. WoodleyIdaho Falls

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 73
County of Bannock **REGISTERED**
City of Idaho Falls **MAINE** Idaho St.)
If death occurs away from usual residence, give facts called for under special information.File No. 37973
Registered 37973

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Florence Maria Wade

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH

June 26 1893
(Month) (Day) (Year)

7. AGE

39 Yrs. 9 Mos. 28 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).at Home

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Geo. White

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Phoebe Saunders

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

F. F. Wade

(Address)

Felt, Idaho

15. Filed

Apr 29 1922 C. F. ...

Local Registrar

C. F. ...

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 28 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Apr 26 1922 to Apr 28 1922
that I last saw him alive on Apr 28 1922and that death occurred on the date stated above, at Idaho Falls, Idaho M.

The CAUSE OF DEATH* was as follows:

Sagema Kidney
Gallstones

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. 6 mos. ds.

(Signed)

4/28/22 1922 C. F. ... M. D.
(Address) Idaho Falls, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

ship

19. PLACE OF BURIAL OR REMOVAL

St. Michaels - Ashton

DATE OF BURIAL

4-28-1922

20. UNDERTAKER

C. F. ...

ADDRESS

Idaho Falls

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bonneville Registration District No. 73
City of Idaho Falls Primary Registration District No. 2100
City of Idaho Falls (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Olivia Wayne CookFile No. 37974
Registered No. 37974

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Child
(Write the word.)

6. DATE OF BIRTH

May 7 1912
(Month) (Day) (Year)

7. AGE

10 Yrs. 11 Mos. 26 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)at home

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Stephen J Cook

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Amy Lord

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Stephen J Cook

(Address)

2100 W 6 City

15. FILED

Apr 29 1922 Local Registrar

16. DATE OF DEATH

April 28 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
..... 19....., to 19.....that I last saw him..... alive on..... 19.....
and that death occurred on the date stated above, at 2A M.

The CAUSE OF DEATH* was as follows:

Unknown - A fatal infection causedNo medical attendance
(Duration) 3-4 hrs. 4 mos. 4 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Dr. J. W. L. L. L. M. D.
1922 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Taylor La.

DATE OF BURIAL

7/30 1922

20. UNDERTAKER

W. W. Woodley

ADDRESS

Idaho Falls

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of BannockCity of Shelton

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No. 73Primary Registration District No. 2140

(No. _____)

(St. _____)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 37975Registered No. 1-1

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

June 12 1884
(Month) (Day) (Year)

7. AGE

37 Yrs. 9 Mos. 7 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)at Home

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Ed. Stauffer

11. BIRTHPLACE OF FATHER

(State or Country)

Pa

12. MAIDEN NAME OF MOTHER

Katie Jones

13. BIRTHPLACE OF MOTHER

(State or Country)

Pa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Joe Plittan

(Address)

Rd 2 Regby

15.

Filed

Apr 11 1922W. H. Woodard

Local Registrar

16. DATE OF DEATH

March 19 1922
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from 3/1 1922, to 3/19 1922that I last saw him alive on 3/19 1922and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Influenza(Duration) _____ Yrs. _____ mos. _____ ds.
Contributory (Secondary) Myocardial
Heart Failure(Duration) _____ Yrs. _____ mos. _____ ds.
(Signed) Sam F Price M. D.340 1922 (Address) Meridian Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Shelton, Ida

DATE OF BURIAL

3/21 1922

20. UNDERTAKER

W. H. Woodard

ADDRESS

Meridian IdahoSt. Price

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Carneville
City of Idaho FallsRegistration District No. 23Primary Registration District No. 21470File No. 37976Registered No. 7

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

John A Bybee

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Male

4. COLOR OR RACE

White5. SINGLE, MARRIED, WIDOWED OR DIVORCED
(Write the word.)married

6. DATE OF BIRTH

Apr 5 1867
(Month) (Day) (Year)

7. AGE

54 Yrs. 11 Mos. 24 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Farming

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

David Bybee

11. BIRTHPLACE OF FATHER

(State or Country)

Ill

12. MAIDEN NAME OF MOTHER

Mary Purrod

13. BIRTHPLACE OF MOTHER

(State or Country)

Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Carrie Bybee

(Address)

R.D. 5 Idaho Falls

15.

Filed

3/29 1922

Local Registrar

16. DATE OF DEATH

McH 29 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

.....19....., to19.....
that I last saw him alive on19.....
and that death occurred on the date stated above, at 9 A. M.
The CAUSE OF DEATH* was as follows:Arterio Sclerosis(Duration) 1 Yrs. mos. ds.Contributory
(Secondary)(Duration) yrs. mos. ds.

(Signed)

W. C. Cullen M. D.3/30 1922 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Idaho Falls

DATE OF BURIAL

3/31 1922

20. UNDERTAKER

Edwin Woodley

ADDRESS

Idaho Falls

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bonneville Registration District No. 73
 City of Idaho Falls Primary Registration District No. 2140
 (State) Idaho St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

German Bauman

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 37977
Registered No. 177

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
 (Write the word.)

6. DATE OF BIRTH

Dec 28 1850
 (Month) (Day) (Year)

7. AGE

71 Yrs. 3 Mos. 18 ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

Farming

9. BIRTHPLACE

(State or Country)

Wis

10. NAME OF FATHER

Frederick Bauman

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Ernestina ?

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs Bauman

(Address)

R D 2 Celiz

15.

Filed Apr 24 1922 L. K. Korman
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 16 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3/27/1922 to 4/16/1922

that I last saw h. 4/13/1922 alive on 4/13/1922
 and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Nephritis

(Duration) Yrs. mos. ds.

Contributory
 (Secondary)

Myocarditis

(Duration) Yrs. mos. ds.

(Signed)

J. C. Hollister

M. D.

4/18/1922 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Idaho Falls

DATE OF BURIAL
4-20-1922

20. UNDERTAKER

E. E. Woodley Idaho Falls

ADDRESS

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **37978**Registered No. **76**

1. PLACE OF DEATH

County of Bonneville
City of AlconRegistration District No. 73Primary Registration District No. 214-0No. 11St. Idaho

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Joan Haymon Godfrey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Child

(Write the word.)

6. DATE OF BIRTH

January 8 1911
(Month) (Day) (Year)

7. AGE

11 Yrs. 3 Mos. 7 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

George Godfrey

11. BIRTHPLACE OF FATHER

(State or Country) Utah

12. MAIDEN NAME OF MOTHER

Mary Haymon

13. BIRTHPLACE OF MOTHER

(State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. J. Dumas, Jr.(Address) Highway 21, Alcon

15.

Filed Apr 21 19 22 Alcon

Local Registrar

16. DATE OF DEATH

April 15 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____ 19____, to _____ 19____

that I last saw him _____ alive on _____ 19____

and that death occurred on the date stated above, at 12:30 M.

The CAUSE OF DEATH* was as follows:

Medical attendance

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

_____ 19____ (Address) _____

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Alcon, Idaho

DATE OF BURIAL

4-17 19 22

20. UNDERTAKER

E. J. Dumas, Jr.

ADDRESS

Idaho Falls

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock
City of Idaho FallsRegistration District No. 73Primary Registration District No. 2100(No. St.)File No. 37979
Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

ChampNielsen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Infant
(Write the word.)

6. DATE OF BIRTH

Sep 23 1921
(Month) (Day) (Year)

7. AGE

0 5 21
Yrs. Mos. ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Leo J Nielsen

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Eleanore Campbell

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

L. P. Nielsen

(Address)

R. R. 3, City

15.

Filed

Mar 21 1922 W. J. Munn

Local Registrar

16. DATE OF DEATH

March 16 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Feb 25 1922 to March 16 1922that I last saw him alive on March 15 1922
and that death occurred on the date stated above, at 430 a M.

The CAUSE OF DEATH* was as follows:

Cerebral Meningitis(Duration) Yrs. mos. 6 ds.
Contributory Influenzal Pneumonia
(Secondary)(Duration) yrs. mos. 14 ds.(Signed) [Signature] M. D.3/17 1922 (Address) Idaho Falls

*State the Disease Causing Death or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Idaho Falls, Ida

DATE OF BURIAL

3/17 1922

20. UNDERTAKER

Edmund Woodley

ADDRESS

Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH ✓
County of Bannock Registration District No. 2-1-2
City of Idaho Falls Primary Registration District No. 2-1-2
(No. _____, _____ St.)

File No. _____
Registered No. 87980

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Bruce B Stanger

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

10

3. SEX Male 4. COLOR OR RACE White 5. SINGLE MARRIED, WIDOWED OR DIVORCED Infant
(Write the word.)

6. DATE OF BIRTH July 7 1921
(Month) (Day) (Year)

7. AGE 8 yrs. 12 mos. 12 ds. IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE Idaho, Ida
(State or Country)

10. NAME OF FATHER Frank Stanger

11. BIRTHPLACE OF FATHER Idaho
(State or Country)

12. MAIDEN NAME OF MOTHER Geneva Ryber

13. BIRTHPLACE OF MOTHER Idaho
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank Stanger
(Address) Idaho, Ida

15. Filed Mar 21 - 1922 W. P. Mendenhall
Local Registrar

16. DATE OF DEATH March 15 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 4, 1922 to Mar. 15, 1922
that I last saw him alive on Mar. 15, 1922
and that death occurred on the date stated above, at 3:30 P.M.

The CAUSE OF DEATH* was as follows:

Influenza
(Duration) 3 weeks yrs. mos. ds.
Contributory (Secondary) Pneumonia
(Duration) 14 yrs. mos. ds.
(Signed) W. T. Meller M. D.
19 _____ (Address) Idaho Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.
Where was disease contracted if not at place of death?
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Idaho, Ida DATE OF BURIAL 3/17/1922
20. UNDERTAKER Edmund ADDRESS _____

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bonneville
City of AmmonRegistration District No. 23
Primary Registration District No. 214-0
(No. 1 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ronald MarshallFile No. 37984
Registered No. 3

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Infant
(Write the word.)6. DATE OF BIRTH May 26 1922
(Month) (Day) (Year)7. AGE 9 Yrs. 18 Mos. 18 ds. IF LESS than 1 day how many..... hrs. or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Ronald Marshall

11. BIRTHPLACE OF FATHER

(State or Country) Idaho

12. MAIDEN NAME OF MOTHER

Lattie Owen

13. BIRTHPLACE OF MOTHER

(State or Country) Ammon Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Rosa Owen(Address) Rt 3 - Idaho15. Filed Mar 24 1922 W. J. P. J.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 16 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Mar 10 1922 to Mar 16 1922 that I last saw him alive on March 15 1922 and that death occurred on the date stated above, at 7:15 M.

The CAUSE OF DEATH* was as follows:

Influenza Pneumonia(Duration) Yrs. 10 mos. 10 ds.
Contributory (Secondary) Influenza(Duration) yrs. 4 mos. 4 ds.
(Signed) W. J. P. J. M. D.3/17/22 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Ammon, Ida

DATE OF BURIAL

3/17/1922

20. UNDERTAKER

Calumwood

ADDRESS

Idaho FallsDr. J. H. J.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **37982**
Registered No. **42**

1. PLACE OF DEATH *Boonville*
County of *Boonville* Registration District No. *13*
City of *Boonville* Primary Registration District No. *210-0*
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Darius Clyde DeMott

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Infant*
(Write the word.)

6. DATE OF BIRTH *Sep 3 1922*
(Month) (Day) (Year)

7. AGE *1 Yrs. 6 Mos. 15 ds.* IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE *Idaho*
(State or Country)

10. NAME OF FATHER *Clyde DeMott*

11. BIRTHPLACE OF FATHER *Utah*
(State or Country)

12. MAIDEN NAME OF MOTHER *Clara Smith*

13. BIRTHPLACE OF MOTHER *Idaho*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Clyde DeMott*
(Address) *Idaho*

15. *Mar 22 1922*
Filed Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 18 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *March 15 1922* to *March 18 1922* that I last saw him alive on *March 17 1922* and that death occurred on the date stated above, at *5 A.* M. The CAUSE OF DEATH* was as follows:

Ulcerative Stomatitis
Gangrenous or Necrotic

(Duration) *Several* yrs. mos. ds.

Contributory (Secondary) *Pneumonia*

(Duration) *2* yrs. mos. ds.

(Signed) *G. D. Pendleton* M. D.
Mar 22 1922 (Address) *Idaho Falls Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Idaho* DATE OF BURIAL *3/19 1922*

20. UNDERTAKER *E. B. Woodward* ADDRESS *Idaho Falls*

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH,

County of *Cameville*

City of *Idaho Falls*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Arthur Leavardson Jr.

CERTIFICATE OF DEATH

Registration District No. *73*

Primary Registration District No. *2140*

73

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. *37984*

Registered No. *40*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Infant
(Write the word.)

6. DATE OF BIRTH

July 22 1919
(Month) (Day) (Year)

7. AGE

2 Yrs. *7* Mos. *25* ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Arthur J. Leavardson

11. BIRTHPLACE OF FATHER

(State or Country)

Mont.

12. MAIDEN NAME OF MOTHER

Mary Wilson

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Edmund

(Address)

Dubois, Idaho

15.

Filed

May 20 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 19 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to *19*

that I last saw him alive on *19*

and that death occurred on the date stated above, at *20* M.

The CAUSE OF DEATH* was as follows:

Acute Peritonitis

(Duration) Yrs. mos. *5* ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

Edmund

M. D.

3/20/22

(Address) *Idaho Falls, Id.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Dubois, Idaho

3/20/22

20. UNDERTAKER

ADDRESS

Edmund

Idaho Falls

Dr. Clive

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

MAY 23 1922

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Boundary
City of Bonners Ferry (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Howard H. Stone

File No. 37285
Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH March 6 1861
(Month) (Day) (Year)

7. AGE 61 Yrs. 1 Mos. 1 ds. IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Carpenter
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) New York

10. NAME OF FATHER Howard H. Stone

11. BIRTHPLACE OF FATHER
(State or Country) N. Y.

12. MAIDEN NAME OF MOTHER Mary Green

13. BIRTHPLACE OF MOTHER
(State or Country) N. Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) George Rank
(Address) _____

15. Filed Apr. 8 1922 S. S. Fry
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 7 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 31 1921 to Apr. 7 1922
that I last saw him alive on Apr. 6 1922
and that death occurred on the date stated above, at 9 P. M.
The CAUSE OF DEATH* was as follows:

Manic Depressive Psychosis (?)

(Duration) 1 Yrs. _____ mos. _____ ds.
Contributory (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) S. S. Fry M. D.
4/8 1922 (Address) Bonners Ferry, Id.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days
Where was disease contracted if not at place of death? _____
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Bonners Ferry DATE OF BURIAL Apr 9 1922
20. UNDERTAKER DRD Toomy ADDRESS Bonners Ferry

1. PLACE OF DEATH

County of Bounday
 City of Bonners Ferry

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Harry A. Graham

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

married
(Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

about

IF LESS than 1 day
 how many hrs.
 or min.?

56 Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

laborer

9. BIRTHPLACE

(State or Country)

Penn.

10. NAME OF FATHER

William Graham

11. BIRTHPLACE OF FATHER

(State or Country)

Penn.

12. MAIDEN NAME OF MOTHER

Kate Blaney

13. BIRTHPLACE OF MOTHER

(State or Country)

Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

James A. Graham

(Address)

15.

Filed

Apr. 5th 1922

E. E. Tracy
 Local Registrar

RECEIVED
 CERTIFICATE OF DEATH
 Registration District No. 79
 Primary Registration District No. 3156
 BUREAU OF VITAL STATISTICS

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No.

37986

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 5, 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19

that I last saw him alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Myocarditis (?)

(Duration) 1/2 hour yrs. mos. ds.

Contributory
 (Secondary)

(Duration) yrs. mos. ds.

(Signed)

4/5/22 (Address) Bonners Ferry M. D.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Bonners Ferry Id.

DATE OF BURIAL

Apr 7 1922

20. UNDERTAKER

W. B. Storky

ADDRESS

Bonners Ferry

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S
should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement
of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

1. PLACE OF DEATH **BOUNDARY** **RECEIVED** **CERTIFICATE OF DEATH**
County of **Boundary** Registration District No. **79**
City of **Haples** **BUREAU** Primary Registration District No. **2156**
If death occurs away from usual residence, give facts called for under special information. 3 (No. St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **37987**
Registered No.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME **Clarence Elmer Chittenden**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **married**
(Write the word.)

6. DATE OF BIRTH. **856**
(Month) (Day) (Year)

7. AGE **66** Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION **Farmer**
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE **Vermont**
(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER **Vermont.**
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER **Vermont.**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **R. R. Bath**
(Address) **Haples, Ida.**

15. **Apr. 16 1922**
Filed **SS**
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **April 15-1922**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Apr. 10, 1922** to **April 15, 1922**
that I last saw him alive on **April 15, 1922**
and that death occurred on the date stated above, at **7 P.** M.

The CAUSE OF DEATH* was as follows:
Carcinoma of face
(Duration) Yrs. mos. ds.

Contributory (Secondary) **Myocarditis**
(Duration) **5** Yrs. mos. ds.
(Signed) **R. R. Bath** M. D.
4/16/22 (Address) **Bonner Ferry, Ida.**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days, In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **Spokane, wa** DATE OF BURIAL **4/17/1922**

20. UNDERTAKER **J. M. Knight** ADDRESS **Spokane, wa**

Form V. S. No. 5 20M.1-16-12

MAR 23 1922 CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics1. PLACE OF DEATH Burnsville Registration District No. 79
County of Boundary Primary Registration District No. 2156
City of Bonners Ferry (No. _____, St.)File No. 37988
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Infant
(Write the word.)6. DATE OF BIRTH April 2 1919
(Month) (Day) (Year)7. AGE 2 yrs. 0 mos. 19 ds.
IF LESS than 1 day
how many _____ hrs. or
_____ mins.?8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)9. BIRTHPLACE
(State or Country) Oregon10. NAME OF FATHER Robert Ernest Williams11. BIRTHPLACE OF FATHER
(State or Country) Wash.12. MAIDEN NAME OF MOTHER Sarah Snyder13. BIRTHPLACE OF MOTHER
(State or Country) Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Robert Ernest Williams
(Address) _____15. Filed Apr. 22 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH. 4616. DATE OF DEATH April 21 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from April 1 1922, to April 21 1922, that I last saw him alive on April 21 1922, and that death occurred on the date stated above, at 11 A. M.

The CAUSE OF DEATH* was as follows:

Brain Tumor
(Istioma)(Duration) ? yrs. mos. ds.Contributory
(Secondary)

(Duration) _____ yrs. mos. ds.

(Signed) Russell M. D.May 1922 (Address) Bonners Ferry Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Bonners Ferry Idh Apr. 23 1922

20. UNDERTAKER ADDRESS

Or Storky Bonners Ferry

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.....
County of Bonanza Registration District No. 79
City of Bonanza Primary Registration District No. 215-6
(No. St.)

File No. **37989**

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Perry Wilson Jeffr

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH Mar 6 1859
(Month) (Day) (Year)

7. AGE 63 yrs. 1 mos. 20 ds. IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Miner
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE Ill.
(State or Country)

10. NAME OF FATHER Benjamin Jeffr

11. BIRTHPLACE OF FATHER Ill.
(State or Country)

12. MAIDEN NAME OF MOTHER Mary Jane Naylor

13. BIRTHPLACE OF MOTHER Ill.
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Emma B. Jeffr
(Address) Copeland, Idaho

15. Filed 4/27/1922 Local Registrar E. E. Jeffr

MEDICAL CERTIFICATE OF DEATH

40

16. DATE OF DEATH Apr. 26 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 5 1922 to April 26 1922
that I last saw him alive on April 26 1922
and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

(Duration) ? yrs. mos. ds.

Contributory Carcinoma of liver
(Secondary)

(Duration) 1 yrs. mos. ds.

(Signed) R. B. Bowell M. D.

May 1922 (Address) Bonanza Ferry Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Bonanza Ferry Ida Apr. 28 1922

20. UNDERTAKER ADDRESS

W. H. Jeffr Bonanza Ferry Ida

1. PLACE OF DEATH

County of BoundaryCity of Bonners Ferry

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED CERTIFICATE OF DEATH

Registration District No. 79Primary Registration District No. 2156(No. 79)

(St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 37990

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Dec
(Month)25
(Day)1922
(Year)

7. AGE

18 Yrs. 4 Mos. 5 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Scholar

9. BIRTHPLACE

(State or Country)

Oklahoma

10. NAME OF FATHER

W. F. Mc Donald

11. BIRTHPLACE OF FATHER

(State or Country)

Kans.

12. MAIDEN NAME OF MOTHER

Catherine Walters

13. BIRTHPLACE OF MOTHER

(State or Country)

Kans.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Home Mc Donald

(Address)

Bonners Ferry Ida

15.

Filed

May 1 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

79

16. DATE OF DEATH

Apr
(Month)30
(Day)1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 24 1922 to April 30 1922that I last saw him alive on April 27 1922and that death occurred on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation(Duration) 12 Yrs. mos. ds.Contributory (Secondary) Myocarditis(Duration) 1 yrs. mos. ds.(Signed) R. B. Burrell M. D.May 22 (Address) Bonners Ferry, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Bonners Paradise Valley

DATE OF BURIAL

5/2 1922

20. UNDERTAKER

Chas. Lockey

ADDRESS

Bonners Ferry

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-

RECEIVED

CERTIFICATE OF DEATH.

 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

 1. PLACE OF DEATH. *Bureau of Vital Statistics*
 County of *Butte* Registration District No. *59*
 City of *Arco* (No. _____ St.)

 File No. *37991*
 Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lorna Jane Curtis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

 3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. *Single*

(Write the word.)

6. DATE OF BIRTH.

May 12 1922
 (Month) (Day) (Year)

7. AGE

 Yrs. *14* Mos. _____ ds.

 IF LESS than 1 day
 how many _____ hrs. or
 _____ min.

8. OCCUPATION

 (a) Trade, profession or particular kind of work. _____
 (b) General nature of industry, business, or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country)

Howe, Idaho

10. NAME OF FATHER

Frank Curtis

11. BIRTHPLACE OF FATHER

(State or Country)

Oregon

12. MAIDEN NAME OF MOTHER

Etta Taylor

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Ray D. Schlegel
Arco, Idaho

15.

Filed

5 26 - 191 22 *E. W. Fox*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 26 191 22
 (Month) (Day) (Year)

 17. I HEREBY CERTIFY, That I attended deceased from *May 26 191 22* to *May 26 191 22*
 that I last saw him alive on *May 26 191 22*
 and that death occurred on the date stated above, at *3 A.M.*

The CAUSE OF DEATH* was as follows:

Stem on edge from vagina and navel

 (Duration) _____ Yrs. _____ mos. *2 hours* ds.

 Contributory
 (Secondary) _____

(Duration) _____ yrs. _____ mos. _____ ds.

 (Signed) *E. W. Fox* M. D.

 19. (Address) *Arco, Idaho*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Howe, Idaho *5 28 191 22*

20. UNDERTAKER

ADDRESS

Ray D. Schlegel *Arco, Idaho*

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD.
N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH RECEIVED
Registration District No. 59
County of Butte JUN 7 1922
Primary Registration District No. _____
City of Arco BUREAU OF VITAL STATIONS St.)

File No. 37992
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME L. J. Fallert

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word)

6. DATE OF BIRTH March 15 1922
(Month) (Day) (Year)

7. AGE _____
If LESS than 1 day how many _____ hrs. or _____ min. 2)

8. OCCUPATION _____
(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE _____
(State or Country) Arco, Idaho

10. NAME OF FATHER Chas. Thompson

11. BIRTHPLACE OF FATHER Indian, Utah
(State or Country)

12. MAIDEN NAME OF MOTHER Abrahamia Petty

13. BIRTHPLACE OF MOTHER Indian, Utah
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. Alice Petty
(Address) Arco, Idaho

15. Filed 5/6 191 2 E. J. Fox
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 5 5 191 22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5/2 191 22 to 5/5 191 22
that I last saw him alive on 5/5 191 22
and that death occurred on the date stated above, at 11 P M.

The CAUSE OF DEATH* was as follows:

Meningitis

(Duration) _____ Yrs. _____ mos. 7 ds.

Contributory (Secondary) _____

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) E. J. Fox M. D.

19. (Address) Arco, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Arco, Idaho DATE OF BURIAL 5/6 191 22

20. UNDERTAKER Alice Petty ADDRESS Arco, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

1. PLACE OF DEATH.

County of *Butte*
City of *Moore*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Sarah Elizabeth Hamblet

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widowed

(Write the word.)

6. DATE OF BIRTH.

Jan
(Month)*2*
(Day)*1849*
(Year)

7. AGE

73 Yrs.*3* Mos.*29* ds.IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*House wife*

9. BIRTHPLACE

(State or Country)

Georgia

10. NAME OF FATHER

Jerry Jones

11. BIRTHPLACE OF FATHER

(State or Country)

Tennessee

12. MAIDEN NAME OF MOTHER

Jane Oxford

13. BIRTHPLACE OF MOTHER

(State or Country)

Georgia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Jess Hamblet
Moore, Okla.

15.

Filed

May 2 191 *22**E. J. Fox*

Local Registrar

RECEIVED CERTIFICATE OF DEATH

JUN 7 1922

Registration District No. *59*

BUREAU OF VITAL STATISTICS

Primary Registration District No.

St.)

File No.

Registered No.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

37993

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May
(Month)*1*
(Day)*1922*
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 1 1922 *May 1* 1922that I last saw her alive on *May 1* 1922and that death occurred on the date stated above, at *3:45* M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

5/1

Address)

Arch. Oak

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death.....yrs.....mos.....days

In the

State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Moore, Okla**5/3**19122*

20. UNDERTAKER

ADDRESS

Ed Hamblet Moore, Okla

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED

MAY 23 1922

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Canyon*

City of _____

Bureau of Vital Statistics

Registration District No. _____

(No. _____)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

George Wm Linney

File No. _____
Registered No. **37994**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(write the word.)

6. DATE OF BIRTH

Mar 1 1862
(Month) (Day) (Year)

7. AGE

60 Yrs. _____ Mos. _____ ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Ill

10. NAME OF FATHER

Henry Linney

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Fanning

13. BIRTHPLACE OF MOTHER

(State or Country)

Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. N. Pearsall
Melba Ida

(Address)

15.

Filed *Apr 25 1922*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 22 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

about Nov. 1920, to Apr 22, 1922

that I last saw him alive on *Apr 15, 1922*

and that death occurred on the date stated above, at *7 A.M.*

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) *over 1 4* Yrs. _____ mos. _____ ds.

Contributory *Valvular heart lesions*
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) *E. R. Proctor* M. D.

19. (Address) *Nampa, Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Nahler Lawn Bur

DATE OF BURIAL

Apr 24 1922

20. UNDERTAKER

L. A. Robinson

ADDRESS

Nampa Ida

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **37995**
Registered No.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED

Registration District No.

Primary Registration District No.

St.)

BUREAU OF VITAL STATISTICS

J. J. Matthews

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

(Duration) Yrs. mos. ds.
Contributory (Secondary)

(Duration) yrs. mos. ds.
(Signed) M. D.
(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.

County of

Primary Registration District No.

City of

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

File No.

Registered No.

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

7. AGE

Yrs.

Mos.

ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF
FATHER11. BIRTHPLACE
OF FATHER

(State or Country)

12. MAIDEN NAME
OF MOTHER13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April

30

19 22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Apr 28 19 22, to Apr 30 19 22

that I last saw him alive on Apr 29 19 22

and that death occurred on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral haemorrhage
Cerebral

(Duration)

Yrs.

mos.

1 ds.

Contributory
(Secondary)

Premature Birth

(Duration)

yrs.

7 1/2 mos.

ds.

(Signed)

Leo W Chilton

M. D.

5/10 1922

(Address) Nauvoo Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place

of death

yrs.

In the

days

State

yrs.

mos.

days

Where was disease contracted
if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Kahlerlawm Cem

May 1 19 22

20. UNDERTAKER

ADDRESS

Fred K Robinson

Nauvoo Ida

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **37997**

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Canyon Registration District No. 1
City of Hailey (No. 1 Boysen Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

for Emma Campbell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female white Married

6. DATE OF BIRTH

Nov 13 1887
(Month) (Day) (Year)

7. AGE

34 Yrs. 5 Mos. 4 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Missionary

9. BIRTHPLACE

(State or Country)

Texas

10. NAME OF FATHER

J. M. Gordon

11. BIRTHPLACE OF FATHER

(State or Country)

Kentucky

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Texas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

L. A. Campbell

(Address)

Huntington Ore

15.

Filed 17 Nov 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

10

16. DATE OF DEATH

Apr 17 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Apr 13 1922 to Apr 17 1922
that I last saw her alive on Apr 17 1922
and that death occurred on the date stated above, at 11 M.

The CAUSE OF DEATH* was as follows:

Influenza Pneumonia

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Thos E Mangum, M. D.my 9 1922 (Address) Hailey, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hailey, Idaho Apr 19 1922

20. UNDERTAKER

ADDRESS

And A. Robison, Hailey, Idaho

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon
City of WilderRegistration District No. 3Primary Registration District No. 2005

(No. _____ St.)

File No. 37999Registered No. 48

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Edna Aline Shumate

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-OWED OR DIVORCED single

6. DATE OF BIRTH

June 12 1912
(Month) (Day) (Year)

7. AGE

9 Yrs. 10 Mos. 1 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)At home.

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

John M. Shumate

11. BIRTHPLACE OF FATHER

(State or Country) Tenn.

12. MAIDEN NAME OF MOTHER

Francis L. Beck

13. BIRTHPLACE OF MOTHER

(State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frances L. Shumate(Address) Wilder Ida

15.

Filed April 15 1922John H. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 13 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar 23 1922 to April 13 1922
that I last saw h.er alive on April 13 1922
and that death occurred on the date stated above, at 5:30 P.
The CAUSE OF DEATH* was as follows:Chorea(Duration) Yrs. mos. 22 ds.Contributory
(Secondary)Pneumonia(Duration) yrs. mos. 1 ds.

(Signed)

C. S. Brock M. D.April 19 22 (Address) Wilder Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Wilder Cem.

DATE OF BURIAL

4-15-22

20. UNDERTAKER

C. V. Beckham

ADDRESS

Caldwell

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon Registration District No. 3
 City of Caldwell Primary Registration District No. 1005
 (No. _____ St.)

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Frank Clin Baker

File No. 38000Registered No. 49

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH

Sept. 6 1876
(Month) (Day) (Year)

7. AGE

45 Yrs. 7 Mos. 7 ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min. ?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer).

Clerk.

9. BIRTHPLACE

(State or Country)

Nebraska

10. NAME OF FATHER

James Lennon

11. BIRTHPLACE OF FATHER

(State or Country)

N. Y.

12. MAIDEN NAME OF MOTHER

Addie C Caldwell

13. BIRTHPLACE OF MOTHER

(State or Country)

I. Id.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

P. A. Bell

(Address)

Cambridge Ida

15. Filed

April 15 - 1922

John V. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 13 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar 1 1922 to April 13 1922
that I last saw him alive on April 13 1922
and that death occurred on the date stated above, at 50 M.

The CAUSE OF DEATH* was as follows:

Generalized Carcinomatosis

(Duration) Yrs. 7 mos. 13 ds.

Contributory Laryngeal carcinoma
(Secondary)

(Duration) yrs. 6 mos. _____ ds.

(Signed) R. G. Young M. D.

4/14/1922 (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Canyon Hill

DATE OF BURIAL

4-16 1922

20. UNDERTAKER

C. V. Peckham

ADDRESS

Caldwell Ida

City of Boise State of Idaho (No. 1)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jens P. Jensen

St.)

Registered No. 7

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
(Write the word.)6. DATE OF BIRTH Apr. 25 1922
(Month) (Day) (Year)7. AGE 74 Yrs. 11 Mos. 21 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession particular kind of work. Contractor and(b) General nature of industry, business or establishment in which employed (or employer). farmer

9. BIRTHPLACE

(State or Country) Denmark10. NAME OF FATHER Jens P. Jensen11. BIRTHPLACE OF FATHER Denmark
(State or Country)12. MAIDEN NAME OF MOTHER Kate13. BIRTHPLACE OF MOTHER Denmark
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Albert Jensen(Address) Ogden, Utah15. Filled April 17 1922 John H. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr. 16 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Feb. 7 1922 to April 16 1922 that I last saw him alive on April 15 1922 and that death occurred on the date stated above, at M. The CAUSE OF DEATH* was as follows:
Circumstances(Duration) 8 yrs. 8 mos. 0 ds.Contributory (Secondary) Obstruction bow(Duration) 10 yrs. 10 mos. 10 ds.(Signed) M. Baker M. D.(Address) Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 0 yrs. 0 mos. 0 days. In the State 0 yrs. 0 mos. 0 days.Where was disease contracted if not at place of death? Former or usual residence 19. PLACE OF BURIAL OR REMOVAL Banyon HillDATE OF BURIAL 4-18 192220. UNDERTAKER Paul E. CaseADDRESS Baldwin

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon Registration District No. 3
City of Caldwell Primary Registration District No. 1005
STATISTICS (No. _____) St. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Bormac Joseph ShorbFile No. 20003
Registered No. 20003

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH

June (Month) 5 (Day) 1893 (Year)

7. AGE

48 Yrs. 10 Mos. 17 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Editor and Publisher
Printing

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Massillon, Ohio

10. NAME OF FATHER

Henry Jacob Shorb
Ohio.

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Mary Elizabeth Henry

13. BIRTHPLACE OF MOTHER

(State or Country)

Canton, Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ida E. Shorb
621 Everett.

(Address)

15.

Filed

April 24- 1922J. D. Meyer
Local Registrar

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Apr. (Month) 22 (Day) 1922 (Year)17. I HEREBY CERTIFY, That I attended deceased from Feb 9 1922 to April 22 1922 that I last saw him alive on April 22 1922 and that death occurred on the date stated above, at 6 P. M.
The CAUSE OF DEATH* was as follows:Brain Abscess

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) 2 or 3 Yrs. _____ mos. _____ ds.

(Signed)

J. D. Meyer M. D.
4/24/1922 (Address) Caldwell, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Canyon Hill

DATE OF BURIAL

4-25-1922

20. UNDERTAKER

Paul R. Case

ADDRESS

Caldwell

RECEIVED
CERTIFICATE OF DEATHMAY 23 1922
Registration District No.BUREAU OF VITAL STATISTICS
Registration District No. 2005

(No. St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 38994
Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of *Blaine Canyon*
City of *Houston*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

2. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

single
(Write the word.)

6. DATE OF BIRTH

Oct 29 1906
(Month) (Day) (Year)

7. AGE

*15 Yrs 6 Mos 8 ds*IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Wyoming

10. NAME OF FATHER

L. C. Benson

11. BIRTHPLACE OF FATHER

(State or Country)

Missouri

12. MAIDEN NAME OF MOTHER

Nora M. Spidell

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *L. C. Benson*(Address) *Houston, Idaho*

15.

Filed *May 6 - 1922* *John H. Meyers*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 7 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to *19*that I last saw him alive on *19*and that death occurred on the date stated above, at *M.*

The CAUSE OF DEATH* was as follows:

*Acute Nephritis**Information from Dr. M. C. Cole M.D.*
(Duration) Yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *Paul L. Base* M. D.*Coroner*
(Address) *Baldwell, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Reynolds Creek Cemetery *5-8 1922*

20. UNDERTAKER

ADDRESS

Paul L. Base *Baldwell*

1. PLACE OF DEATH

County of Canyon Registration District No. 3
 City of Baldwell Primary Registration District No. 2005
 (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

E. T. Tiday

CERTIFICATE OF DEATH

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 38005
 Registered No. 60

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male White Probably Single
 (Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

30 about
 Yrs. Mos. ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

Sheep Herding

9. BIRTHPLACE

(State or Country)

Not Known

10. NAME OF FATHER

" "

11. BIRTHPLACE OF FATHER

(State or Country)

" "

12. MAIDEN NAME OF MOTHER

" "

13. BIRTHPLACE OF MOTHER

(State or Country)

" "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Murray Harrington
 (Address) Jordan Valley, Oregon

15.

Filed May 8 1922

John H. Meyer
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

79

16. DATE OF DEATH

May 7 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

.....19....., to19.....

that I last saw h..... alive on.....19.....

and that death occurred on the date stated above, at.....M.

The CAUSE OF DEATH* was as follows:

Found dead in bed
Indications heart failure.

(Duration) Yrs. mos. ds.

Contributory
 (Secondary)

(Duration) yrs. mos. ds.

(Signed) Paul L. Base M. D.

58-1922 (Address) Corner Baldwin Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Neashe mo

19

20. UNDERTAKER

ADDRESS

Paul L. Base

Baldwell

1. PLACE OF DEATH

County of CanyonCity of Baldwell

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED

CERTIFICATE OF DEATH

Registration District No. 3Primary Registration District No. 1005(No. 1005)

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 38006Registered No. 39

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

May
(Month)6
(Day)1922
(Year)

7. AGE

Yrs.

Mos.

1

ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Baldwell Ida.

10. NAME OF FATHER

Carroll H. Atkinson

11. BIRTHPLACE OF FATHER

(State or Country)

Nebraska

12. MAIDEN NAME OF MOTHER

Ruby H. Baker

13. BIRTHPLACE OF MOTHER

(State or Country)

Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

222 So. 1st Caldwell, Id.

15.

Filed

May 7, 1922John B. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May
(Month)6
(Day)1922
(Year)

17. I HEREBY CERTIFY, That, I attended deceased from

May 6, 1922 to May 6, 1922that I last saw him alive on May 6, 1922and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration)

Yrs.

mos.

1 ds.Contributory
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

5/7/22

(Address)

Edmund Adair
M. D.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

Yrs.

mos.

In the

days.

State

Yrs.

mos.

days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Canyon Hill

DATE OF BURIAL

May 7, 1922

20. UNDERTAKER

Paul L. Case

ADDRESS

Caldwell

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 3
 County of Canyon Primary Registration District No. 2005
 City of Nature (No. 115) St.

 File No. 38007
 Registered No. 58

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Chester Verbena Ode

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

 3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
 (write the word.)

6. DATE OF BIRTH

Dec 13 1906
 (Month) (Day) (Year)

7. AGE

15 Yrs. 4 Mos. 14 ds.

 IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

 (a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

Schoolgirl.

9. BIRTHPLACE

 (State or Country) Idaho

10. NAME OF FATHER

Wm H. Ode

11. BIRTHPLACE OF FATHER

 (State or Country) Wis.

12. MAIDEN NAME OF MOTHER

Daisy May Clark

13. BIRTHPLACE OF MOTHER

 (State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

 (Informant) Bird Sherman

 (Address) Nature, Idaho.

15.

 Filed April 28 - 1922 Joh. H. Meyer
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

175a

16. DATE OF DEATH

Apr 27 1922
 (Month) (Day) (Year)

 17. I HEREBY CERTIFY, That I attended deceased from 19 to 19

 that I last saw h. alive on 19 and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Struck by train
accident

(Duration) Yrs. mos. ds.

 Contributory
 (Secondary)

(Duration) yrs. mos. ds.

 (Signed) Paul L. Base M. D.

4-28-22 (Address) Baldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Canyon Hill

 DATE OF BURIAL 4-30-1922

20. UNDERTAKER

Paul L. Base

ADDRESS

Baldwell

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED

MAY 23 1922

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Canyon Registration District No. 3
City of Notus Primary Registration District No. 2005
(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Daisy May Ode

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 38008
Registered No. 57

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH

June 8 1922
(Month) (Day) (Year)

7. AGE

45 Yrs. 10 Mos. 19 ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work housewife
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Ohio

10. NAME OF FATHER

W. L. Clark

11. BIRTHPLACE OF FATHER

(State or Country) Ohio

12. MAIDEN NAME OF MOTHER

Elizabeth Bradburn

13. BIRTHPLACE OF MOTHER

(State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Bill Sherman
(Address) Notus, Idaho

15.

Filed April 28 - 1922 John H. Meyer
Local Registrar

SYNOPSIS CO., PRINTERS & BINDERS, BOISE 51067

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Apr. 27 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 19____, to _____ 19____.

that I last saw him _____ alive on _____ 19____, and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH was as follows:

Struck by train
accident

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Paul L. Case M. D.

4-28-22 (Address) Baldwell

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Canyon Hill

DATE OF BURIAL

4-30-1922

20. UNDERTAKER

Paul L. Case

ADDRESS

Baldwell

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 3
County of Canyon Primary Registration District No. 2005
City of Hammond (No. Caldwell) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby CoxFile No. 38009
Registered No. 36

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-OWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH

April 24 1922
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many 3 hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Carl E. Cox

11. BIRTHPLACE OF FATHER

(State or Country) Iowa

12. MAIDEN NAME OF MOTHER

Bessie Mammen

13. BIRTHPLACE OF MOTHER

(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Carl E. Cox(Address) Hammond, Idaho

15.

Filed April 25 1922John V. Meyer
Local Registrar

16. DATE OF DEATH

April 24 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Apr 24 1922 to 19
that I last saw her alive on Apr 24 1922
and that death occurred on the date stated above, at 10:22 A.M.

The CAUSE OF DEATH* was as follows:

Premature birth
less than 7 mos.
3 hrs.
(Duration) Yrs. mos. ds.Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) J. V. Meyer M. D.19 (Address) 4/25/22

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Canyon Hill 4-25 1922

20. UNDERTAKER

C. V. Beckham Caldwell

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **38010**Registered No. **54**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH **RECEIVED**
County of **Canyon** MAY 23 1922
City of **Baldwell** Registration District No. **1005**
St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Georgell E. Shepherd**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **male** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED **Married**
(Write the word.)6. DATE OF BIRTH **March 29 1852**
(Month) (Day) (Year)7. AGE **70** Yrs. — **20** Mos. — **20** ds.
IF LESS than 1 day
how many _____ hrs.
or _____ min.?8. OCCUPATION **Farmer**
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).9. BIRTHPLACE **Iowa**
(State or Country)10. NAME OF FATHER **Jno. W. Shepherd**11. BIRTHPLACE OF FATHER **Indiana**
(State or Country)12. MAIDEN NAME OF MOTHER **Sanderson**13. BIRTHPLACE OF MOTHER **Indiana**
(State or Country)14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) **Rennie J. Shepherd**(Address) **Baldwell Id.**15. Filed **April 22 - 1922** **John H. Meyer**
Local RegistrarMEDICAL CERTIFICATE OF DEATH **106**16. DATE OF DEATH **Apr. 19 1922**
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from **Oct 10 1922** to **Apr 19 1922**
that I last saw him alive on **Apr 19 1922**
and that death occurred on the date stated above, at **8 P. M.**

The CAUSE OF DEATH* was as follows:

Tumor involving Spleen and Liver.(Duration) **Yrs 12** mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) **T. J. Farmer** M. D.4/21/1922 (Address) **Baldwell Id.**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **Canyon Hill** DATE OF BURIAL **4-22-1922**20. UNDERTAKER **Paul R. Base** ADDRESS **Baldwell**

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon District No. 3
 City of Caldwell Registration District No. 1005
 (No. St.)

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Raymond T. Ott

File No. 38941

Registered No. _____

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

10

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED married

6. DATE OF BIRTH

Nov. 12, 1873
 (Month) (Day) (Year)

7. AGE

48 Yrs. 5 Mos. 4 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

Truck driver

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

Daniel P. Ott

11. BIRTHPLACE OF FATHER

(State or Country)

Virginia

12. MAIDEN NAME OF MOTHER

Mary A. Thomas

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Emma Ott

(Address)

Caldwell, Idaho

15.

Filed

April 18, 1922

John C. Meyer

Local Registrar

16. DATE OF DEATH

April 16, 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar 4, 1922 to Apr 16, 1922
 that I last saw him alive on Apr 16, 1922
 and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Influenza & Epilepsy
with coma.

(Duration) Yrs. mos. 2 ds.

Contributory
(Secondary)

Influenza

(Duration) yrs. mos. 4 ds.

(Signed)

T. D. Farver M. D.

4/17, 1922 (Address) Caldwell, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Marion Hill Apr 19, 1922

20. UNDERTAKER

ADDRESS

E. V. Beckham Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH
 in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of CanyonCity of Caldwell

Registration District No.

Primary Registration District No. 2005

(No. St.)

File No.

Registered No. 38912If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Margaret Alice VanderwiltIf death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

Oct. 14 1868
(Month) (Day) (Year)

7. AGE

53 Yrs. 6 Mos. — ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.Housewife.(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer).....

9. BIRTHPLACE

(State or Country)

Maryland.10. NAME OF
FATHEREdward K. Vanderwilt11. BIRTHPLACE
OF FATHER

(State or Country)

Penn.12. MAIDEN NAME
OF MOTHERAnna Liza Gibbens13. BIRTHPLACE
OF MOTHER

(State or Country)

Maryland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

D. J. Vanderwilt
Huston, Ida

(Address)

15.

Filed April 15 1922John H. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

19

16. DATE OF DEATH

May 3 April 14 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
May 3 1921 to April 14 1922
that I last saw her alive on April 12 1922
and that death occurred on the date stated above, at 1:45 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(Duration) Yrs. mos. ds.

Contributory
(Secondary)Dropsy

(Duration) Yrs. mos. ds.

(Signed)

M. J. Gley M. D.478 1922 (Address) Caldwell, Ida*State the Disease Causing Death, or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted
if not at place of death?.....Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Soloman, Kansas

19.....

20. UNDERTAKER

ADDRESS

C. V. LickhamCaldwell, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 3
County of banyon Primary Registration District No. 2005
City of Wilder (No. 57 St.)File No. 38013
Registered No. 50

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Forest Dean Ferguson

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male white Single
(Write the word.)

6. DATE OF BIRTH

Oct 12 1921
(Month) (Day) (Year)

7. AGE

6 2 ds.
Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Lloyd Marshall Ferguson

11. BIRTHPLACE OF FATHER

(State or Country) Nebraska

12. MAIDEN NAME OF MOTHER

Alice Dean

13. BIRTHPLACE OF MOTHER

(State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John V. Ferguson
(Address) Griffith Idaho (P.R. 1)

15.

Filed April 14 - 1922 John V. Inyer
Local Registrar

16. DATE OF DEATH

Apr. 14 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from April 14 1922 to April 14 1922
that I last saw him alive on April 14 1922
and that death occurred on the date stated above, at 5:30 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia
Pneumonia(Duration) Yrs. 2 mos. 2 ds.Contributory
(Secondary)(Duration) yrs. 5 mos. 5 ds.

(Signed)

4/14 1922 (Address) Caldwell, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Emmett Idaho

DATE OF BURIAL

4-15 1922

20. UNDERTAKER

Paul L. Base

ADDRESS

Caldwell

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon
City of BaldwellRegistration District No. 3Primary Registration District No. 2005File No. 38014Registered No. 97

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mrs Luann M. Jordan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

married
(Write the word.)

6. DATE OF BIRTH

Feb 29 1848
(Month) (Day) (Year)

7. AGE

74 Yrs. 1 Mos. 12 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Housewife

9. BIRTHPLACE

(State or Country)

Iles

10. NAME OF FATHER

Rice Beadles

11. BIRTHPLACE OF FATHER

(State or Country)

Ky.

12. MAIDEN NAME OF MOTHER

Warren

13. BIRTHPLACE OF MOTHER

(State or Country)

Ky.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

James Jordan
Baldwell, Ida

15.

Filed April-13-1922 John H. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Apr 11 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Apr 2 1922 to Apr 11 1922
that I last saw her alive on Apr 11th 1922,
and that death occurred on the date stated above, at 10 P. M.
The CAUSE OF DEATH* was as follows:Influenza pneumonia(Duration) Yrs. mos. 15 ds.Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

W. Montgomery M. D.
Apr 13 1922 (Address) Baldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Canyon Hill

DATE OF BURIAL

4-13 1922

20. UNDERTAKER

Paul L. Bree

ADDRESS

Baldwell

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 3
 County of Canyon Primary Registration District No. 2005
 City of Caldwell ST (No. _____ St.)

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Ida May Criter

File No. 38015Registered No. 46

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH

May 11 1872
(Month) (Day) (Year)

7. AGE

48 Yrs. 11 Mos. - da.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Nebraska

10. NAME OF FATHER

Ezra Losey

11. BIRTHPLACE OF FATHER

(State or Country)

Iowa

12. MAIDEN NAME OF MOTHER

Susana Kennedy

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A E Coriter

(Address)

15.

Filed April 12 1922

John H. Meyer
Local Registrar

16. DATE OF DEATH

April 11 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 10 1921, to April 11 1922
that I last saw her alive on Mar 1 1922
and that death occurred on the date stated above, at 7:15 A.M.
The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

(Duration) 2 Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

4-11-22 (Address) Ida May Criter

*State the Disease Causing Death, or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Canyon Hill

DATE OF BURIAL

4-12-1922

20. UNDERTAKER

C. V. Peckham

ADDRESS

Caldwell, Ida

Patterson.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **38046**
Registered No. **117**
117
2196

1. PLACE OF DEATH
County of Cassia
City of Seeley
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME Elizabeth Parker

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)
6. DATE OF BIRTH. Unknown
(Month) (Day) (Year)

7. AGE 62 Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Bingham City Utah

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER
(State or Country) Unknown

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M. C. Savage
(Address) Seeley Ida.

15. Filed Apr. 29 1922 Prof. C. Patterson
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 7 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1 1922 to April 7 1922
that I last saw him alive on April 3 1922
and that death occurred on the date stated above, at 4:30 A.M.

The CAUSE OF DEATH* was as follows:
Bright's Disease
chronic nephritis
(Duration) Yrs. mos. ds.

Contributory (Secondary)
(Duration) Yrs. mos. ds.
(Signed) J. C. Patterson M. D.
410-24922 (Address) Burley, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE. (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days, State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Elba Ida. DATE OF BURIAL April 9 1922

20. UNDERTAKER L. B. Goolsby ADDRESS Burley Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Cassia Registered District No. 117
City of Burley Bureau of Vital Statistics Registration District No. 2196 St.

File No. 38017Registered No. 584

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Eldred Meacham

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the words)

6. DATE OF BIRTH

Apr. 28 1922
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many 5 hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Burley, Ida.

10. NAME OF FATHER

J. E. Meacham

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Ethel Fearnley

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ethel F. Meacham

(Address)

Burley, Ida.

15.

Filed

Apr. 29 1922 D. J. C. Pattison

Local Registrar

16. DATE OF DEATH

Apr. 28 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 28 1922 to Apr. 28 1922
that I last saw him alive on Apr. 28 1922
and that death occurred on the date stated above, at 10:30 P.M.

The CAUSE OF DEATH* was as follows:

Premature
7 months.

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

4/29 1922 (Address) Burley, Ida. M. D.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Yosh. Utah

Apr. 29 1922

20. UNDERTAKER

ADDRESS

H. M.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Cassia
City of Burley

Registration District No. 117
Registration District No. 2196 St.)

File No. 38018
Registered No. 386

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edward C. Boynton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX M. 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-OWED OR DIVORCED. Single

16. DATE OF DEATH

6. DATE OF BIRTH.

Aug 5 1901
(Month) (Day) (Year)

April 30 1922
(Month) (Day) (Year)

7. AGE

20 Yrs. 8 Mos. 25 ds.

IF LESS than 1 day
how many.....hrs. or
.....min.?)

17. I HEREBY CERTIFY, That I attended deceased from April 30 1922 to April 30 1922, that I last saw him alive on April 30 1922, and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

8. OCCUPATION

(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

(Duration) Yrs. mos. / ds.

9. BIRTHPLACE

(State or Country) Utah

Contributory
(Secondary)

10. NAME OF FATHER

C. Boynton

(Duration) yrs. mos. ds.

11. BIRTHPLACE OF FATHER

(State or Country) Utah

(Signed) J. C. Patterson M. D.

12. MAIDEN NAME OF MOTHER

Alice Robbins

(Address) Burley Ida

13. BIRTHPLACE OF MOTHER

(State or Country) Utah

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address) Burley Ida

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

15.

Filed May 8 1922 J. C. Patterson
Local Registrar

19. PLACE OF BURIAL OR REMOVAL

Pleasant View Cemetery

DATE OF BURIAL

May 4 1922

20. UNDERTAKER

R. W. Watt

ADDRESS

Burley Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

U. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Casper* Registration District No. *130*
 City of *Casper* Registration District No. *299* St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Sarah Ann Tuttle

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. *22040*Registered No. *13*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. *Widow*
 (Write the word.)

6. DATE OF BIRTH. *March 9 1856*
 (Month) (Day) (Year)

7. AGE *66* Yrs. *2* Mos. *1* ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
 (b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country) *Keywood Lancashire England*

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Rome Adams*(Address) *Casper Idaho*

15. Filed *June 1st 1922* *W. B. Nelson*
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 30 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *191* to *191*, that I last saw him alive on *191* and that death occurred on the date stated above, at *M.* The CAUSE OF DEATH was as follows:

probably Strangled by
(no doctor in attendance)
 (Duration) *1* yrs. *1* mos. *1* ds.
 (Signed) *M. D.*
 19 (Address) *Casper Idaho*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Casper Idaho *April 2 1922*

20. UNDERTAKER

ADDRESS

Ed. Adams *Casper Idaho*

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of

City of

Registration District No. 120

Registration District No. 299

File No.

Registered No. 4

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2.

BUREAU OF VITAL STATISTICS

Herman Hector Swoore

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

6. DATE OF BIRTH.

7. AGE

IF LESS than 1 day
how many.....hrs. or
.....min.

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15.

Filed

191

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

15th March.

(Month)

Wed.

(Day)

1922

(Year)

I HEREBY CERTIFY, That I attended deceased from March 10, 1922, to March 15, 1922, that I last saw her alive on March 15, 1922, and that death occurred on the date stated above, at 11 P. M. The CAUSE OF DEATH* was as follows:

Scarlet Fever

(Duration)

Yrs.

mos.

ds.

Contributory (Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

M. D.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

38021 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Cassia
City of OakleyRegistration District No. 174
Primary Registration District No. 2197
(No. 174 St.)File No. X444
Registered No. 10If death occurs away from
usual residence, give facts
called for under special
information.

2. FULL NAME

Thomas R. WoodworthIf death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

X January 22 1832
(Month) (Day) (Year)

7. AGE

X 90 Yrs. 1 Mos. 17 ds.IF LESS than 1 day
how many.....hrs. or
.....min.

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
(b) General nature of in-
dustry, business, or estab-
lishment in which employ-
ed (or employer).Physician (retired)

9. BIRTHPLACE

(State or Country)

North Carolina U.S.A.10. NAME OF
FATHER11. BIRTHPLACE
OF FATHER

(State or Country)

Not known12. MAIDEN NAME
OF MOTHER13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Bornie Adams
Oakley Idaho.

15.

Filed

June 1st 1922 W. O. Nelson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

X March 14 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
.....191..... to191.....that I last saw him.....alive on.....191.....
and that death occurred on the date stated above, at.....M.

The CAUSE OF DEATH was as follows:

probable Cerebral Hemorrhage
(no physician in attendance)
(Duration).....Yrs.....mos.....ds.Contributory
(Secondary)

(Duration).....Yrs.....mos.....ds.

(Signed).....M. D.

.....19..... (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death.....Yrs.....mos.....days In the State.....Yrs.....mos.....days

Where was disease contracted
if not at place of death?.....Former or
usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Oakley Idaho March 1922

20. UNDERTAKER

ADDRESS

B. Adams Oakley Id.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

38022 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Cassia
City of CalleyRegistration District No. 120Primary Registration District No. 2199
(No. 152 St.)File No. XVIIRegistered No. 9

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME August Larson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single

(Write the word.)

6. DATE OF BIRTH.

Nov 3 1921
(Month) (Day) (Year)

7. AGE

4 Yrs. 10 Mos. 10 ds.IF LESS than 1 day
how many.....hrs. or
.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country) Calley Idaho

10. NAME OF FATHER

John August Larson

11. BIRTHPLACE OF FATHER

(State or Country) Grantsville, Utah

12. MAIDEN NAME OF MOTHER

Mary Edna Mooso

13. BIRTHPLACE OF MOTHER

(State or Country) Farmington Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Edna Larson(Address) Calley Idaho

15.

Filed June 14 1922 H. E. Nelson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 13 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from March 12 1922 to March 13 1922that I last saw him alive on March 13 1922and that death occurred on the date stated above, at 5 AM.

The CAUSE OF DEATH* was as follows:

Pneumonia(Duration) 7 Yrs. 7 mos. 7 ds.

Contributory (Secondary)

(Duration) 7 Yrs. 7 mos. 7 ds.(Signed) H. E. Nelson M. D.(Address) Calley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL Calley Idaho DATE OF BURIAL March 15 192220. UNDERTAKER E. J. Harper ADDRESS Calley Id.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Cassia
City of DaltonRegistration District No. 120Registration District No. 2199

38023

File No. X-461
Registered No. 5If death occurs away from
usual residence, give facts
called for under special
information.

FULL NAME

PerryDunfeeIf death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH.

Jan. 27 1867
(Month) (Day) (Year)

7. AGE

55 Yrs. 1 Mos. 15 ds.IF LESS than 1 day
how many.....hrs. or
.....min.

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
(b) General nature of in-
dustry, business, or estab-
lishment in which employ-
ed (or employer).Farmer

9. BIRTHPLACE

(State or Country)

California10. NAME OF
FATHERCather Dunfee11. BIRTHPLACE
OF FATHER

(State or Country)

Elizabethtown12. MAIDEN NAME
OF MOTHER13. BIRTHPLACE
OF MOTHER

(State or Country)

Bonham Texas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm A Davidson

(Address)

Dalton, Idaho

15.

Filed

June 10 1927H. H. Nelson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 12 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
March 7 1922 to March 12 1922that I last saw him alive on March 12 1922
and that death occurred on the date stated above, at 9:00 AM.

The CAUSE OF DEATH* was as follows:

Sepsis from Carbuncles

(Duration)

17 ds.Contributory
(Secondary)Diabetes

(Duration)

4 yrs. 10 mos. 10 ds.

(Signed)

H. H. Nelson M. D.

(Address)

Dalton, Idaho*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Dalton, Idaho March 14 1922

20. UNDERTAKER

ADDRESS

B. J. Jones Dalton

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

St.)

File No.

Registered No.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1922

Local Registrar

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from
April 11 1919 to March 6 1922
that I last saw her alive on March 6 1922
and that death occurred on the date stated above, at 4:50 P.M.

The CAUSE OF DEATH* was as follows:

(Duration) 1 Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

March 6 1922

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFAADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of *Canyon*

City of *Oshtemo*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No. *12*
Primary Registration District No. *2199*
(No. *2199* St.)

38025

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. *XV111*

Registered No. *2*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *married*
(Write the word.)

6. DATE OF BIRTH *Febr 26 1896*
(Month) (Day) (Year)

7. AGE *20* Yrs. *4* Mos. *18* ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

June 14 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Febr 24 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Jan 14 1922* to *Feb 14 1922* that I last saw him alive on *Feb 14 1922* and that death occurred on the date stated above, at *7 P.* M. The CAUSE OF DEATH* was as follows:

Typhoid - Pneumonia
(Duration) Yrs. *1* mos. ds.

Contributory (Secondary) (Duration) Yrs. *4* mos. ds.

(Signed) *H. H. Stueben* M. D. *Feb 14 1922* (Address) *Oshtemo, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Oshtemo, Idaho *Feb 14 1922*

20. UNDERTAKER

ADDRESS

Ed. Bauney *Oshtemo, Idaho*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. 9, No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 120

County of Carne

Registration District No. 2199

City of Oakley

St.)

File No. XVIIIRegistered No. 5

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jesse Edwin Mayne

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married

(Write the word.)

6. DATE OF BIRTH.

September 30

(Month)

(Day)

1887

(Year)

7. AGE

34Yrs. 4Mos. 0

ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....Farmer

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Jesse Amos Mayne

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Rosabelle Campbell

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. J. A. Mayne

(Address)

Logan Utah

15.

Filed

June 1922

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

January 30

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

January 24 1922 to January 30 1922that I last saw him alive on January 30 1922and that death occurred on the date stated above, at 9:30

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(Duration) Yrs. mos.

Contributory
(Secondary)

(Duration) Yrs. mos.

(Signed)

Jesse L. RainsFeb 3 1922 (Address) Oakley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state the MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

1. PLACE OF DEATH

County of Cassia
City of Oakley
If death occurs away from usual residence, give facts called for under special information.

Registration District

Primary Registration District No.

(No.)

CERTIFICATE OF DEATH

38027

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. X 471
Registered No. 471

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

George Jeffe

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married

(Give the word.)

6. DATE OF BIRTH.

July 22 - 1869
(Month) (Day) (Year)

7. AGE

52 Yrs. 11 Mos. 2 ds.

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer,

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

William Jeffe

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Alice Ward

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. E. JeffeOakley, Ida.

15.

Filed

June 1st 1922W. H. Nelson

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 23 - 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to 191

that I last saw him alive on 191and that death occurred on the date stated above, at 191 M.

The CAUSE OF DEATH* was as follows:

Gun Shot Wound In Head.Self Inflicted.

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) L. B. Goegey, (Coroner) D.1/30/1922 (Address) Burley, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death . . . yrs. . . mos. . . days, State . . . yrs. . . mos. . . days

Where was disease contracted

if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Little Basin, Ida.

DATE OF BURIAL

Jan. 26 - 1922

20. UNDERTAKER

L. B. Goegey

ADDRESS

Burley, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

38028

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of *Cassia*
City of *Oakley*

Registration District No. *120*
Primary Registration District No. *245*
(No. *1148* St.)

File No. *AKH*
Registered No. *3*

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Robert M. Goring

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *single*
(Write the word.)

6. DATE OF BIRTH *Dec. 28 1919*
(Month) (Day) (Year)

7. AGE *2* Yrs. *1* Mos. *3* ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE *Idaho*
(State or Country)

10. NAME OF FATHER *Robt M. Goring*

11. BIRTHPLACE OF FATHER *Idaho*
(State or Country)

12. MAIDEN NAME OF MOTHER *Betta M. Boren*

13. BIRTHPLACE OF MOTHER *Idaho*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *Robt. Goring*
(Address) *Oakley Idaho*

15. Filled *June 1st 1922* *H. H. Fisher*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *Jan 3 1922*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Jan 28 1922* to *Jan 3 1922*
that I last saw him alive on *Jan 3 1922*
and that death occurred on the date stated above, at *11 P.* M.
The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) Yrs. *3* mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) *H. H. Fisher* M. D.

June 1 1922 (Address) *Oakley Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Oakley, Id.* DATE OF BURIAL *Feb 2 1922*

20. UNDERTAKER *Wm. Adams* ADDRESS *Oakley Id.*

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of *Oakley*City of *Oakley*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration

Primary Registrar's District No. *2194*(No. *12* St.)

CERTIFICATE OF DEATH

RECEIVED
JUN 8 1922
BUREAU OF VITAL STATISTICS

38031

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *XV 111*Registered No. *16*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*

(Write the word)

6. DATE OF BIRTH

*Febr**16**1922*

(Month)

(Day)

(Year)

7. AGE

Yrs. *1*

Mos.

ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

James Reid

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Miss Sutherland

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

James Reid

(Address)

Oakley, Id.

15.

Filed *June 1st 1922**W. W. W. W.*

Local Registrar

16. DATE OF DEATH

*March 16**1922*

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19

to

*19*that I last saw him alive on *19*and that death occurred on the date stated above, at *M.*

The CAUSE OF DEATH* was as follows:

doctor

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

June 1st 1922 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Oakley Id.**March 16 1922*

20. UNDERTAKER

ADDRESS

*Sp. Garney**Oakley Id.*

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of *Cassia*

City of *Oakley*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No. *120*

Primary Registration District No. *2199*

(No. *2199* St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. *XV 111*

Registered No. *15*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WID-OWED OR DIVORCED *married*
(Write the word.)

6. DATE OF BIRTH *June 25 1880*
(Month) (Day) (Year)

7. AGE *41* Yrs. *11* Mos. *ds.* IF LESS than 1 day how many *hrs.* or *min.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work. *Farmer + Stock-Raiser*
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE *Grantville Utah*
(State or Country)

10. NAME OF FATHER *Eric Erickson*

11. BIRTHPLACE OF FATHER *Sweden*
(State or Country)

12. MAIDEN NAME OF MOTHER *Sophia Larsen*

13. BIRTHPLACE OF MOTHER *Sweden*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Sophia Erickson*
(Address) *Oakley Idaho*

15. Filed *June 1st 1922*
Local Registrar *H. H. Nelson*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *May 31 1922*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *May 28 1922* to *May 30 1922*
that I last saw him alive on *May 30 1922*
and that death occurred on the date stated above, at *6 P.* M.

The CAUSE OF DEATH* was as follows:

Tuberculosis (Pulmonary)
(Duration) *3* Yrs. *mos.* *ds.*

Contributory (Secondary) *None*
(Duration) *Yrs.* *mos.* *ds.*

(Signed) *H. H. Nelson* M. D.
June 1st 1922 (Address) *Oakley Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death *Yrs.* *mos.* *days.* In the State *Yrs.* *mos.* *days*

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Oakley Idaho* DATE OF BURIAL *June 2 1922*

20. UNDERTAKER *Ep. Jones* ADDRESS *Oakley Id*

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of CassiaCity of Oakley

If death occurs away from usual residence, give facts called for under special information.

Registration District 122Primary Registration District No. 2499(No. 132 St.)

38033

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. XV 44Registered No. 14

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James M. LeeBride

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married

(Write the word.)

6. DATE OF BIRTH Sept. 2, 1884

(Month) (Day) (Year)

7. AGE 37 Yrs. 7 Mos. 10 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Housewife

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Geo. White

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Jane Lee

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

James M. Lee

(Address)

Oakley, Idaho

15.

Filed June 11, 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 12, 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 8, 1922 to April 12, 1922that I last saw him alive on April 12, 1922and that death occurred on the date stated above, at 4:50 P.M.

The CAUSE OF DEATH* was as follows:

1. True(Duration) Yrs. mos. 14 ds.Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

W. H. Tichenor M. D.June 10, 1922 (Address) Oakley, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Oakley, Idaho June 11, 1922

20. UNDERTAKER

ADDRESS

B. P. Harper Oakley, Id.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of CassiaCity of Oakley

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 120Primary Registration District No. 2199(No. JUN 8 1922 St.)

38034

File No. XV 111Registered No. 13

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

married
(Write the word.)

6. DATE OF BIRTH

Jan 29 1900

(Month)

(Day)

(Year)

7. AGE

22 Yrs. 2 Mos. 12 ds.

IF LESS than 1 day

how many hrs.or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Mathie Fennel

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Caroline Shields

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Mathie Fennel
Oakley Idaho

15.

Filed June 1st 19221922H. H. Theron
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 11 1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 8 1922 to April 11 1922that I last saw him alive on April 11 1922and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Acute Dilation of Stomach(Duration) Yrs. 2 mos. 2 ds.Contributory
(Secondary)(Duration) Yrs. 44 mos. ds.

(Signed)

June 1st 1922 (Address) Oakley Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Oakley Idaho June 13 1922

20. UNDERTAKER

ADDRESS

Sp. Gense Oakley Idaho

1. PLACE OF DEATH

County of ClarkCity of Subois

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED
MAY 25 1922
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 128Primary Registration District No. 2203

St.)

Registered No.

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 38035

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Married
(Write the word.)6. DATE OF BIRTH Jan'y 7, 1891
Do not know 1. (Month) (Day) (Year)7. AGE about 31 Yrs. Mos. ds. 29
IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

North Dakota

10. NAME OF FATHER

Daniel Leahy

11. BIRTHPLACE OF FATHER

(State or Country)

Do not know
New York

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15. Mar 6 1922 E. J. Jones M.D.
Filed Local Registrar

MEDICAL CERTIFICATE OF DEATH

175a

16. DATE OF DEATH

March61922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19..... to 19.....

that I last saw him alive on 19.....

and that death occurred on the date stated above, at 3:00 PM.

The CAUSE OF DEATH* was as follows:

Instantly Killed (accident)

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

E. J. Jones

M. D.

Mar 6 1922 (Address) Subois Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Blackfoot Idaho 19.....

20. UNDERTAKER

ADDRESS

E. J. Jones Blackfoot

1. PLACE OF DEATH

County of Blaine
City of Subois

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Arthur Dale Albritsen

RECEIVED CERTIFICATE OF DEATH

Registration District No. 125Primary Registration District No. 2203MAY 23 1922
BUREAU OF VITAL STATISTICSState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 38036

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Infant
(Write the word.)

6. DATE OF BIRTH

Apr 27 1922
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many 4 hrs.
or 40 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Subois Idaho

10. NAME OF FATHER

Arthur Albritsen

11. BIRTHPLACE OF FATHER

(State or Country) Denmark

12. MAIDEN NAME OF MOTHER

Esther Wilson

13. BIRTHPLACE OF MOTHER

(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Arthur Albritsen(Address) Subois Idaho

15.

Filed Apr 27 1922W E Jones M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Apr 27 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from 12:20 PM Apr 27 1922, to 5 PM 19, that I last saw him alive on April 27 1922, and that death occurred on the date stated above, at 5 PM.
The CAUSE OF DEATH* was as follows:Premature

(Duration) Yrs. mos. ds.

Contributory (Secondary) Influenza

(Duration) yrs. mos. ds.

(Signed) W E Jones M. D.4/27/1922 (Address) Subois Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Subois Idaho

DATE OF BURIAL

Apr 28 1922

20. UNDERTAKER

None

ADDRESS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Clearwater Registration District No. 90
City of Chippewa Registration District No. 2168 St.)File No. 38037Registered No. 19

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Prady Pruvake

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Female

4. COLOR OR RACE

Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Feb
(Month)12
(Day)1912
(Year)

7. AGE

10 Yrs. Mos. ds.IF LESS than 1 day
how many hrs. or
.... min.?

16. DATE OF DEATH

April
(Month)2
(Day)1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to 191that I last saw him alive on July 28 1912and that death occurred on the date stated above, at 4:00 P.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonalis(Duration) About 1 Yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. M. Fairley M. D.4/4 1922 (Address) Chippewa, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Chippewa, Ida4/4 1922

20. UNDERTAKER

ADDRESS

V. H. ShattChippewa, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED

Registration District No.

MAY 27 1922

Registration District No.

BUREAU OF VITAL STATISTICS

Local Registrar

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
38038

1. PLACE OF DEATH
County of *Cheyenne*
City of *Griffin*

Registration District No. *90*
Primary Registration District No. *2168*
(*Notation*) St.

File No.
Registered No. *20*

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME *Lucetta Taylor*

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*
(Write the word.)

6. DATE OF BIRTH *July 16 1910*
(Month) (Day) (Year)

7. AGE *11* Yrs. *9* Mos. *13* ds. IF LESS than 1 day how many *20* hrs. or *5* min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work *none*
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE *White Bird Idaho*
(State or Country)

10. NAME OF FATHER *Frank T. Taylor*

11. BIRTHPLACE OF FATHER *Oregon*
(State or Country)

12. MAIDEN NAME OF MOTHER *Lillie E. Canaan*

13. BIRTHPLACE OF MOTHER *Kansas*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *Frank T. Taylor*
(Address) *Griffin*

15. Filed *May 24 1922* *J. M. Fairley*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

120

16. DATE OF DEATH *April 30 1922*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *April 13 1922* to *April 30 1922*
that I last saw him alive on *April 30 1922*
and that death occurred on the date stated above, at..... M.
The CAUSE OF DEATH* was as follows:

Acute nephritis

(Duration) Yrs. *2* mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) *J. M. Fairley* M. D.
4/30/22 (Address) *Griffin Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Griffin Idaho* DATE OF BURIAL *May 2 1922*

20. UNDERTAKER *C. E. Baba* ADDRESS *Griffin Idaho*

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

I. PLACE OF DEATH.

County of Custer Registration District No. 76
City of Dickinson Registration District No. 2153 St.)

File No. 38039
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Cora B. Fulton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH.

May 30, 1895
(Month) (Day) (Year)

7. AGE

46 Yrs. 7 Mos. 28 ds.

IF LESS than 1 day
how many hrs. or
..... min. > |

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

Housewife

9. BIRTHPLACE

(State or Country)

Ohio (Cannonsburg)

10. NAME OF FATHER

G. W. Mull

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Barbara Corfman

13. BIRTHPLACE OF MOTHER

(State or Country)

Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Ralph W. Fulton

(Address)

Dickinson, S.D.

15.

Filed

5/22 1922 Rose Mowat

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

January 30, 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 24, 1912, to Jan 26, 1912, that I last saw him alive on Jan 26, 1912, and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Paralytic disease

Toxemia

Myocarditis

(Duration) _____ Yrs. _____ mos. 6 ds.

Contributory (Secondary)

Epilepsy

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Carroll A. B. Jones M. D.

720 19 1/2 (Address) Wachman, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Chelly

Feb. 1, 1922

20. UNDERTAKER

ADDRESS

J. H. Baxter

Wachman, Idaho

Form V. S. No. 5. 10M. 6-20-11. **RECEIVED** CERTIFICATE OF DEATH1. PLACE OF DEATH. **RECEIVED**
County of Elmore District No. 1
City of Glenris Ferry Registration District No. 1
St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lee Gordon DannerState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **38040**

Registered No. _____

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. At Home
(Write the word.)6. DATE OF BIRTH June 2nd 1921
(Month) (Day) (Year)7. AGE 9 yrs. 17 mos. 17 ds. IF LESS than 1 day how many.....hrs. or.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business or establishment in which employed (or employer) At Home9. BIRTHPLACE (State or Country) Ida. Elmore County10. NAME OF FATHER Lee Danner11. BIRTHPLACE OF FATHER (State or Country) Tenn.12. MAIDEN NAME OF MOTHER Thelma Sickler13. BIRTHPLACE OF MOTHER (State or Country) Ogden Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) L. G. Danner
(Address) Glenris Ferry Idaho15. May 8 1922
Filed J. G. P. and
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 19 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from June 11 1922, to June 19 1922
that I last saw him alive on June 14 1922
and that death occurred on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH* was as follows:

acute dilatation of heart(Duration) 20 minutes
Contributory (Secondary) asthenia(Duration) 0 yrs. 0 mos. 0 ds.
(Signed) J. G. P. and M. D.
19 (Address) Glenris Ferry

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.
Where was disease contracted,
If not at place of death?
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Glenris Ferry May 21 1922
20. UNDERTAKER J. W. Ruben ADDRESS Glenris Ferry

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11

RECEIVED
MAY 23 1922

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. _____
County of Elmore Primary Registration District No. _____
City of Stemmer Ferry (No. _____, St.)

File No. **38041**

Registered No. _____

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ledbetter

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. at home
(Write the word.)

6. DATE OF BIRTH April 10 1922
(Month) (Day) (Year)

7. AGE _____ yrs. _____ mos. _____ ds. IF LESS than 1 day how many _____ hrs. or _____ min.

8. OCCUPATION

- (a) Trade, profession or particular kind of work _____
(b) General nature of industry business or establishment in which employed (or employer) _____

9. BIRTHPLACE Elmore Co.
(State or Country)

10. NAME OF FATHER C. T. Ledbetter

11. BIRTHPLACE OF FATHER Ark.
(State or Country)

12. MAIDEN NAME OF MOTHER Jewel Rose

13. BIRTHPLACE OF MOTHER Ark.
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. T. Ledbetter

(Address) _____

15. Filed May 8 1922 J. P. Rand
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 10 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-10-1922 to 4-10-1922
that I last saw him alive on 4-10-1922
and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was, as follows:

Asphyxia - Premature Birth
(Seven months)

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. E. Evans M. D.
4-13-1922 (Address) Mtn Home Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL _____ 191____

20. UNDERTAKER ADDRESS _____

J. W. Ruebman

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11

RECEIVED

MAY 23 1922

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. **38042**

1. PLACE OF DEATH Home Registration District No. 1
County of Blaine BUREAU OF VITAL STATISTICS
City of Glenn Ferry (No. 1, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Miss Mary Ferguson

Registered No.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED widow
(Write the word.)

6. DATE OF BIRTH

Nov 14 1844
(Month) (Day) (Year)

7. AGE

77 yrs. 6 mos. X ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

At Home

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

Joe Parker

11. BIRTHPLACE OF FATHER

(State or Country)

Penn

12. MAIDEN NAME OF MOTHER

—

13. BIRTHPLACE OF MOTHER

(State or Country)

Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wm F. A. Loring

(Address)

Glenn Ferry Idaho

15.

Filed

May 5 1922 J. H. R. [Signature]
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 13 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 20 1922, to Oct 13 1922 that I last saw her alive on Oct 12 1922, and that death occurred on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral thrombosis

(Duration) 0 yrs. 8 mos. 10 ds.

Contributory (Secondary)

senility

(Duration) 2 yrs. — mos. — ds.

(Signed)

J. H. R. [Signature] M. D.
Oct 14 1922 (Address) Glenn Ferry

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was Disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho Falls

4-16-1922

20. UNDERTAKER

ADDRESS

J. H. R. [Signature] Glenn Ferry

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. **38043**

Registered No.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH. Registration District No. **Elmore**
County of **Elmore** Primary Registration District No. **Glenn's Ferry**
City of **Glenn's Ferry** (No. **St.**)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Charles Skipper**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Widower**
(Write the word.)

6. DATE OF BIRTH **July 14 1852**
(Month) (Day) (Year)

7. AGE **69** yrs. **8** mos. **8** ds.

IF LESS than 1 day
how many.....hrs. or
.....min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Stationary Engineer

9. BIRTHPLACE

(State or Country)

Ellenville N. Y.

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

Holland

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Holland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Blanche Skipper
Glenn's Ferry

15.

Filed **Mar 22 1922**

Local Registrar **J. J. Pond**

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **Mar 14 1922**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Feb 20 1922** to **Mar 13 1922**
that I last saw him alive on **Mar 12 1922**
and that death occurred on the date stated above, at **4 A.M.**

The CAUSE OF DEATH* was as follows:

Acute dilatation of stomach

(Duration) **9** yrs. **0** mos. **15** ds.

Contributory (Secondary)

spinal sclerosis

(Duration) **9** yrs. **0** mos. **0** ds.

(Signed)

J. J. Pond M. D.
Mar 15 1922 (Address) **Glenn's Ferry**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was Disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Glenn's Ferry

Mar 17 1922

20. UNDERTAKER

ADDRESS

J. W. Ruckham

Glenn's Ferry

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED

MAY 23 1922

Form V. S. No. 5. 10M. 6-20-11. MAY 23 1922 CERTIFICATE OF DEATH

1. PLACE OF DEATH. **BUREAU OF VITAL STATISTICS** Registration District No. _____
County of Elmore Primary Registration District No. _____
City of Glenn Ferry (No. _____) St. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

J. D. Clark

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **38044**

Registered No. _____

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH

Aug 8 - 1865 1
(Month) (Day) (Year)

7. AGE

56 yrs. 8 mos. 6 ds. IF LESS than 1 day
how many.....hrs. or
.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Book binder
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Grand Rapids, Mich.

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Rev. A. W. James
(Address) Glenn Ferry

15.

Filed

May 8 1922 J. D. Clark
Local Registrar

MEDICAL CERTIFICATE OF DEATH

79

16. DATE OF DEATH

April 14 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Farm live to dead 191

that I last saw h..... alive on..... 191
and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Valvular heart disease

(Duration)..... yrs..... mos..... ds.

Contributory (Secondary)

One exertion

(Duration)..... yrs..... mos..... ds.

(Signed) J. D. Clark M. D.

19..... (Address) Glenn Ferry

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place..... yrs..... mos..... ds. In the
of death..... yrs..... mos..... ds. State..... yrs..... mos..... ds.

Where was disease contracted.

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Glenn Ferry, Idaho April 24 1922

20. UNDERTAKER

ADDRESS

J. W. Ruben Glenn Ferry

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Elmore Registered District No. 30
 City of mt. Home Registration District No. 2026
 (St.)

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Carrie Stewart

File No. 38045
 Registered No. 0

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH

22 6 November 2 1862
 (Month) (Day) (Year)

7. AGE

IF LESS than 1 day
how many..... hrs.
or..... min.?

Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

William Muggford

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Doctor E. R. R. R.

(Address)

15.

Filed 4-3- 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 1 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
April 1, 1922 to April 1, 1922
 that I last saw her alive on April 1, 1922
 and that death occurred on the date stated above, at 6:45 P.M.

The CAUSE OF DEATH was as follows:

Hemorrhage of Brain
started, facial area, left side
of forehead. Extending to opposite
side. (Duration) 2 1/2 Yrs. 18 mos. 18 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Dr. O. G. Hamilton M. D.
4/3 1922 (Address) Mountain Home, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state
 (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
 if not at place of death?

Former or
usual residencemt. Home Idaho.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

MT. Home. 19

20. UNDERTAKER

ADDRESS

L. S. Benson Nampa Ida

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **38046**
Registered No. **38046**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of **Elmore**
City of **Mt. Home**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Guy Lynn Brooks

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **married**
(Write the word.)

6. DATE OF BIRTH

June 12 1894
(Month) (Day) (Year)

7. AGE

27 Yrs 10 Mos. 6 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)**Sheep man**

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

W. W. Brooks

11. BIRTHPLACE OF FATHER

(State or Country)

California

12. MAIDEN NAME OF MOTHER

Ellie Shapow

13. BIRTHPLACE OF MOTHER

(State or Country)

Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

W. W. Brooks
Mountain View

15.

Filed

4-19-1922**J. E. Evans**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 15 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from **April 17 1922** to **April 18 1922**that I last saw him alive on **April 15 1922**
and that death occurred on the date stated above, at **9:15 P.M.**

The CAUSE OF DEATH* was as follows:

Peritonitis
Ruptured appendix(Duration) Yrs. mos. **4** ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) **J. J. Hamilton** M. D.**4/19/1922** (Address) **Mt. Home Ida**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mt. Home Ida**4/11/1922**

20. UNDERTAKER

ADDRESS

W. M. Grady**Boise Idaho**

1. PLACE OF DEATH

County of ElmoreCity of Idaho Falls

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Arthur D. Turner

CERTIFICATE OF DEATH

Registration District No. 34Primary Registration District No. 2020

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 38047Registered No. 10

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year) 1876

7. AGE

46 Yrs. Mos. ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

Cattle man

9. BIRTHPLACE

(State or Country) Ohio

10. NAME OF FATHER

Richard Turner

11. BIRTHPLACE OF FATHER

(State or Country) Ohio

12. MAIDEN NAME OF MOTHER

Elizabeth Towel

13. BIRTHPLACE OF MOTHER

(State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed 4-19-1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from April 18 1922 to April 18 1922
that I last saw him alive on April 18 1922
and that death occurred on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH* was as follows:

Isabete MelitrusIsabete Cornea(Duration) 10 Yrs. mos. ds.

Contributory (Secondary)

(Duration) Many yrs. mos. ds.

(Signed)

O. P. Thompson M.D.4-19-1922(Address) Idaho Falls, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Idaho Falls, Idaho

DATE OF BURIAL

4-19-1922

20. UNDERTAKER

O. P. Thompson

ADDRESS

Idaho Falls, Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

38048

1. PLACE OF DEATH

County of Elmore
City of Mountain HomeRegistration District No. 34Primary Registration District No. 2120

File No. _____

Registered No. 14

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Jose Amable

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single

(Write the word.)

6. DATE OF BIRTH

Feb. 28 1915
(Month) (Day) (Year)

7. AGE

17 Yrs. 2 Mos. 11 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Student

9. BIRTHPLACE

(State or Country)

Idaho
Elmore, Ore.

10. NAME OF FATHER

Cipriano
Jose Amable

11. BIRTHPLACE OF FATHER

(State or Country)

Spain

12. MAIDEN NAME OF MOTHER

Blanca Arguinchona

13. BIRTHPLACE OF MOTHER

(State or Country)

Spain

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Jose Amable
Mountain Home, Idaho

15.

Filed

5-14-1922J. E. Evans
Local Registrar

16. DATE OF DEATH

May 11 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 11 1922 to May 11 1922that I last saw him alive on May 11 1922and that death occurred on the date stated above, at 10:30 P. M.

The CAUSE OF DEATH* was as follows:

Hemorrhage from
left inner side of hand(Duration) 1 1/2 hrs. 2 mos. 0 ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) O. P. Hamilton M. D.5-14-1922 (Address) Mountain Home, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mountain Home, IdahoMay 14, 1922

20. UNDERTAKER

ADDRESS

Mountain Home, IdahoMountain Home, Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of ElmoreCity of My Home

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 34Primary Registration District No. 2020BUREAU OF VITAL STATISTICS
JUN 10 1922File No. 38049Registered No. 72

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Snell Allen Hopkins

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male4. COLOR OR RACE White5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH Oct. 5 1919

(Month)

(Day)

(Year)

7. AGE 2 6 26

Yrs.

Mos.

ds.

IF LESS than 1 day

how many _____ hrs.

or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Grand View, Ida10. NAME OF FATHER Fred C. Hopkins

11. BIRTHPLACE OF FATHER

(State or Country) Kansas12. MAIDEN NAME OF MOTHER Agnes A. Eral

13. BIRTHPLACE OF MOTHER

(State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Fred C. Hopkins(Address) Grand View, Idaho

15.

Filed 5-12-1922Local Registrar J E Evans

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 1st 22

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 _____ to 19 _____

that I last saw h. _____ alive on 19 _____

and that death occurred on the date stated above, at 9:45 M.

The CAUSE OF DEATH* was as follows:

Drowning, accidental

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J E Evans

M. D.

5-12-1922 (Address) My Home

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Mountain View, IdaDATE OF BURIAL May 12 192220. UNDERTAKER G. W. ConoverADDRESS My Home

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 27
County of Frankl Primary Registration District No. 2119
City of Preston (No. 102) St.File No. 38050
Registered No. 23

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Sean Swenson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH

Apr 30 1922
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Preston Ida

10. NAME OF FATHER

R. C. Swenson

11. BIRTHPLACE OF FATHER

(State or Country) Utah

12. MAIDEN NAME OF MOTHER

Josephine Godfrey

13. BIRTHPLACE OF MOTHER

(State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) R. C. Swenson

(Address) Preston Idaho

15.

Filed 5-5 1922 Mrs Ida Lippert Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 30 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Apr. 30 1922, to Apr. 30 1922 that I last saw him alive on Apr. 30 1922 and that death occurred on the date stated above, at 6 P. M. The CAUSE OF DEATH* was as follows:
Asphyxia

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) R. C. Swenson M. D.

19 (Address) Preston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Preston Ida

DATE OF BURIAL

May 19 1922

20. UNDERTAKER

W. B. Skidmore

ADDRESS

Preston

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

Registration District No.

Primary Registration District No.

St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

BUREAU OF VITAL STATISTICS

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1922

Local Registrar

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

June 5 1922, to April 10 1922

that I last saw her alive on April 5 1922

and that death occurred on the date stated above, at 10:30 A.M.

The CAUSE OF DEATH* was as follows:

Hodgkin's Disease

(Duration) 2 Yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed) T. R. Cutler M. D.

4-11-1922 (Address) Preston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Preston Ida

April 12 1922

20. UNDERTAKER

ADDRESS

W. A. Redmore

Preston

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 27
 County of Franklin Primary Registration District No. 2119
 City of Preston (No. _____ St.)

If death occurs away from
usual residence, give facts
called for under special in-
formation.

RECEIVED
MAY 23 1922
BUREAU OF VITAL
STATISTICS

2. FULL NAME

Ann H Casperson

File No. 38052
 Registered No. 27

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH

Nov 10 1852
(Month) (Day) (Year)

7. AGE

69 Yrs. 5 Mos. 17 ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

William Harris

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Jane Roberts

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

A. H. Casperson
Danish & Idaho

15.

Filed 5-5 19 22

Mrs. Ida Tippet
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

4 28 22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

4-18 1922 to 4-27 1922
 that I last saw her alive on 4-27 1922
 and that death occurred on the date stated above, at 3 A.M.

The CAUSE OF DEATH was as follows:

Hypostatic pneumonia

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributor
(Secondary)

Asphyxia

(Duration) _____ yrs. _____ mos. 10 ds.

(Signed)

A. H. Cutter M. D.

425 1922 (Address) Preston, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

W. A. Skidmore

Preston

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **38053**Registered No. **28**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Franklin Registration District No. 27
City of Preston Primary Registration District No. 2119
(No. STATISTICS St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Wilford W. Seamons

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH

Apr. 15 1922
(Month) (Day) (Year)

7. AGE

— Yrs. — Mos. 2 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).at home

9. BIRTHPLACE

(State or Country)

Preston Ida

10. NAME OF FATHER

Wilford R. Seamons

11. BIRTHPLACE OF FATHER

(State or Country)

Hidepark Utah

12. MAIDEN NAME OF MOTHER

Effie Paton

13. BIRTHPLACE OF MOTHER

(State or Country)

Preston Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Wilford R. Seamons
Preston Ida

15.

Filed 5-5 19 22

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

4 17 22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

4-15 19 22 to 4-17 19 22that I last saw him alive on 4-17 19 22and that death occurred on the date stated above, at 4:40 P.M.

The CAUSE OF DEATH* was as follows:

Chronic of duodenum(Duration) life yrs. 1 mos. 1 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

A. R. Cutler M. D.4-5 19 22 (Address) Preston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Preston Apr. 18 19 22

20. UNDERTAKER

ADDRESS

W. A. Skidmore Preston Ida

FORM V. S. No. 5-25 M. 1-19.

RECEIVED CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Franklin Registration District No. 27
City of Weston Primary Registration District No. 2119
St. IdahoFile No. 38054Registered No. 24

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Christian Peter Monson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH

Nov 17 1866
(Month) (Day) (Year)

7. AGE

55 Yrs. 5 Mos. 11 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)Farmer

9. BIRTHPLACE

(State or Country)

Denmark

10. NAME OF FATHER

J. C. Monson

11. BIRTHPLACE OF FATHER

(State or Country)

Denmark

12. MAIDEN NAME OF MOTHER

unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Alma Monson

(Address)

Weston, Ida

15.

Filed 5-5 1922Mrs. Ida Lippich
Local Registrar

16. DATE OF DEATH

Apr 28 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19... to 19...

that I last saw h... alive on... 19...

and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Phthisis

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) No med. attendance M. D.

19... (Address)...

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death... yrs... mos... days. In the State... yrs... mos... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Weston IdaMay 1 1922

20. UNDERTAKER

ADDRESS

W. A. SkidmorePreston

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
38055
File No. _____
Registered No. 26

1. PLACE OF DEATH

County of Franklin Union District No. 27
City of Fairview Registration District No. 2119
(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Anna Jamison Larsen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7- 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH January 5 1872
(Month) (Day) (Year)

7. AGE 50 Yrs. 3 Mos. 21 ds. IF LESS than 1 day how many _____ hrs. or _____ min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE Bemington - Idaho
(State or Country)

10. NAME OF FATHER John R. Jamison

11. BIRTHPLACE OF FATHER Indiana
(State or Country)

12. MAIDEN NAME OF MOTHER Caroline M. Garr

13. BIRTHPLACE OF MOTHER Indiana
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. Willard Larsen
(Address) Preston R 7 P 2103 Idaho

15. Filed 5-5 19 22 Mrs. Ida Tingle
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 26 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 13 1922, to April 26 1922, that I last saw him alive on April 25 1922, and that death occurred on the date stated above, at 9 A.M. The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(Duration) 4 Yrs. 4 mos. 13 ds.

Contributory Typhoid
(Secondary)

(Duration) 2 yrs. 2 mos. 21 ds.

(Signed) G. W. States M. D.

(Address) Preston, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Fairview Idaho April 29 1922

20. UNDERTAKER ADDRESS

Bishop Henry Rawling

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH
in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of FranklinCity of Fairview

If death occurs away from
usual residence, give facts
called for under special in-
formation.

RECEIVED
MAY 29 1922
BUREAU OF VITAL
STATISTICS

Registration District No. 27Registration District No. 2119

St.)

File No. 38056Registered No. 22

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

2. FULL NAME

Hellen S. Egbert

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

F

4. COLOR OR RACE

W.5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.Widow
(Write the word.)

6. DATE OF BIRTH

Oct.51859

(Month)

(Day)

(Year)

7. AGE

62

Yrs.

5

Mos.

26

ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.Housewife(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer).

9. BIRTHPLACE

(State or Country)

Utah10. NAME OF
FATHERJohn C. Hegley11. BIRTHPLACE
OF FATHER

(State or Country)

Germany12. MAIDEN NAME
OF MOTHERSusan Gennomon13. BIRTHPLACE
OF MOTHER

(State or Country)

U. S.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Jas M. Egbert

(Address)

Fairview Ida

15.

Filed

5-5

19

22Mrs. H. Tupper

Local Registrar

16. DATE OF DEATH

March 31

(Month)

(Day)

1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 24 1922 to March 31 1922that I last saw her alive on March 24 1922and that death occurred on the date stated above, at 1:30 P. M.

The CAUSE OF DEATH* was as follows:

SenilityArterio-sclerosis(Duration) — Yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Curry Blum

M. D.

April 1922

(Address)

Preston, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Lewiston, Id

DATE OF BURIAL

Apr 2 1922

20. UNDERTAKER

W. C. Richmond

ADDRESS

Preston, Ida

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. **RECEIVED**
Registration District No. 27
County of Franklin MAY 23 1922
Primary Registration District No. 2119
City of Preston **BUREAU OF VITAL STATISTICS** St.)

File No. 38057
Registered No. 27

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Mary Ann Shandy

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

Female white widowed
(Write the word.)

6. DATE OF BIRTH.

Mar. 17 1890
April 30 1922
(Month) (Day) (Year)

7. AGE 32 IF LESS than 1 day
how many hrs. or
..... min. 2

8. OCCUPATION
(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)

House keeping

9. BIRTHPLACE
(State or Country)

Essexshire England

10. NAME OF FATHER

Joseph Day

11. BIRTHPLACE OF FATHER
(State or Country)

Parish of North England

12. MAIDEN NAME OF MOTHER

Anna Shandy

13. BIRTHPLACE OF MOTHER
(State or Country)

Parish of North England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. A. Shandy

(Address) Preston Idaho

15. Mrs. O. L. Lippert

Filed 5-5 1922 Local Registrar

16. DATE OF DEATH

April 30 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Apr 10 1922 to Apr 30 1922

that I last saw her alive on Apr 10 1922

and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Bright Disease

(Duration) 2 Yrs. — mos. — ds.

Contributory (Secondary)

(Duration) 2 Yrs. — mos. — ds.

(Signed) E. J. Englefield M. D.

Apr. 1922 (Address) Preston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Franklin Ida.

DATE OF BURIAL

May 3 1922

20. UNDERTAKER 2

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Franklin Registration District No. 27
City of Glendale Registration District No. 2119
St.

File No. 38058
Registered No. 38058

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
MAY 25 1922
BUREAU OF VITAL STATISTICS

2. FULL NAME Alice Margaret L. Owen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX F 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

16. DATE OF DEATH
April 9 19 22
(Month) (Day) (Year)

6. DATE OF BIRTH
Aug 1 18 82
(Month) (Day) (Year)

7. AGE 40 Yrs. 8 Mos. 8 ds.
IF LESS than 1 day how many hrs. or min.?

17. I HEREBY CERTIFY, That I attended deceased from March 18 19 22 to April 9 19 22 that I last saw her alive on April 9 19 22 and that death occurred on the date stated above, at 10 A. M.

8. OCCUPATION
(a) Trade, profession or particular kind of work. Housewife
(b) General nature of industry, business or establishment in which employed (or employer).

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency.
Had Influenza 3-16-22 to 3-28-22 which made heart worse.
(Duration) ✓ Yrs. — mos. — ds.

9. BIRTHPLACE
(State or Country) Logan Utah

Contributory Rheumatism
(Secondary)
(Duration) ✓ yrs. — mos. — ds.

10. NAME OF FATHER Lars C Larsen

(Signed) Carrie Blundy M. D.

11. BIRTHPLACE OF FATHER
(State or Country) unknown

4/2/1922 (Address) Preston, Idaho

12. MAIDEN NAME OF MOTHER Clara Jensen

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

13. BIRTHPLACE OF MOTHER
(State or Country) Denmark

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Leah Owen
(Address) Preston R.F.D. 1

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

15. Filed 5-5 19 22 Mrs Ida Tippet
Local Registrar

19. PLACE OF BURIAL OR REMOVAL Preston, Idaho DATE OF BURIAL Apr 13 1922

20. UNDERTAKER W. C. Redmon ADDRESS Preston

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Franklin
City of CliftonRegistration District No. 2119 27Primary Registration District No. 27 2119City of Clifton

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Emley DennyFile No. 38059Registered No. 38

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

June 9 1897
(Month) (Day) (Year)

7. AGE

24 Yrs. 11 Mos. 8 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Housewife

9. BIRTHPLACE

(State or Country)

Clifton Ida

10. NAME OF FATHER

Peter Larsen

11. BIRTHPLACE OF FATHER

(State or Country)

Denmark

12. MAIDEN NAME OF MOTHER

Wilhelmina Erickson

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wm E Larsen

(Address)

15.

Filed

June 3 1922Mrs Ida Lippert
Local Registrar

16. DATE OF DEATH

May 17 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from April 26 1922, to May 1922that I last saw him alive on April 26 1922and that death occurred on the date stated above, at 6 A M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Common Gall
duct extending into Pancreas
and Liver & Spleen
(Duration) Yrs. 10 mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Lucius Blank M. D.5/17 1922 (Address) Preston, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the Sta. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Swan Lake

DATE OF BURIAL

May 19 1922

20. UNDERTAKER

W. A. Skidmore

ADDRESS

Preston

1. PLACE OF DEATH

County of Franklin
 City of Preston

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED
CERTIFICATE OF DEATH
 Registration District No. 27
 Primary Registration District No. 27 2119
BUREAU OF VITAL STATISTICS

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. **38060**Registered No. 34

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX F 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widow
 (Write the word.)

6. DATE OF BIRTH

25 May 1853
 (Month) (Day) (Year)

7. AGE

69 Yrs. 8 Mos. 4 ds.

IF LESS than 1 day
 how many _____ hrs.
 or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Barnabus Lake

11. BIRTHPLACE OF FATHER

(State or Country)

Canada

12. MAIDEN NAME OF MOTHER

Lucey Jane Herrick

13. BIRTHPLACE OF MOTHER

(State or Country)

U.S.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

G M Cafferty
Preston

15. Filed

June 3 1922

Mrs. D. Lippert
 Local Registrar

16. DATE OF DEATH

April 27 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 23 1922 to April 27 1922, that I last saw him alive on April 27 1922, and that death occurred on the date stated above, at 4:30 P.M.
 The CAUSE OF DEATH* was as follows:

Carcinoma - Cecum(Duration) 1 Yrs. 6 mos. 5 ds.Contributory (Secondary) Cerebral hemorrhage(Duration) 4 yrs. 5 mos. 3 ds.(Signed) G. W. States M. D.

Apr. 27 1922 (Address) Preston, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Fairview Idaho

DATE OF BURIAL

May 1, 1922

20. UNDERTAKER

W. G. Skidmore

ADDRESS

Preston, Ida

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

JUN 7 1922

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Franklin
City of PrestonBUREAU OF VITAL
STATISTICS

(No. _____)

Registration District No. _____

2119 27

Administration District No. _____

(St.) _____

File No. _____

38061

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Don Swenson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W.5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDSingle
(Write the word.)

6. DATE OF BIRTH

Apr. 30 1922
(Month) (Day) (Year)

7. AGE

Yrs. 7 Mos. _____ ds. _____IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work _____

(b) General nature of industry, business or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country) Preston Ida

10. NAME OF FATHER

R. C. Swenson

11. BIRTHPLACE OF FATHER

(State or Country) Utah

12. MAIDEN NAME OF MOTHER

Josephine Godfrey

13. BIRTHPLACE OF MOTHER

(State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) R. C. Swenson(Address) Preston Idaho

15.

Filed June 3 1922Mrs. Ida Lipscomb
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 6 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Apr. 30 1922 to May 6 1922that I last saw him alive on May 5 1922and that death occurred on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:

Asphyxia

(Duration) Yrs. _____ mos. _____ ds. _____

Contributory
(Secondary)Asphyxia

(Duration) Yrs. _____ mos. _____ ds. _____

(Signed) _____

R. C. Swenson

M. D.

5/6 1922 (Address) Preston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Preston

DATE OF BURIAL

May 7 1922

20. UNDERTAKER

W. H. Lidmore

ADDRESS

Preston

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Franklin
City of Preston

JUN 7 1922

Registration District No. 2119 27BUREAU OF VITAL
STATISTICSRegistration District No. 27 2119File No. 38062Registered No. 35If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Gelnora StevensonIf death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W.5. SINGLE, MARRIED, WID-
OWED OR DIVORCED(Widow)
(Write the word.)

6. DATE OF BIRTH

Feb 17 1850
(Month) (Day) (Year)

7. AGE

71 Yrs. 2 Mos. 10 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.Housewife(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer).

9. BIRTHPLACE

(State or Country)

Utah10. NAME OF
FATHERMiles W. West11. BIRTHPLACE
OF FATHER

(State or Country)

U.S.12. MAIDEN NAME
OF MOTHERSarah Clark13. BIRTHPLACE
OF MOTHER

(State or Country)

U.S.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. M. Stevenson

(Address)

Preston

15.

Filed June 3 1922 Mrs. H. Lippert

Local Registrar

MEDICAL CERTIFICATE OF DEATH

120

16. DATE OF DEATH

May 27 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 6 1922 to May 27 1922that I last saw him alive on May 24 1922,and that death occurred on the date stated above, at 8:20 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous nephritis(Duration) ✓ Yrs. ✓ mos. ✓ ds.Contributory
(Secondary)(Duration) ✓ yrs. ✓ mos. ✓ ds.(Signed) Curtis Plante M. D.5/29/22 (Address) Preston, Idaho*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)At place of death ✓ yrs. ✓ mos. ✓ days. In the State ✓ yrs. ✓ mos. ✓ daysWhere was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Preston IdaMay 30 1922

20. UNDERTAKER

ADDRESS

H. A. SkidmorePreston Ida

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No.

BUREAU Registration District No.

(STATISTICAL)

27

2119

St.)

State of Idaho
BUREAU OF HEALTH
Bureau of Vital Statistics

File No.

38063

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

June 2

1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Signed)

4-1-1922 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registered District No.

County of Franklin

Primary Registration District No.

City of Weston

BUREAU OF VITAL

St.)

File No.

Registered No.

38064

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

STATISTICS

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female whitewidow
(Write the word.)

6. DATE OF BIRTH.

Sept 25 1834
(Month) (Day) (Year)

7. AGE

87 Yrs. 8 Mos. 28 ds.IF LESS than 1 day
how many.....hrs. or
.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

House Keeper

(b) General nature of industry, business, or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Hennarck

10. NAME OF FATHER

Lars Miller

11. BIRTHPLACE OF FATHER

(State or Country)

Hennarck

12. MAIDEN NAME OF MOTHER

Elsie M. Peterson

13. BIRTHPLACE OF MOTHER

(State or Country)

Hennarck

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

J. Fredrickson

(Address)

Weston Idaho

15.

Filed

June 3 191252W. A. Skidmore

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May
(Month)23
(Day)1912
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 1 1912, to May 20 1912.that I last saw her alive on Mar 20 1912.and that death occurred on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:

nephritis(Duration) 3 Yrs. mos. ds.

Contributory (Secondary)

Old age

(Duration) yrs. mos. ds.

(Signed)

J. B. Holder

M. D.

19..... (Address) Weston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Weston IdaMay 25 1912

20. UNDERTAKER

ADDRESS

W. A. SkidmorePreston

RECEIVED
JUN 5 1922
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of **Fremont** Registration District No. **102**
City of **Ashton** (No. _____ St.)

File No. _____
Registered No. **38065**

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME **ELLA MARTHA HENRY**

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WID-OWED OR DIVORCED **Married**
(Write the word.)

16. DATE OF DEATH

May, **13**, **1922**
(Month) (Day) (Year)

6. DATE OF BIRTH

September 6th 1991
(Month) (Day) (Year)

7. AGE

30 Yrs. **7** Mos. **6** ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

House wife

9. BIRTHPLACE

(State or Country)

Neb.

10. NAME OF FATHER

John Helms

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Dont Know

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Claud Henry**
(Address) **Ashton Idaho**

15.

Filed **5-12** 19**22**

Albuquerque
Local Registrar

I HEREBY CERTIFY, That I attended deceased from **May 10 1922** to **May 12 1922** that I last saw her alive on **May 12 1922** and that death occurred on the date stated above, at **9 P. M.**

The CAUSE OF DEATH* was as follows:

Puerperal clamping

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

E. P. Hagg M. D.

May 15 1922 (Address) **Ashton Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL **Ashton Idaho**

DATE OF BURIAL **5/15/22**

20. UNDERTAKER **Lewis Kiser**

ADDRESS **Ashton Idaho.**

MAY 20 1900

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

276

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of **Fremont**City of **Ashton**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mads Christensen Hansen.Registration District No. **103**Registration District No. **6**

File No.

Registered No.

38066

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Widowed

(Write the word.)

6. DATE OF BIRTH

May

(Month)

8

(Day)

1843

(Year)

7. AGE

79

Yrs.

Mos.

ds.

15IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Retired Farmer

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Denmark

10. NAME OF FATHER

Christian Hansen

11. BIRTHPLACE OF FATHER

(State or Country)

Denmark

12. MAIDEN NAME OF MOTHER

Karren Andersen

13. BIRTHPLACE OF MOTHER

(State or Country)

Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Alma Hansen**(Address) **Ashton Idaho**

15.

Filed

19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May

(Month)

23rd 1922

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from **May 13 1922** to **May 23 1922** that I last saw him alive on **May 23 1922** and that death occurred on the date stated above, at **11 P.M.**

The CAUSE OF DEATH* was as follows:

Inflammatory Rheumatism

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

E. S. Harris1922 (Address) **Ashton Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Ashton Idaho

DATE OF BURIAL

5/26/22

20. UNDERTAKER

Lewis Kiser

ADDRESS

Ashton Idaho

1. PLACE OF DEATH

County of GemCity of Emmett

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED

MAY 23 1922

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No.

Registration District No.

STATISTICS

St.)

George Perron

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

38069

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

About 72 yrs.

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address) Emmett, Idaho

15.

Filed

4/18 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Apr 12 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

August 19 19, to April 12 1922

that I last saw him alive on September 19 21.

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis Disease

(Duration) 4 Yrs. mos. ds.

Contributory
(Secondary)

General Sensibility

(Duration) yrs. mos. ds.

(Signed)

A. G. B. M. D.

4/12 1922 (Address) Emmett, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Ida

DATE OF BURIAL

19

20. UNDERTAKER

Family

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Gem*City of *Emmett*

RECEIVED

Registration District No.

Primary Registration District No.

No.

St.)

File No.

38070

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant Son M. J. Phillips

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Infant
(Write the word.)

6. DATE OF BIRTH

Mar 25 1922
(Month) (Day) (Year)

7. AGE

Still Born
Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Infant

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Milo J. Phillips

11. BIRTHPLACE OF FATHER

(State or Country)

Indiana

12. MAIDEN NAME OF MOTHER

Nina Friesner

13. BIRTHPLACE OF MOTHER

(State or Country)

Neb.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Milo Phillips*(Address) *Emmett Ida*

15. Filed

*3/26**1922*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

3/26
(Month) (Day) (Year)*1898*
19 *22* (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19....., to 19.....

that I last saw him alive on 19.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)..... M. D.

3/26 1922 (Address).....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Emmett Idaho

DATE OF BURIAL

3/26 1922

20. UNDERTAKER

O. Bucknum

ADDRESS

*Emmett**Ida*

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Ben* Registration District No. *V*
City of *Emmett* Primary Registration District No. *1*
St. *ID*File No. **38071**

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Herman Dale Yall

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *child*
(Write the word.)

6. DATE OF BIRTH

July *3* *1913*
(Month) (Day) (Year)

7. AGE

8 Yrs. *8* Mos. *21* ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)*child*

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

James Yall

11. BIRTHPLACE OF FATHER

(State or Country)

not known

12. MAIDEN NAME OF MOTHER

" "

13. BIRTHPLACE OF MOTHER

(State or Country)

" "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

3/25 *1922*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar *24* *1922*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar 21 *1922* to *Mar 24* *1922*
that I last saw him alive on *Mar 24* *1922*
and that death occurred on the date stated above, at *9 P. M.*
The CAUSE OF DEATH* was as follows:*diphtheria*

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *A. E. Byrd* M. D.*3/25* *1922* (Address) *Emmett*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Emmett Idaho

DATE OF BURIAL

3/25 *1922*

20. UNDERTAKER

W. Bucknum

ADDRESS

Emmett Idaho

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

If LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw her alive on
and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

19. (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Gem*
City of *Emmett*Registration District No. *1*
Primary Registration District No. *1*
(No. *1* St.)File No. *38074*
Registered No. *38074*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Matilda Baker
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *female* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *married*
(Write the word.)

6. DATE OF BIRTH

not known
(Month) (Day) (Year)

7. AGE

about 64 yrs
Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).*Housewife*

9. BIRTHPLACE

(State or Country)

Maine

10. NAME OF FATHER

Coltson

11. BIRTHPLACE OF FATHER

(State or Country)

Not known

12. MAIDEN NAME OF MOTHER

" "

13. BIRTHPLACE OF MOTHER

(State or Country)

" "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. L. Baker

(Address)

Emmett Idaho

15.

Filed *8/1* 19 *22*Local Registrar *J. H. Rasmussen*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 31 19 *22*
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *May 20* 19 *22* to *May 30* 19 *22*
that I last saw him alive on *May 30* 19 *22*
and that death occurred on the date stated above, at *M.*

The CAUSE OF DEATH* was as follows:

apoplexy

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Benton O. Clark M. D.

19

(Address)

Emmett

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Emmett Idaho

DATE OF BURIAL

7/1 19 *22*

20. UNDERTAKER

O. Buckner

ADDRESS

*Emmett**Idaho*

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED
JUN 1 1922

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Gem*
City of *Emmett*

Registration District No.
Primary Registration District No.
(No. St.)

File No. **38075**
Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Sterling Price Bane

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *Male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*
(Write the word.)

6. DATE OF BIRTH *Mar 30 1864*
(Month) (Day) (Year)

7. AGE *58* Yrs. *1* Mos. *22* ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION *Farmer*
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE *Illinois*
(State or Country)

10. NAME OF FATHER *Clayton Bane*

11. BIRTHPLACE OF FATHER *not known*
(State or Country)

12. MAIDEN NAME OF MOTHER *Martha Moore*

13. BIRTHPLACE OF MOTHER *not known*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *M. J. Bane*
(Address) *Emmett Idaho*

15. Filed *6/6* 19*22* *J. Reynolds*
Local Registrar

16. DATE OF DEATH *May 22 1922*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *May 22 1922* to *19* that I last saw him alive on *19* and that death occurred on the date stated above, at *M.*

The CAUSE OF DEATH* was as follows:
Drowning
was dead when I saw him

..... (Duration) Yrs. mos. ds.

Contributory (Secondary)

..... (Duration) yrs. mos. ds.

(Signed) *R. N. Cunningham* M. D.
5/23/22 (Address) *Emmett*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Emmett Idaho* DATE OF BURIAL *May 24 1922*

20. UNDERTAKER *Ed Bucknum* ADDRESS *Emmett Idaho*

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 24County of GoodingPrimary Registration District No. 102City of Gooding(No. 24)

St.)

File No.

38076

Registered No.

If death occurs away from
usual residence, give facts
called for under special
information.2. FULL NAME BradfordIf death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.Single
(Write the word.)

6. DATE OF BIRTH.

April

(Month)

14

(Day)

1922

(Year)

7. AGE

Yrs. 2 Mos. 2 ds.IF LESS than 1 day
how many hrs. or
min.

8. OCCUPATION

(a) Trade, profession or
particular kind of work...
(b) General nature of in-
dustry, business, or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho10. NAME OF
FATHERS J Bradford11. BIRTHPLACE
OF FATHER

(State or Country)

Idaho12. MAIDEN NAME
OF MOTHERKatherine Heselton13. BIRTHPLACE
OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

S J Bradford

(Address)

Gooding Idaho

15.

Filed

4-17-22

191

J. H. May MD

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April

(Month)

16

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from
April 14 19122, to Apr 16 19122,that I last saw him alive on Apr 16 19122,
and that death occurred on the date stated above, at 5:15 A M.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

4/17/1922 (Address) Gooding Idaho M. D.*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place

of death

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Gooding, Idaho

DATE OF BURIAL

4/18 19122

20. UNDERTAKER

ADDRESS

Gooding Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS
should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement
of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Idaho
City of Brangerville
Registration District No. 103
Primary Registration District No. 1001
(No.) St.)

File No. 38078
Registered No. 172

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Janis Wilson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH.

April 11 1922
(Month) (Day) (Year)

7. AGE

.....Yrs.....Mos.....2ds.
IF LESS than 1 day how many.....hrs. or.....min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country)

Brangerville

10. NAME OF FATHER

Otis Wilson

11. BIRTHPLACE OF FATHER

(State or Country)

Brangerville

12. MAIDEN NAME OF MOTHER

Edna Long

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Otis Wilson

(Address)

Brangerville Idaho

15.

Filed May 1 1922

E. L. Stockton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

150-6

16. DATE OF DEATH

April 11 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 9 1922 to April 11 1922, that I last saw him alive on April 10 1922 and that death occurred on the date stated above, at 5 A. M.

The CAUSE OF DEATH* was as follows:

Failure of closure of foramen Ovale

(Duration) Yrs. mos. 2 ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) E. L. Stockton M. D.

4/11/1922 (Address) Brangerville Idaho

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Prairie View

DATE OF BURIAL

April 12 1922

20. UNDERTAKER

E. L. Hancock

ADDRESS

Brangerville

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **38079**
Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Idaho
City of HoodlandRegistration District No. 49
Primary Registration District No. 348
(No. Edwood Patchiff St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widowed
(Write the word.)

6. DATE OF BIRTH.

Apr 14 1851
(Month) (Day) (Year)

7. AGE

71 Yrs. 13 Mos. 13 ds.IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)Retired farmer

9. BIRTHPLACE

(State or Country)

Louisiana

10. NAME OF FATHER

Isaac Patchiff

11. BIRTHPLACE OF FATHER

(State or Country)

No car

12. MAIDEN NAME OF MOTHER

Hulda Carr

13. BIRTHPLACE OF MOTHER

(State or Country)

?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15.

Filed

Apr 27/22

191

Local Registrar

MEDICAL CERTIFICATE OF DEATH

28

16. DATE OF DEATH

April 27 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 191 to April 15 1922
that I last saw him alive on April 15 1922
and that death occurred on the date stated above, at 12 AM.
The CAUSE OF DEATH* was as follows:Pulmonary tuberculosis(Duration) 7 Yrs. 1 mos. 1 ds.Contributory
(Secondary)(Duration) 7 yrs. 1 mos. 1 ds.(Signed) Chas. Bryan M. D.19. (Address) Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hoodland4/28 1922

20. UNDERTAKER

ADDRESS

Chas. BryanIdaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

22
23
CERTIFICATE OF DEATH.State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 49

County of Lewis

Primary Registration District No. 2428

City of Kammiah

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Josephine Maguire

File No. 38080
Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married

(Write the word.)

6. DATE OF BIRTH.

April 12 1849
(Month) (Day) (Year)

7. AGE

73

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...

Housewife

9. BIRTHPLACE

(State or Country)

Pennsylvania

10. NAME OF FATHER

Wm Miller

11. BIRTHPLACE OF FATHER

(State or Country)

Penn.

12. MAIDEN NAME OF MOTHER

Elizabeth Sausel

13. BIRTHPLACE OF MOTHER

(State or Country)

Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Mrs M R Rawson
Spokane, Wash

15.

Filed

6/14

1922

J. Johnson

Local Registrar

MEDICAL CERTIFICATE OF DEATH 64

16. DATE OF DEATH

April 14 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 191 to April 1922
that I last saw her alive on April 10 1922

and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Central Nervous System

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

A. Bryer

M. D.

19 (Address) Kammiah

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days In the State. yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

2007 Cen. Kammiah

DATE OF BURIAL

4/15 1922

20. UNDERTAKER

J. Johnson

ADDRESS

Kammiah

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **38081**

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Idaho
City of Westlake

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lucile Wilson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F.

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

April 6 1922
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many 60 hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Joseph Wilson

11. BIRTHPLACE OF FATHER

(State or Country) Idaho

12. MAIDEN NAME OF MOTHER

Estella Smith

13. BIRTHPLACE OF MOTHER

(State or Country) Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary Eastman(Address) Westlake Idaho

15.

Filed 5-6 1922W.F. Orr

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 8 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19that I last saw him alive on 19and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Strangulated Umbilical Hernia

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

4/8 1922 Dr. Schinick M. D.(Address) Calton wood

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Westlake Idaho 4/8 1922

20. UNDERTAKER

ADDRESS

Mary Eastman, Westlake, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Idaho
City of Ferdinand

If death occurs away from usual residence, give facts called for under special information.

RECEIVED

MAY 23 1922

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 105
Primary Registration District No. 2183 St.)State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 38082

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Marcella Sarbacher

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

April 23 1922
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many 8 hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Joseph H. Sarbacher

11. BIRTHPLACE OF FATHER

(State or Country) Idaho, Minn.

12. MAIDEN NAME OF MOTHER

Certrude Romer

13. BIRTHPLACE OF MOTHER

(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Joseph Sarbacher
Ferdinand, Ida.

15.

Filed 5-619 22W. F. Orr

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 23 22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

— 19 — to — 19 —
that I last saw him alive on — 19 —
and that death occurred on the date stated above, at 12:15 P.M.

The CAUSE OF DEATH* was as follows:

Premature birth. Congenital debility.

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Wesley F. Orr M. D.4/23 1922 (Address) Cottonwood

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Ferdinand, Ida.

DATE OF BURIAL

4/23 1922

20. UNDERTAKER

Rev. Jerome Beth Ferdinand, Ida.

ADDRESS

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
MAY 23 1922
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **38083**

1. PLACE OF DEATH

County of Idaho Registration District No. 105
City of Cottonwood Primary Registration District No. 2183
(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Paul Jacob Welte

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH

April 7 1922
(Month) (Day) (Year)

7. AGE

_____ Yrs. 4 Mos. _____ ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. _____
(b) General nature of industry, business or establishment in which employed (or employer). _____

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Jacob Welte

11. BIRTHPLACE OF FATHER

(State or Country) Iowa

12. MAIDEN NAME OF MOTHER

Beelia Koczynski

13. BIRTHPLACE OF MOTHER

(State or Country) Kan.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. H. Welte(Address) Cottonwood Idaho

15.

Filed 5-6 1922 W. F. Orr
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 11 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 7, 1922 to April 11, 1922
that I last saw him alive on April 11, 1922
and that death occurred on the date stated above, at 11:30 P.M.
The CAUSE OF DEATH* was as follows:Cerebral Compression

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W. F. Orr M. D.4/12, 1922 (Address) Cottonwood, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Cottonwood Idaho 4/13 1922August Koczynski Cottonwood, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH

County of *Idaho*
City of *Cottonwood*

If death occurs away from usual residence, give facts called for under special information.

RECEIVED CERTIFICATE OF DEATH

Registration District No. *183*
Primary Registration District No. *2183*
St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. *38084*
Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Jessie B. Burrell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*
(Write the word.)

6. DATE OF BIRTH *Sept 8 1887*
(Month) (Day) (Year)

7. AGE *35* Yrs. *6* Mos. _____ ds.
IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION *Housewife*
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE *South D.*
(State or Country)

10. NAME OF FATHER *Mathias Lucas*

11. BIRTHPLACE OF FATHER *Java*
(State or Country)

12. MAIDEN NAME OF MOTHER *Mary Bies*

13. BIRTHPLACE OF MOTHER *Germany*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *Mathias Lucas*
(Address) *Cottonwood Id*

15. Filed *5-6* *1922* *W. F. Orr*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 6 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Mar. 28 1922*, to *April 6 1922*, that I last saw her alive on *April 6 1922*, and that death occurred on the date stated above, at *1:30 P.M.*

The CAUSE OF DEATH* was as follows:

Cholelithiasis, Rupture of gall Bladder.
(Duration) _____ Yrs. *4* mos. *8* ds.

Contributory (Secondary)

(Signed) *Wesley F. Orr* M. D.
4/7 1922 (Address) *Cottonwood Id*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL *Cottonwood Id* DATE OF BURIAL *4-8 1922*

20. UNDERTAKER *Atman* ADDRESS *Cottonwood Id*

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of IdahoCity of Ferdinand

MAY 23 1922

Registration District No. 105Primary Registration District No. 2183

(No. _____)

St.)

File No. 38085

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Carfield Hammer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

single

(Write the word.)

6. DATE OF BIRTH

July211921

(Month)

(Day)

(Year)

7. AGE

8 Yrs. 19 Mos. 19 ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Lewiston, Idaho

10. NAME OF FATHER

G. H. Hammer

11. BIRTHPLACE OF FATHER

(State or Country)

Iowa Co Iowa

12. MAIDEN NAME OF MOTHER

Nellie Larkin

13. BIRTHPLACE OF MOTHER

(State or Country)

St. Louis, Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. G. N. Hammer

(Address)

Ferdinand, Idaho

15.

Filed

5-6 1922W. F. Orr

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March

(Month)

30

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 26 1922 to March 30 1922that I last saw him alive on March 30 1922,and that death occurred on the date stated above, at 9:20 M.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(Duration)

Yrs.

mos.

4 ds.Contributory
(Secondary)

(Duration)

yrs.

mos.

2 ds.

(Signed)

J. D. Shrimick M. D.3-31-1922 (Address) Coltonwood, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death..... yrs..... mos.....

In the

days. State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Lewiston

DATE OF BURIAL

Mar 30 1922

20. UNDERTAKER

G. F. Maughey

ADDRESS

Changerville

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **38087**Registered No. **32**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Jefferson Registration District No. 78
City of Highway R.D.#3 Primary Registration District No. 2176 St.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

JUN 8 1922
BUREAU OF VITAL STATISTICSLessey

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-OWED OR DIVORCED

Female White (Write the word.)

6. DATE OF BIRTH

6 13 1918
(Month) (Day) (Year)

7. AGE

3 Yrs. 10 Mos. 5 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Highway R.D.#3

10. NAME OF FATHER

Truman Lessey

11. BIRTHPLACE OF FATHER

(State or Country) Utah

12. MAIDEN NAME OF MOTHER

Mary E Taylor

13. BIRTHPLACE OF MOTHER

(State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Truman Lessey
(Address) Highway R.D.#315. Filled 5 10 1922 Ray N. Fisher
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

4 19
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from April 18 19 22 to April 21 19 22
that I last saw her alive on April 20 19 22
and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia(Duration) Yrs. mos. 4 ds.Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) O. K. Call M. D.

19 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Highway 4/23/1922

20. UNDERTAKER

ADDRESS

Ed. Williams Highway

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **38988**Registered No. **95**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of **Jefferson**Registration District No. **98**City of **Lewistown**Primary Registration District No. **2176**(No. **JUN 8 1922** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

BUREAU OF VITAL STATISTICS

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

male**white****single**

(Write the word.)

6. DATE OF BIRTH

March 4 -

(Month)

4

(Day)

1899

(Year)

7. AGE

22

Yrs.

11

Mos.

28

ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Farmer

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

Harry A. Havens

11. BIRTHPLACE OF FATHER

(State or Country)

Illinois

12. MAIDEN NAME OF MOTHER

Mary J. Meadley

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

5-10

19

22**Ray A. Fish**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March

(Month)

2

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from **Feb. 25** 1922 to **March 2** 1922that I last saw him alive on **March 2** 1922and that death occurred on the date stated above, at **6 P.M.**

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) **A. M. Palmer** M. D.19 (Address) **Bigby, Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lewistown Idaho**3-6-1922**

20. UNDERTAKER

ADDRESS

E. W. Helmer**Bigby, Ida**

1. PLACE OF DEATH

County of Jefferson
City of Regby

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No. 98
Registration District No. 2176

BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 38089
Registered No. 34

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH

July 16 1899
(Month) (Day) (Year)

7. AGE

72 Yrs. 9 Mos. 4 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) England

10. NAME OF FATHER

Samuel Chandler

11. BIRTHPLACE OF FATHER

(State or Country) England

12. MAIDEN NAME OF MOTHER

Mary Jarvis

13. BIRTHPLACE OF MOTHER

(State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary J. Chandler
(Address) Regby, Ida

15.

Filed 5-10 1922Ray H. Fisher
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 20 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from April 25 1922, to April 29 1922 that I last saw him alive on April 19 1922 and that death occurred on the date stated above, at 8 P. M.
The CAUSE OF DEATH* was as follows:Acute dilatation of heart(Duration) Yrs. mos. 1 ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed)

G. E. Ball M. D.
4/24 1922 (Address) Regby, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Regby, Idaho

DATE OF BURIAL

4/24 1922

20. UNDERTAKER

E. E. Linwood Idaho Falls
License # 100

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of JeffersonCity of BigbyIf death occurs away from
usual residence, give facts
called for under special in-
formation.Registration District No. 98
County Registration District No. 2176
BUREAU OF VITAL STATISTICSFile No. 38090Registered No. 33If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

2. FULL NAME

Richard Sharp Wolfensberger

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDSingle
(Write the word.)

6. DATE OF BIRTH

4 24 1921
(Month) (Day) (Year)

7. AGE

10 Yrs. 14 Mos. 14 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country) Bigby, Idaho.10. NAME OF
FATHEROtto Wolfensberger11. BIRTHPLACE
OF FATHER(State or Country) Switzerland12. MAIDEN NAME
OF MOTHERRuby Sharp13. BIRTHPLACE
OF MOTHER(State or Country) Smithfield, Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Otto Wolfensberger(Address) Bigby, Idaho.

15.

Filed 5-10 22 Ray N. Fische
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 6 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb. 6 1922 to March 5 1922that I last saw him alive on March 5 1922and that death occurred on the date stated above, at 7 A. M.

The CAUSE OF DEATH* was as follows:

Septicemia(Duration) Yrs. 1 mos. _____ ds.Contributory Septicemia + Otitis media
(Secondary)

(Duration) yrs. _____ mos. _____ ds.

(Signed) A. M. Palmer M. D.19 (Address) Bigby, Idaho.*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lincoln, Idaho 3-9 1922

20. UNDERTAKER

ADDRESS

Edw. Gietlin

1. PLACE OF DEATH

County of BenewahCity of Reids P.O.

If death occurs away from usual residence, give facts called for under special information.

CERTIFICATE OF DEATH

Registration District No. 98Registration District No. 2176

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 380916Registered No. 380916

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Arthur P. Ball

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

Jan 25

(Month)

(Day)

1859 (Year)

7. AGE

63 Yrs. 3 Mos. 21 ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Farmer

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

W. M. Ball

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Elizabeth England

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Arthur P. Ball

(Address)

Reids P.O., Ida

15.

Filed

5-11

19

Ray Stike

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 11

(Month)

11

(Day)

22

(Year)

I HEREBY CERTIFY, That I attended deceased from 5/11 1922 to 5/15 1922that I last saw him alive on: 5/15 1922and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Influenza Pneumonia

(Duration)

Yrs.

mos.

ds. 6

Contributory (Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

Sam F. Price

19

(Address)

Reids Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death.....yrs.....mos.....days.

In the

State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Reids Idaho5-18 1922

20. UNDERTAKER

ADDRESS

Ed. L. L. L.Reids

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

1. PLACE OF DEATH
County of *Kootenai*
City of *Harrison*
Registration District No. *126*
Primary Registration District No. *2204*
BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. *3*
Registered No. *38092*

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME *May Williams*

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. *Single*
(Write the word.)

6. DATE OF BIRTH. *Oct 6 1920*
(Month) (Day) (Year)

7. AGE *2* Yrs. *6* Mos. *28* ds.
IF LESS than 1 day how many hrs. or min. 2

8. OCCUPATION
(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE *Harrison Idaho*
(State or Country)

10. NAME OF FATHER *Leo Williams*

11. BIRTHPLACE OF FATHER *Wis*
(State or Country)

12. MAIDEN NAME OF MOTHER *Mable Thornton*

13. BIRTHPLACE OF MOTHER *Wis*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) *Oliver Williams*
(Address) *Harrison Ida*

15. Filed *6-1* 19*22* *J. H. Perry*
Local Registrar

16. DATE OF DEATH *May 4 1922*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *May 22 1922* to *May 4 1922*, that I last saw her alive on *May 3 1922* and that death occurred on the date stated above, at *8 A.M.*

The CAUSE OF DEATH* was as follows:
Influenza

(Duration) *12* yrs. *6* mos. *12* ds.
Contributory *Ant. Hepatitis*
(Secondary)
(Duration) *6* yrs. *6* mos. *6* ds.
(Signed) *J. H. Perry* M. D.
5-4 19*22* (Address) *Harrison Ida*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Harrison Ida* DATE OF BURIAL *5-6 1922*

20. UNDERTAKER *B. C. Cassidy* ADDRESS *My M. Ketchum*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Kootenai District No. 126
City of Hammon Primary Registration District No. 2204
(No. St.)

File No. 88093Registered No. 70

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ethyl Noble Morley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH.

June 19 1891
(Month) (Day) (Year)

7. AGE

30 Yrs. 10 Mos. ds.

If LESS than 1 day
how many hrs. or
..... min.?)

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

Housewife

9. BIRTHPLACE

(State or Country) Tenn

10. NAME OF FATHER

Doc Mc Kenney

11. BIRTHPLACE OF FATHER

(State or Country) Tenn

12. MAIDEN NAME OF MOTHER

Molly Gibson

13. BIRTHPLACE OF MOTHER

(State or Country) Tenn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) R. E. Morley

(Address) Black Lake

15.

Filed 4-14-22 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 13 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar 22 1922 to April 13 1922
that I last saw her alive on Dec 23 1922

and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Dr. E. J. Gray M. D.

Address Hammon, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Hammon, Idaho

DATE OF BURIAL

4-16-22 1922

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 2 **38094**
Registered No. 2

1. PLACE OF DEATH

County of Waterbury
City of HarrisonRegistration District No. 126Primary Registration District No. 2204

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Fredrick Knutson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Dec
(Month)

(Day)

1916
(Year)

7. AGE

5 Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Harrison Ida

10. NAME OF FATHER

See Knutson

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Math Holcho

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) See Knutson(Address) Harrison Ida

15.

Filed 5-17-22

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April
(Month)14
(Day)1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 3 1922 to April 14 1922
that I last saw him alive on April 14 1922
and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. B. Barry

M. D.

4-14-22 (Address) Harrison Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Harrison

DATE OF BURIAL

4-16-22

20. UNDERTAKER

ADDRESS

J. B. Barry
W. M. Ketchum

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **38095**
Registered No. **72**

1. PLACE OF DEATH
County of Hotena
City of Barron
Registration District No. 126
Primary Registration District No. 2204
St. Idaho

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Louis Waldo

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH
Aug 30 30 1859
(Month) (Day) (Year)

7. AGE 62 Yrs. 8 Mos. 22 ds.
IF LESS than 1 day
how many.....hrs.
or.....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Housewife
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Germany

10. NAME OF FATHER Chris Wischner

11. BIRTHPLACE OF FATHER
(State or Country) Germany

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mabel Brutsen
(Address) Harrison Idaho

15. Filed 5-1 19 22 M. Brutsen
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Apr 23 19 22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-21 19 22 to 4-23 19 22
that I last saw her alive on 4-23 19 22
and that death occurred on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH was as follows:
Blood Poisoning

(Duration)Yrs.....mos.....ds.

Contributory (Secondary)

(Duration)yrs.....mos.....ds.

(Signed) M. Brutsen M. D.

4-23 19 22 (Address) Harrison

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Barron Idaho DATE OF BURIAL 4/26 19 22

20. UNDERTAKER E. E. Sweeney ADDRESS Edward Sweeney

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Kootenai
City of HarrisonRegistration District No. 126Primary Registration District No. 2204(No. 126 St.)File No. 38096Registered No. 718

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Orange S Dewey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.Widower
(Write the word.)

6. DATE OF BIRTH.

June 21 1874
(Month) (Day) (Year)

7. AGE

77 Yrs. 10 Mos. 4 ds.IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...

(b) General nature of industry, business, or establishment in which employed (or employer).....
Dom labor

9. BIRTHPLACE

(State or Country) Mich

10. NAME OF FATHER

Levi Brown

11. BIRTHPLACE OF FATHER

(State or Country) Mich

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country) Mich

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm S Lake(Address) Harrison
Clark

15.

Filed 5-11912

Local Registrar

MEDICAL CERTIFICATE OF DEATH

40

16. DATE OF DEATH

4-25-1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from 8-13-1922 to 4-25-1922that I last saw him alive on 4-24-1922

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Wm S Lake

M. D.

426 10 (Address) Harrison

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Harrison

DATE OF BURIAL

5-26-1922

20. UNDERTAKER

B. Cassidy
by M. R. R. R.

ADDRESS

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

RECEIVED

District No.

MAY 23 1922

County of *Kootenai*

Registration District No.

City of *Hooley Ida. R.*

BUREAU OF VITAL STATISTICS

St.)

File No. **38097**Registered No. *5*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Clarence Elton Tuley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

April - 14th 1908
(Month) (Day) (Year)

7. AGE

*14 yrs. mos. 11 ds.*IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)*Worked on farm at home.*

9. BIRTHPLACE

(State or Country)

Willawa Co. Oregon.

10. NAME OF FATHER

L. A. Tuley.

11. BIRTHPLACE OF FATHER

(State or Country)

Union Co. Oregon.

12. MAIDEN NAME OF MOTHER

Anna Burlingame

13. BIRTHPLACE OF MOTHER

(State or Country)

Salem, Oregon.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

L. A. Tuley.

(Address)

Hooley, Idaho R.R. 1.

15.

Filed

May 1 1922 H. G. Jaeger

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

120

16. DATE OF DEATH

April 25th 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *April 25th 1922* to *April 25th 1922*that I last saw him alive on *April 25th 1922* and that death occurred on the date stated above, at *9:30 P. M.*

The CAUSE OF DEATH* was as follows:

Acute Brights.(Duration) yrs. mos. *12* ds.

Contributory (Secondary)

Influenza, March 24th - 1922

(Duration) yrs. mos. ds.

(Signed)

april 27 1922 J. J. Rimmer M. D.
(Address) *Hooley, Idaho.*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

Hooley - Idaho

DATE OF BURIAL

Apr. 27 1922

20. UNDERTAKER

H. G. Jaeger

ADDRESS

Rimmer.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of NathropCity of Nathrop

If death occurs away from usual residence, give facts called for under special information.

RECEIVED

JUN 8 1922

BUREAU OF VITAL STATISTICS

Registration District No. 30County Registration District No. 1051

St.)

File No.

38098

Registered No.

1064

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Helena M. Allison

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F.

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widowed
(Write the word.)

6. DATE OF BIRTH

January 22
(Month) (Day) (Year)

7. AGE

76 Yrs. 2 Mos. 16 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Housewife

9. BIRTHPLACE

(State or Country)

New York

10. NAME OF FATHER

John Mowry

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Melina

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jennie M. Reese
(Address)

15.

Filed

6/5

19

W. D. Dorman

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 8 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct. 10 1920, to Apr. 8 1922that I last saw him alive on Apr. 8 1922and that death occurred on the date stated above, at 8:00 M.

The CAUSE OF DEATH* was as follows:

Loose Pulmonary(Duration) Yrs. 3 mos. 3 ds.Contributory
(Secondary)Chronic infectious
nephritis (Duration) yrs. 2 mos. 2 ds.

(Signed)

Frank P. King, M. D.4/9 1922 (Address) Nathrop, Colo.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Pres. Gov. Cem. Nathrop4/13 1922

20. UNDERTAKER

ADDRESS

C. L. CassidyNathrop, Colo.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH *Kootenai* REGISTRATION District No. *30*
County of *Kootenai* JUN 5 1922 Primary Registration District No. *1051*
City of *Blaine* St.)

File No. *38099*
Registered No. *1065*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Blaine R. Leiske

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *single*
(Write the word.)

6. DATE OF BIRTH

July 12 1920
(Month) (Day) (Year)

7. AGE

1 Yrs. *9* Mos. *6* ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

North Dakota

10. NAME OF FATHER

William Leiske

11. BIRTHPLACE OF FATHER

(State or Country)

N. Dak

12. MAIDEN NAME OF MOTHER

Idella Rink

13. BIRTHPLACE OF MOTHER

(State or Country)

Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *William Leiske*
(Address) *Blaine, Idaho*

15.

Filed *4/18* 19 *22*

D. J. Brennan

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 18 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Apr. 7 1922* to *Apr. 18 1922*
that I last saw him alive on *Apr. 17 1922*
and that death occurred on the date stated above, at *2:00* M.
The CAUSE OF DEATH* was as follows:
Bronchopneumonia

(Duration) Yrs. mos. *11* ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *Frank Weary* M. D.

4/18 1922 (Address) *Booth, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Near Pocatello, Idaho *4/20 1922*

20. UNDERTAKER

ADDRESS

R B Mooney Pocatello, Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Postlewaite*City of *Grand Island*

If death occurs away from usual residence, give facts called for under special information.

Registration District No. *30*Health District No. *1051*

St.)

File No.

Registered No. *38400*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Hannah Johnson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

Nov

(Month)

23

(Day)

1854

(Year)

7. AGE

67

Yrs.

5

Mos.

10

ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Housewife

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Surdan

10. NAME OF FATHER

Lindquist

11. BIRTHPLACE OF FATHER

(State or Country)

Surdan

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Surdan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Gustaf Johnson

(Address)

Grand Island, Neb.

15.

Filed

6

19

*1922**25**Dec**Dr. J. W. Drinnan*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May

(Month)

3

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 28

19

22

to

May 3

19

*22*that I last saw him alive on *May 3* 19*22*and that death occurred on the date stated above, at *9 P. M.*

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia.

(Duration)

Yrs.

mos.

7 ds.Contributory
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

May 3 1922

(Address)

*John O'Leary, M. D.
Grand Island, Neb.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death..... yrs..... mos..... days.

In the

State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Local Cemetery

DATE OF BURIAL

5/7 1922

20. UNDERTAKER

O. Cassidy

ADDRESS

Grand Island

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH **JUN 8 1922** Registration District No. **30**
 County of **Kootenai** **BUREAU OF VITAL STATISTICS** Registration District No. **1051** **38193**
 City of **Bozeman** (No.) **Bozeman** (St.) File No. _____
 If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME **George H Marker** Registered No. **1169**
 If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX **male** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **married**
 (Write the word.)

6. DATE OF BIRTH **April 23 1855**
 (Month) (Day) (Year)

7. AGE **67** Yrs. **0** Mos. **15** ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION (a) Trade, profession or particular kind of work **Farmer**
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) **Maryland**

10. NAME OF FATHER **John Marker**

11. BIRTHPLACE OF FATHER (State or Country) **Maryland**

12. MAIDEN NAME OF MOTHER **Unknown**

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Mrs Geo Marker**
 (Address) **Bozeman Idaho 2da**

15. Filed **6/5** 19 **22** **W D Drennan**
 Local Registrar

16. DATE OF DEATH **May 9 1922**
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **May 7 1922**, to **May 9 1922**
 that I last saw him alive on **May 8 1922**
 and that death occurred on the date stated above, at **10 A. M.**
 The CAUSE OF DEATH* was as follows:

Pulmonary Thrombosis

(Duration) Yrs. Mos. ds.
 Contributory (Secondary) **Chronic Valvular Heart Disease**

(Duration) Yrs. Mos. ds.

(Signed) **J. D. Owen** M. D.
May 10 1922 (Address) **Bozeman Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State **14** yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **Forest Cemetery** DATE OF BURIAL **5, 11 1922**

20. UNDERTAKER **R B Mooney** ADDRESS **Bozeman Idaho**

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Kootenai* Registration District No. *30*
City of *Coeur d'Alene* Primary Registration District No. *105138104*
St. *River*Registered No. *070*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Laura Mary La Fontaine
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F.

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

single

(Write the word.)

6. DATE OF BIRTH

*July**3**1918*

(Month)

(Day)

(Year)

7. AGE

*3*Yrs. *10*Mos. *6*

ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho.

10. NAME OF FATHER

J. S. La Fontaine

11. BIRTHPLACE OF FATHER

(State or Country)

Mich.

12. MAIDEN NAME OF MOTHER

Laurie LeGault

13. BIRTHPLACE OF MOTHER

(State or Country)

Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. S. La Fontaine

(Address)

Coeur d'Alene, Idaho

15.

Filed

*4/4*19 *22**W. D. Drennan*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

*May**9**1922*

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 9, 1922 to *19*that I last saw her alive on *May 9, 1922*and that death occurred on the date stated above, at *1 P.*

The CAUSE OF DEATH* was as follows:

Parelysis. Tick.

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *W. D. Drennan* M. D.*5/10 1922* (Address) *Coeur d'Alene*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Thomas Cem. Coeur d'Alene *5-11 1922*

20. UNDERTAKER

ADDRESS

Corrady *Coeur d'Alene*

CERTIFICATE OF DEATH

State of Idaho
DEPARTMENT OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Boatmanville Registration District No. 20
City of Boatmanville Primary Registration District No. 051
St. PointFile No. 38106Registered No. 1071

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH

April 7 1885
(Month) (Day) (Year)

7. AGE

66 Yrs. 1 Mos. 3 ds.
IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed 4/41922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 10 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 10 1922, to May 10 1922that I last saw him alive on April 10 1922and that death occurred on the date stated above, at 7:30 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial
nephritis(Duration) 2 Yrs. — mos. — ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

May 12 1922 (Address) Boatmanville

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State 22 yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Boatmanville, Idaho May 12 1922

20. UNDERTAKER

ADDRESS

R.B. Mooney Boatmanville, Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Routenai Registration District No. 30
City of Coeur d'Alene Registration District No. 1051 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Arletta M. HartFile No. 38107
Registered No. 1020

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F.

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

single married
(Write the word.)

6. DATE OF BIRTH

June 9 1896
(Month) (Day) (Year)

7. AGE

65 Yrs. 11 Mos. 11 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

House wife

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

N. Y.

10. NAME OF FATHER

Cross

11. BIRTHPLACE OF FATHER

(State or Country)

N. Y.

12. MAIDEN NAME OF MOTHER

Rachel Huyck

13. BIRTHPLACE OF MOTHER

(State or Country)

N. Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Miss C. L. Bolton

(Address)

Salt Lake City, Utah

15.

Filed

6/6 1922 D. P. Hengen
Local Registrar

MEDICAL CERTIFICATE OF DEATH

64

16. DATE OF DEATH

May 20 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 15, 1922, to May 20, 1922that I last saw him alive on May 20, 1922and that death occurred on the date stated above, at 12:45 M.

The CAUSE OF DEATH* was as follows:

Coronary atherosclerosis

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory (Secondary)

General arteriosclerosis(Duration) 3 or more yrs. _____ mos. _____ ds.

(Signed)

Frank H. Hengen, M. D.5/22 1922 (Address) Ratholm, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Spokane, Wn. 5/23 1922

20. UNDERTAKER

ADDRESS

Constance L. Casady Ratholm, Ida

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **38108**Registered No. **1274**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of *Kootenai*
City of *Coeur d'Alene*Registration District No. *38*Primary Registration District No. *1051*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Pauline Frederic

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F.

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

single

(Write the word.)

6. DATE OF BIRTH

May 18 1822
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

W. H. Frederic

11. BIRTHPLACE OF FATHER

(State or Country)

Mont.

12. MAIDEN NAME OF MOTHER

Alice Boomer

13. BIRTHPLACE OF MOTHER

(State or Country)

Mont.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

W. H. Frederic
207 Garden Coeur d'Alene

15.

Filed

7/2

19

2022

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 20 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 19 1922 to *May 20 1922*that I last saw him alive on *May 19 1922*

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Primateur berce

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

May 20 1922 (Address) *Coeur d'Alene Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Forest Cem. Coeur d'Alene

DATE OF BURIAL

5-20 1922

20. UNDERTAKER

C. Carney

ADDRESS

Coeur d'Alene

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

38109

1. PLACE OF DEATH

County of Boone Registration District No. 30
City of Boone Primary Registration District No. 1051
City of Boone Hospital Hospital St.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Sydia Ann HooperFile No. 1075
Registered No. 1075

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH

April 23 1862
(Month) (Day) (Year)

7. AGE

60 Yrs. 0 Mos. 27 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Ill.

10. NAME OF FATHER

John Mayer

11. BIRTHPLACE OF FATHER

(State or Country)

Penn

12. MAIDEN NAME OF MOTHER

Mary Adam

13. BIRTHPLACE OF MOTHER

(State or Country)

Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs F E Nilson

(Address)

White Sulphur Springs, Mo

15.

Filed

6/6 1922D. W. Adair

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 20 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 14 1922 to May 20 1922
that I last saw him alive on May 19 1922
and that death occurred on the date stated above, at 29 M.

The CAUSE OF DEATH* was as follows:

Albuminuria(Duration) 4 Yrs. 4 mos. 20 ds.Contributory
(Secondary)Arterio-sclerosis(Duration) 4 yrs. 4 mos. 4 ds.

(Signed)

J. H. Hoedem M. D.5/22 1922 (Address) Boone, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State 7 yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

Walton Gardens, Mo

19. PLACE OF BURIAL OR REMOVAL

Forest Cemetery

DATE OF BURIAL

May 23 1922

20. UNDERTAKER

P. B. Mowrey

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Montenai
City of C. H. A.Registered District No. 30
Primary Registration District No. 1051
(No. of Vital Statistics)File No. 6826
Registered No. 4826If death occurs away from
usual residence, give facts
called for under special in-
formation.If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.2. FULL NAME Barbara Mogg

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED M.
(Write the word.)

6. DATE OF BIRTH

Jan 13 1922
(Month) (Day) (Year)

7. AGE

70 Yrs. 3 Mos. 11 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer).House Wife

9. BIRTHPLACE

(State or Country)

New York10. NAME OF
FATHERHubert Kriner11. BIRTHPLACE
OF FATHER

(State or Country)

France12. MAIDEN NAME
OF MOTHER13. BIRTHPLACE
OF MOTHER

(State or Country)

unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Asual Mogg
St. Marie's Edg.

15.

Filed May 9 19 22 DD unway
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 24 19 22
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
March 28 1922 to April 24 1922
that I last saw him alive on April 22 1922
and that death occurred on the date stated above, at M.
The CAUSE OF DEATH* was as follows:
General anasarea

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) John S. W. M. D.(Address) C. H. A.*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)At place of death yrs. mos. days. In the State 14 yrs. 1 mos. 1 daysWhere was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Thomas Co.4/26 19 22

20. UNDERTAKER

ADDRESS

B. B. MoggC. H. A.MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH
in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Kootenai* Registration District No. *30*
City of *Post Falls* Registration District No. *1851*
St. *Idaho*

File No.

Registered No. *1077*

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Harry M. Wilhoit

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *married*
(Write the word.)

6. DATE OF BIRTH

April 11 1883
(Month) (Day) (Year)

7. AGE

39 Yrs. *1* Mos. *13* ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

Farmer

9. BIRTHPLACE

(State or Country)

Kansas

10. NAME OF FATHER

James Wilhoit

11. BIRTHPLACE OF FATHER

(State or Country)

Ill

12. MAIDEN NAME OF MOTHER

Louise Platt

13. BIRTHPLACE OF MOTHER

(State or Country)

Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mrs H M Wilhoit*
(Address) *Post Falls, 2 dr.*

15.

Filed *6/6 1922*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 24 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *May 10 1922* to *May 24 1922*
that I last saw him alive on *May 24 1922*
and that death occurred on the date stated above, at *3:30 P.* M.

The CAUSE OF DEATH* was as follows:

*Diabetes Mellitus*Contributory
(Secondary)(Duration) *2 or 3* yrs. — mos. — ds.(Signed) *Frank W. Noy* M. D.*5/24/22* (Address) *Post Falls, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death *3* yrs. — mos. — days. In the State *3* yrs. — mos. — days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Post Falls 2 dr

DATE OF BURIAL

May 28 1922

20. UNDERTAKER

R B Mooney

ADDRESS

Post Falls

CERTIFICATE OF DEATH

38112

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bedar Creek Registration District No. 20
City of Bedar Creek Primary Registration District No. 1251
St.)

File No. _____

Registered No. 1251

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

John D. Needham

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH

Oct- 20 1853
(Month) (Day) (Year)

7. AGE

65 Yrs. 7 Mos. 9 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Farmer

9. BIRTHPLACE

(State or Country)

Ill.

10. NAME OF FATHER

Gordon B. Needham

11. BIRTHPLACE OF FATHER

(State or Country)

N. Y.

12. MAIDEN NAME OF MOTHER

Eldridge

13. BIRTHPLACE OF MOTHER

(State or Country)

N. Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. J. D. Needham
(Address) Bedar Creek, Idaho

15.

Filed 6 19 22 500

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 29 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 26 1922, to May 26 1922
that I last saw him alive on May 26 1922,
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Chronic pulmonary tuberculosis
coria(Duration) coria Yrs. _____ mos. _____ ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) E. L. Reger M. D.June 3, 1922 (Address) Bedar Creek, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Cathol. Ida

DATE OF BURIAL

5-31 1922

20. UNDERTAKER

ADDRESS

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Pooten*
City of *Pour d'Alene*Registration District No. *30*Primary Registration District No. *051*(No. *812*)

38113

File No.

Registered No. *1069*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Barbra Mogg

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

Jan 13 1852
(Month) (Day) (Year)

7. AGE

70 Yrs. *3* Mos. *11* ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Housewife

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

New York

10. NAME OF FATHER

Hubert Greiner

11. BIRTHPLACE OF FATHER

(State or Country)

France

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Oswald Mogg

(Address)

St. Mary's - 2nd

15.

Filed

May 9 1922
W. Cannon
Local Registrar

16. DATE OF DEATH

April 24 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

*Mar. 28 1922 to Apr. 24 1922*that I last saw h. or alive on *April 22 1922*and that death occurred on the date stated above, at *8 A.* M.

The CAUSE OF DEATH* was as follows:

General anasarca.(Duration) Yrs. *2* mos. ds.Contributory
(Secondary)*Mitral regurgitation.*

(Duration) Yrs. mos. ds.

unknown.

(Signed)

John Wood
Apr. 22 1922 (Address) *Pour d'Alene, Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State *14* yrs. *1* mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Thomas Cem *4/26 1922*

20. UNDERTAKER

ADDRESS

W. Cannon
Pour d'Alene

File No.
Registered No. 1061

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

Female white married (with the word.)

_____ Feb 12 1880
(Month) (Day) (Year)

36 Yrs. 2 Mos. 9 ds. how many..... hr
or..... min.?

(a) Trade, profession or particular kind of work..... *House Wife*

(b) General nature of industry, business or establishment in which employed (or employer).....

(State or Country) *China*

Don A Sprague

(State or Country) Ohio

Chas & Leth Woolley

(State or Country) Germany

(Informant) H. C. [Signature]

(Address) Power of Attorney

15. $71, 9, 25, 16, 4, 11$

April 21 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 8 1972 to April 21 1972
that I last saw h. lv alive on April 21 1972
and that death occurred on the date stated above, at 11 A.M.
The CAUSE OF DEATH* was as follows:

Brain Abscess

(Duration) _____ Yrs. _____ mos. 12 ds.

**Contributory
(Secondary)**

(Duration) 12 yrs. 0 mos. 0 ds.

(Signed)

427.22 (Address) Corn & Henry Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State / yrs.....mos.....days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL

Forest Cemetery	4/24/1927
20. UNDERTAKER	ADDRESS

20. UNDERTAKER *R B Mooney* ADDRESS *Peardale*

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

WRITE PLAINLY. WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of FootenaiRegistration District No. 30City of Post Falls, IdahoPrimary Registration District No. 1051If death occurs away from
usual residence, give facts
called for under special
information.

(No. St.)

2. FULL NAME

Ulyssis H DodgeFile No.
Registered No. 1054
If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white5. SINGLE, MARRIED, WID-
OWED OR DIVORCED
married
(Write the word.)

6. DATE OF BIRTH

June 18th 1860
(Month) (Day) (Year)

7. AGE

61 Yrs. 6 Mos. 24 ds.IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of in-
dustry, business, or estab-
lishment in which em-
ployed (or employer)Farmer

9. BIRTHPLACE

(State or Country)

Erie, Penn.

10. NAME OF

FATHER X

David E. Dodge11. BIRTHPLACE
OF FATHER

(State or Country)

York State12. MAIDEN NAME
OF MOTHERHarriet Cole13. BIRTHPLACE
OF MOTHER

(State or Country)

York State

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Jennie Dodge

(Address)

Post Falls, Idaho

15.

Filed May 4 1912 L. H. Cannon

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 2 1912
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 30 1912 to March 1 1912
that I last saw him alive on Mar 1st 1912and that death occurred on the date stated above, at 9:45 A.M.

The CAUSE OF DEATH* was as follows:

Paralysis

(Duration) Yrs. mos. ds.

Contributory
(Secondary)Chronic Gastritis(Duration) 1 Yrs. 4 mos. ds.

(Signed)

F. L. McCauley M. D.Mar 2 1912 (Address) Post Falls, Idaho*State the Disease Causing Death; or in deaths from Violent
Causes, state (1) Means of Injury; and (2) whether Accidental,
Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)At place In the
of death yrs. mos. days, State yrs. mos. daysWhere was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

..... 191...

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Butte Registration District No. 21
City of Paer & Adams Primary Registration District No. 1051
St. Third

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mildred CoffeeRegistered No. 38116

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH

mech 13 1895
(Month) (Day) (Year)

7. AGE

47 Yrs. 0 Mos. 25 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. House Wife
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Id.

10. NAME OF FATHER

Amos Andrews

11. BIRTHPLACE OF FATHER

(State or Country) Id.

12. MAIDEN NAME OF MOTHER

Elizabeth Briggs

13. BIRTHPLACE OF MOTHER

(State or Country) Id.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H. G. Coffee
(Address) Paer & Adams St.15. Filed May 4 19 22 H. H. H. H. H.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 8 19 22
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from April 1 19 22 to April 8 19 22
that I last saw h. ex. alive on April 8 19 22
and that death occurred on the date stated above, at 5 P. M.
The CAUSE OF DEATH* was as follows:
Bronchial asthma.(Duration) Yrs. _____ mos. 4 ds.
Contributory (Secondary) Influenza.(Duration) Yrs. _____ mos. 7 ds.
(Signed) John Wood M. D.April 10 19 22 (Address) Paer & Adams St.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State 11 yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Forest Cemetery DATE OF BURIAL 4/10 19 2220. UNDERTAKER R B Mooney ADDRESS Paer & Adams St.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

1. PLACE OF DEATH.

County of *Kootenai*
City of *Hooley, Ida R.R. 1.*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED
MAY 23 1922
CERTIFICATE OF DEATH
Registration District No. *20*
Bureau of Vital Statistics
Registration District No. *100*

(No. _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. _____

Registered No. *1855*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

American

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

July 25th 1904
(Month) (Day) (Year)

7. AGE

13 yrs. *7* mos. *22* ds.IF LESS than 1 day
how many hrs. or
..... mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

Worked at home as

(b) General nature of industry business, or establishment in which employed (or employer)

Farmer.

9. BIRTHPLACE

(State or Country)

Missouri, Lewis Co

10. NAME OF FATHER

Harry F. Wright.

11. BIRTHPLACE OF FATHER

(State or Country)

Missouri, Lewis Co

12. MAIDEN NAME OF MOTHER

Edith Kennedy.

13. BIRTHPLACE OF MOTHER

(State or Country)

Missouri, Lewis Co

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Harry F. Wright, Father

(Address)

Hooley, Ida R.R. 1.

15.

Filed

May 9

1922

O. H. Brennan

Local Registrar

MEDICAL CERTIFICATE OF DEATH

10

16. DATE OF DEATH

March 18th 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *March 17th* 1922, to *March 18th* 1922.that I last saw him alive on *March 18th* 1922.and that death occurred on the date stated above, at *2:30 P.M.*

The CAUSE OF DEATH* was as follows:

Perfluorosis.(Duration) *1* yrs. *1* mos. *12* ds.

Contributory

(Secondary) *Congestion of Brain*(Duration) *1* yrs. *1* mos. *12* ds.

(Signed)

J. J. Birmingham M. D.

19

(Address) *Hooley, Idaho.*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

Hooley Cemetery.

DATE OF BURIAL

3/19/22 1922.

20. UNDERTAKER

Haul -

ADDRESS

RECEIVED CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 20
 County of Hotenau Primary Registration District No. 1051
 City of Sagehen Lake St.)

 File No. 38419
 Registered No. 1159

 If death occurs away from
 usual residence, give facts
 called for under special in-
 formation.

2. FULL NAME

Edward A. Anthony
 If death occurred in a hos-
 pital, institution or camp,
 give its NAME instead of
 street and number.

PERSONAL AND STATISTICAL PARTICULARS

 3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED married
 (Write the word.)

6. DATE OF BIRTH

Aug 15 1841
 (Month) (Day) (Year)

7. AGE

80 Yrs. 8 Mos. 25 ds.

 IF LESS than 1 day
 how many..... hrs.
 or..... min.?

8. OCCUPATION

 (a) Trade, profession or
 particular kind of work Retired
 (b) General nature of in-
 dustry, business or estab-
 lishment in which employ-
 ed (or employer)

9. BIRTHPLACE

(State or Country)

Mass.

10. NAME OF FATHER

A Anthony

11. BIRTHPLACE OF FATHER

(State or Country)

Mass.

12. MAIDEN NAME OF MOTHER

Emmie Eddy

13. BIRTHPLACE OF MOTHER

(State or Country)

New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Harry Anthony
Sagehen Lake Idaho

15.

Filed..... 19.....

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 10 1927
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

..... 19....., to 19.....

that I last saw h..... alive on..... 19.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows: A

vascular heart disease

(Duration) Yrs..... mos..... ds.

Contributory
(Secondary)

(Duration) yrs..... mos..... ds.

(Signed)..... M. D.

..... 19..... (Address).....

 *State the Disease Causing Death; or in deaths from Violent Causes, state
 (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

 At place of death..... yrs..... mos..... days. In the State 16 yrs..... mos..... days

 Where was disease contracted
 if not at place of death?.....
Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Forest CemeteryApril 11 1927

20. UNDERTAKER

ADDRESS

R B Mooney Pocatello

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

Registration District No.

City of

Primary Registration District No.

(No.)

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many.....hrs.
or.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at J. P. M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) Not known yrs. mos. ds.

Contributory ~~Heart~~ Arterio Sclerosis
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

(Address) Coeur d'Alene, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

RECEIVED CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Proctor Registration District No. 30
City of Pocur d alone Primary Registration District No. 1051
(No. 9th Best Ave St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John H JacksonFile No. 38122
Registered No. 1060

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married

6. DATE OF BIRTH

July 14 1832
(Month) (Day) (Year)

7. AGE

89 Yrs. 9 Mos. 5 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Retired

9. BIRTHPLACE

(State or Country)

Canada

10. NAME OF FATHER

Thomas Jackson

11. BIRTHPLACE OF FATHER

(State or Country)

Canada

12. MAIDEN NAME OF MOTHER

Hart

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. J. Jackson
Pocur d alone Ida

15.

Filed

May 9 1922H. H. H. H.
Local Registrar

16. DATE OF DEATH

April 19 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Insane psychosis; to 19
that I last saw h. _____ alive on 19
and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral aneurysm.(Duration) _____ Yrs. _____ mos. 7 ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

John O. Wood M. D.Apr. 20 1922 (Address) Pocur d alone Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State 6 yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Forest Cemetery 4/20 1922

20. UNDERTAKER

ADDRESS

R. B. Mooney Pocur d alone

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Idaho Registration District No. 62
 City of Genesee Registration District No. 2142 (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED
 JUN 2 1922
 BUREAU OF VITAL STATISTICS

Baby 7 corners

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 38123

Registered No. 6

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
 (Write the word.)

6. DATE OF BIRTH May 13 22
 (Month) (Day) (Year)

7. AGE 14 IF LESS than 1 day how many 14 hrs. or min?
 Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

none

9. BIRTHPLACE

(State or Country)

Genesee

10. NAME OF FATHER

Mr D F Lower

11. BIRTHPLACE OF FATHER

(State or Country)

Genesee Ida

12. MAIDEN NAME OF MOTHER

Alma Horbeck

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W F Lower

(Address)

Genesee

15.

Filed May 14 1922 W F Lower
 Local Registrar

16. DATE OF DEATH

May 14 22
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 13 1922 to May 14 1922
 that I last saw h. her alive on May 14 1922
 and that death occurred on the date stated above, at 1 P. M.
 The CAUSE OF DEATH* was as follows:

Birth injuries

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

W F Lower M. D.

5-14-22 (Address) Genesee

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Genesee

DATE OF BURIAL

May 15 1922

20. UNDERTAKER

F J Lambert

ADDRESS

Genesee

1. PLACE OF DEATH

County of

Tatah
Troy

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

(Baby) Anderson

CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

St. No.

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 38124

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

single
(Write the word.)

6. DATE OF BIRTH

May 6 1922
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work.
-
- (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Malcus H. Anderson

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Leona Cornelia Seckman

13. BIRTHPLACE OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Malcus H. Anderson

(Address)

Troy, Ida.

15.

Filed

May 30 1922 Lucy M. Pickard
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 6 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19

that I last saw her alive on May 6 1922

and that death occurred on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

R. S. Nelson

M. D.

76 19 22 (Address) Troy, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Moscow, Ida., May 8, 1922

20. UNDERTAKER

ADDRESS

None

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

Registration District No.

Primary Registration District No.

St.)

File No. 38125

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

Contributory (Secondary)

(Signed)

571 1922

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Latah
City of Potlatch

Registration District No. 65
Primary Registration District No. 2145
(No. _____) (St. _____)

File No. 38126
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Edward Thompson

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widowed
(Write the word.)

16. DATE OF DEATH
March 18 1922
(Month) (Day) (Year)

6. DATE OF BIRTH
Mar 15 1886
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 16th 1922, to March 18th 1922 that I last saw him alive on March 17th 1922 and that death occurred on the date stated above, at 4:30 P.M.

7. AGE 86 Yrs. 3 Mos. 5 ds.
IF LESS than 1 day how many _____ hrs. or _____ min.?

The CAUSE OF DEATH* was as follows:
Senility
(Duration) _____ Yrs. _____ mos. _____ ds.

8. OCCUPATION
(a) Trade, profession or particular kind of work. Farmer
(b) General nature of industry, business or establishment in which employed (or employer)

Contributory none
(Secondary)
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) Emmett H. H. M. D.
March 18, 22 (Address) Potlatch Idaho

9. BIRTHPLACE
(State or Country) Penn

10. NAME OF FATHER Edward Thompson

11. BIRTHPLACE OF FATHER
(State or Country) Indiana

12. MAIDEN NAME OF MOTHER Barnahan

13. BIRTHPLACE OF MOTHER
(State or Country) Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. N. Thompson
(Address) Palouse Wash

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.
Where was disease contracted if not at place of death?
Former or usual residence _____

15. Filled March 18th 1922 E. J. W. Thompson
Local Registrar

19. PLACE OF BURIAL OR REMOVAL Freige DATE OF BURIAL Mar 20 1922
20. UNDERTAKER E. J. W. Thompson ADDRESS Palouse

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

PLACE OF DEATH

County of Idaho
City of PrincetonRegistration District No. 65
Primary Registration District No. 2145
(No. St.)File No. 38127
Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Sarah Feiger

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widow
(Write the word.)

6. DATE OF BIRTH

June 14 1888
(Month) (Day) (Year)

7. AGE

96 Yrs. 10 Mos. 12 ds.IF LESS than 1 day
how many hrs.
or min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Housewife

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

John Humminger

11. BIRTHPLACE OF FATHER

(State or Country)

Not known

12. MAIDEN NAME OF MOTHER

Shae

13. BIRTHPLACE OF MOTHER

(State or Country)

Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Wm. E. Feiger
Princeton, Ida

15.

Filed April 14 1922D. W. Thompson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

92

16. DATE OF DEATH

April 12 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from April 1st 1922, to April 12 1922.that I last saw her alive on April 12 1922,
and that death occurred on the date stated above, at 9 A. M.
The CAUSE OF DEATH* was as follows:Pneumonia(Duration) Yrs. mos. 6 ds.Contributory
(Secondary)General debility(Duration) yrs. 5 mos. ds.

(Signed)

D. W. Cook

M. D.

4/14/1922 (Address) Princeton

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Wendinville Cemetery

DATE OF BURIAL

April 14 1922

20. UNDERTAKER

E. J. J. J.

ADDRESS

Princeton

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Idaho*City of *Genesee*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No. *62*Registration District No. *2142*

St.)

File No.

38128

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED
(Write the word.)

6. DATE OF BIRTH

7. AGE

Yrs. *74* Mos. *4* ds. *1*IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

4-27 1922

1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Apr 27 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 14 1922 to Apr 27 1922

that I last saw him alive on Apr 27 1922

and that death occurred on the date stated above, at 2:13 P.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(Duration) Yrs. mos. ds.

Contributory (Secondary) Chronic Nephritis

(Duration) yrs. mos. ds.

(Signed) W. H. Mervyn M. D.

427 1922 (Address) Genesee

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Genesee Idaho

4-29 1922

20. UNDERTAKER

ADDRESS

J. B. Lambert

Genesee

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **38129**
Registered No. **16**

1. PLACE OF DEATH

County of

City of

RECEIVED
MAY 23 1922
BUREAU OF VITAL STATISTICS

District No.

Registration District No.

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Christina Ida Severson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

19

W. H. Barthens
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

19

17. I HEREBY CERTIFY, That I attended deceased from

Feb 26 1922, to Apr 3 1922

that I last saw h. *in* alive on Apr 3 1922

and that death occurred on the date stated above, at 4:15 P.M.

The CAUSE OF DEATH* was as follows:

*Syphilis, secondary to
Pulv. Perforation*

(Duration)

Yrs.

mos.

ds.

Contributory (Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

Vigil M. Sevelius
4/5/1922 (Address) *Moscow Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

Yrs.

mos.

days.

In the

State

Yrs.

mos.

days

Where was disease contracted if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Moscow

4/5 1922

20. UNDERTAKER

ADDRESS

Blue Rice

Moscow

FORM V. S. No. 5-A—25 M. 1-19.

RECORDED

CERTIFICATE OF DEATH

61 38130

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

Registration District No.

Primary Registration District No.

(No.

St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE MARRIED, WID-
OWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

March 26, 1922 to April 12, 1922

that I last saw him alive on April 12, 1922

and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Cancer of Rectum

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) J. H. Clarke M. D.

4/13, 1922 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

38131 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

Registration District No.

Primary Registration District No.

(No.

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-

OWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

Apr. 15th 1922, to Apr. 19th 1922
that I last saw her alive on Apr. 16th 1922
and that death occurred on the date stated above at 10:45 P.M.

The CAUSE OF DEATH* was as follows:

Acute myocarditis
arterio sclerosis

(Duration) Not known mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

420 1925 (Address) Moscow

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Moscow 4/21/22

20. UNDERTAKER

ADDRESS

Elen Price Moscow

CERTIFICATE OF DEATH

61 38132

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County

City

Registration District No.

Primary Registration District No.

(No.

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Malissie Catherine Stair

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1922

Local Registrar

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from April 18th 9^{am} 1922 to April 18th 1^{mid} 1922that I last saw her alive on April 18th 9^{am} 1922 and that death occurred on the date stated above, April 18th 1922

The CAUSE OF DEATH* was as follows:

Cardiac failure & Pul Edema
Was told she had arthritis
Saw her once twice in extremis
(Duration) Yrs. mos. ds.Primary — Arthritis from History
(Secondary) Arterial
(Duration) Yrs. mos. ds.(Signed) M. Nagel M. D.
4/19/22 (Address) Moscow

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

20. UNDERTAKER

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **38133**

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of LatahCity of BozelleRegistration District No. 66Primary Registration District No. 2146

St.)

If death occurs away from usual residence, give facts called for under special information.

STATISTICS

2. FULL NAME

Julia Elaine Smith

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

(Write the word.)

6. DATE OF BIRTH

April

(Month)

22

(Day)

1922

(Year)

7. AGE

Yrs.

Mos.

11

ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

None

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Ernie Smith

11. BIRTHPLACE OF FATHER

(State or Country)

Missouri

12. MAIDEN NAME OF MOTHER

Jellie Eudora Woods

13. BIRTHPLACE OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Ernie Smith

(Address)

Bozelle Idaho

15.

Filed

May 2nd 1922Mrs. R.C. Gibson

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May

(Month)

3rd

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 22 1922 to May 3rd 1922that I last saw her alive on May 2nd 1922and that death occurred on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:

Congenital Absence of Sigmoid and portion of transverse Colon.(Duration) Yrs. mos. 11 ds.Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

F.C. Gibson

M. D.

19

(Address)

Bozelle Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Bozelle Idaho

DATE OF BURIAL

May 4 1922

20. UNDERTAKER

Ernie Smith

ADDRESS

Bozelle Idaho

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of LatahCity of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 66Primary Registration District No. 2146No. 72011 Hospital St.)File No. 38134

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

James Harvey Gray

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word)

6. DATE OF BIRTH

September - 7 - 1883
(Month) (Day) (Year)

7. AGE

38 Yrs. 7 Mos. 22 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Logger

(b) General nature of industry, business or establishment in which employed (or employer)

Blackwell Lumber Co

9. BIRTHPLACE

(State or Country) Oregon

10. NAME OF FATHER

M. T. Gray

11. BIRTHPLACE OF FATHER

(State or Country) Arkansas

12. MAIDEN NAME OF MOTHER

Ellen Wright

13. BIRTHPLACE OF MOTHER

(State or Country) Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Marie Gray(Address) Santa Idaho

15.

Filed May 30 1922Mrs J. P. Gibson
Local Registrar

16. DATE OF DEATH

May 29 - 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 25 - 1922 to May 29 - 1922that I last saw him alive on May 29 - 1922and that death occurred on the date stated above, at 5:30 A.M.

The CAUSE OF DEATH* was as follows:

Influenza and Pneumonia(Duration) _____ Yrs. _____ mos. 7 ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

J. C. Gibson M. D.May 29 - 1922 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. 4 days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Boise Idaho

DATE OF BURIAL

May 30 1922

20. UNDERTAKER

Glen Price

ADDRESS

Moscow Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Latah
City of KendrickRegistration District No. 68
Primary Registration District No. _____
(No. _____) (St. _____)File No. 38135
Registered No. _____If death occurs away from
usual residence, give facts
called for under special in-
formation.If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.2. FULL NAME Andry Fay Battlett

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDMale White (Write the word.)

6. DATE OF BIRTH

April 22 1922
(Month) (Day) (Year)

7. AGE

13 Yrs. 3 Mos. 3 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country) Winona, Washington10. NAME OF
FATHERClaud Clifton Battlett11. BIRTHPLACE
OF FATHER(State or Country) Pawnee City, Nebraska12. MAIDEN NAME
OF MOTHERNancy Catherine Broyles13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Claud Clifton Battlett
(Address) Kendrick, Idaho15. Apr. 27 1922 R. F. Bepple
Filed _____ Local Registrar

16. DATE OF DEATH

April 25 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 20 1922, to April 24 1922,
that I last saw him alive on April 20 1922,
and that death occurred on the date stated above, at 1 A.M.

The CAUSE OF DEATH* was as follows:

Laryngeal Abscess
Submaxillary cellulitis(Duration) Yrs. _____ mos. 4 ds.Contributory (Secondary) Acute Toxicemia(Duration) yrs. _____ mos. 7 ds.(Signed) Andrew Ottersen M. D.4/26/1922 (Address) Kendrick, Idaho*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days.

Where was disease contracted
if not at place of death?Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Kendrick Cemetery Apr 27 1922

20. UNDERTAKER

ADDRESS

E. E. Dickhof Kendrick, Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **38136**

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Nez Perce Registration District No. 68
City of Southwick Registration District No.
St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Franklin Davis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDMale White (Write the word.)

6. DATE OF BIRTH

November 12 1918
(Month) (Day) (Year)

7. AGE

3 Yrs. 5 Mos. 5 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

infant

9. BIRTHPLACE

(State or Country)

Kendrick, Idaho

10. NAME OF FATHER

Clifford G. Davis

11. BIRTHPLACE OF FATHER

(State or Country)

Monroe, Wisconsin

12. MAIDEN NAME OF MOTHER

Pearl Mida Billups

13. BIRTHPLACE OF MOTHER

(State or Country)

Dayton, Washington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Clifford G. Davis

(Address)

Southwick, Idaho

15.

Filed

Apr. 18 22

19

R. T. Peppley

Local Registrar

MEDICAL CERTIFICATE OF DEATH

50

16. DATE OF DEATH

April 17 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan. 21 1922, to April 15 1922that I last saw him alive on April 15 1922and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Diabetes mellitus(Duration) Yrs. 4 mos. 15 ds.Contributory Influenza, Nephritis
(Secondary)(Duration) yrs. 1 mos. 15 ds.(Signed) Andrew Ottersano M. D.4/18/1922 (Address) Kendrick, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Kendrick CemeteryApr 19 1922

20. UNDERTAKER

ADDRESS

E. E. BechtelKendrick, Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. _____
Registered No. **38137**

1. PLACE OF DEATH

County of *Latah*
City of *Linden*Registration District No. *68*
Primary Registration District No. _____
(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Elmer Henry Keeler

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *married*
(Write the word.)6. DATE OF BIRTH *April 8 1867*
(Month) (Day) (Year)7. AGE *55* Yrs. *12* Mos. *12* ds.
IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. *Farmer*
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) *Baldwilles, New York.*

10. NAME OF FATHER

Charles Keeler

11. BIRTHPLACE OF FATHER

(State or Country) *Do not know*

12. MAIDEN NAME OF MOTHER

do not know

13. BIRTHPLACE OF MOTHER

(State or Country) *do not know*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mrs. E. H. Keeler*
(Address) *Linden, Idaho*15. *Apr. 24 1922*
Filed _____ 19 _____ *R. J. Peppel*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

1752

16. DATE OF DEATH

April 20 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from _____ 19____, to _____ 19____
that I last saw h. _____ alive on _____ 19____
and that death occurred on the date stated above, at *2 P.M.*
The CAUSE OF DEATH* was as follows:*Killed while blasting - accident*

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory (Secondary) *Fracture of Skull*

(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed) *Andrew Ottensmeyer* M. D.*4/21 1922* (Address) *Pendrick, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL *Linden Cemetery* DATE OF BURIAL *Apr 25 1922*20. UNDERTAKER *E. E. Bechtoff* ADDRESS *Pendrick, Idaho*

RECEIVED

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Lemhi
City of Baker, Ida
Registration District No. 41
Primary Registration District No. 2116
St.)File No. 38138
Registered No.If death occurs away from
usual residence, give facts
called for under special
information.

2. FULL NAME

Louisa Fredia Schopper
If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.Female whiteMarried

(Write the word.)

6. DATE OF BIRTH.

July 18

(Month)

(Day)

1884
(Year)

7. AGE

37 Yrs. 9 Mos. 3 ds.IF LESS than 1 day
how many hrs. or
min. >

8. OCCUPATION

(a) Trade, profession or
particular kind of work...
(b) General nature of in-
dustry, business, or estab-
lishment in which employ-
(or employer).....House wife

9. BIRTHPLACE

(State or Country)

Fountain City Wis10. NAME OF
FATHERFrederick Schroeder11. BIRTHPLACE
OF FATHER

(State or Country)

Germany12. MAIDEN NAME
OF MOTHERNot known13. BIRTHPLACE
OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Henry Schopper
Baker, Ida

(Address)

15.

Filed

5/101922Chas E. Bellamy
dep
Local Registrar

16. DATE OF DEATH

April 15

(Month)

(Day)

1922
(Year)17. I HEREBY CERTIFY, That I attended deceased from
April 8 1922 to April 15 1922that I last saw her alive on Apr 15 1922and that death occurred on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration)

about Yrs.mos. 17 ds.Contributory
(Secondary)

(Duration)

Yrs.

mos. ds.

(Signed)

Chas E. Hammer

M. D.

4/16 1922 (Address) Salmon*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place

of death.....

Where was disease contracted
if not at place of death?.....Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Fountain City Wis1922

20. UNDERTAKER

ADDRESS

W.C. DaehlerSalmon
Ida

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

MAY 23 1922

Registration District No.

County of *Lewia*

BUREAU OF VITAL

Registration District No.

City of *Salmon*

STATISTICS

St.)

File No.

38139

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Warren Shepard

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

*Male**White**Single*

(Write the word.)

6. DATE OF BIRTH

Dec 15th 1839

(Month)

(Day)

(Year)

7. AGE

83

Yrs.

Mos.

ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Rancher

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

Not known

11. BIRTHPLACE OF FATHER

(State or Country)

Not known

12. MAIDEN NAME OF MOTHER

Not known

13. BIRTHPLACE OF MOTHER

(State or Country)

Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. W. W. Schultz

(Address)

Salmon

15.

Filed

5/10

1922

Chas. E. Bell

Local Registrar

16. DATE OF DEATH

April 23rd 1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19

to

19

that I last saw him alive on

19

and that death occurred on the date stated above, at *3 P.M.*

The CAUSE OF DEATH* was as follows:

old age, due to asthma

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

*W. C. Doeblen**4-24-22*

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Salmon Cemetery**4-25-1922*

20. UNDERTAKER

ADDRESS

*W. C. Doeblen**Salmon*

RECEIVED

CERTIFICATE OF DEATH.

1. PLACE OF DEATH. *Leucib* MAY 23 1922
 County of *Leucib* Registration District No. *41*
 City of *Carmen* BUREAU OF VITAL STATISTICS Registration District No. *2116*
 (No.) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Martin Larsen

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. *38140*
 Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male *White* *Single*
 (Write the word.)

6. DATE OF BIRTH.

May 12 1884
 (Month) (Day) (Year)

7. AGE

38 Yrs. *11* Mos. *1* ds.

IF LESS than 1 day
 how many hrs. or
 min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business, or establishment in which employed (or employer)

Rancher
Employed on ranch

9. BIRTHPLACE

(State or Country)

Maine

10. NAME OF FATHER

Not known

11. BIRTHPLACE OF FATHER

(State or Country)

Not known

12. MAIDEN NAME OF MOTHER

Not known

13. BIRTHPLACE OF MOTHER

(State or Country)

Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

W. C. Doebler

(Address)

Salmon Idaho

15.

Filed

5/10

1922

Chas C. Bill

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 13 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to 191

that I last saw h. alive on 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Heart failure due to pneumonia

(Duration) Yrs. mos. ds.

Contributory
 (Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. C. Doebler, Carmen

#5 1922 (Address) *Salmon Ida*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Salmon Cemetery**4-20 1922*

20. UNDERTAKER

ADDRESS

*W. C. Doebler**Salmon Ida*

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A-25 M. 1-19. RECEIVED MAY 23 1922

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH *Lemhi*
County of *Lemhi* Registration District No. *2116*
City of *Leadore* (No. _____ St.)

File No. *38141*
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME *Albert G. Power*

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *Male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*
(Write the word.)

16. DATE OF DEATH *April 29th* 19*22*
(Month) (Day) (Year)

6. DATE OF BIRTH *Not known*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 19____ to _____ 19____
that I last saw h. _____ alive on _____ 19____
and that death occurred on the date stated above, at _____ M.
The CAUSE OF DEATH* was as follows:

7. AGE *about 70*
Yrs. _____ Mos. _____ ds. _____
IF LESS than 1 day how many _____ hrs. or _____ min.?

Natural Causes, due to old age, and Pneumonia.
(Duration) _____ Yrs. _____ mos. _____ ds.

8. OCCUPATION *Wine Watchman*
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Contributory (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) _____ M. D.
_____ 19____ (Address) _____

9. BIRTHPLACE *American*
(State or Country)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

10. NAME OF FATHER *Not known*

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

11. BIRTHPLACE OF FATHER *Not known*
(State or Country)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

12. MAIDEN NAME OF MOTHER *Not known*

Where was disease contracted if not at place of death? _____

13. BIRTHPLACE OF MOTHER *Not known*
(State or Country)

Former or usual residence _____

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

19. PLACE OF BURIAL OR REMOVAL *Junction Cemetery* DATE OF BURIAL *5-7-1922*

(Informant) *A. C. Jaebler*
(Address) *Salmon, Idaho*

20. UNDERTAKER *A. C. Jaebler* ADDRESS *Salmon Ida.*

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH **Longley** MAY 23 1922 Registration District No. **41**
 County of **Longley** Registration District No. **2116**
 City of **Salmon** STATION **STATION** (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Infant Longley**

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. **38142**
 Registered No. _____
 If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Single**
 (Write the word.)

6. DATE OF BIRTH. **5-1-1922**
 (Month) (Day) (Year)

7. AGE _____ If LESS than 1 day how many... hrs. or min.?
 Yrs. Mos. ds.

8. OCCUPATION **None**
 (a) Trade, profession or particular kind of work...
 (b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE **Idaho.**
 (State or Country)

10. NAME OF FATHER **Thos. H. Longley**

11. BIRTHPLACE OF FATHER **Montana**
 (State or Country)

12. MAIDEN NAME OF MOTHER **Myrtle E. Magg.**

13. BIRTHPLACE OF MOTHER **Idaho.**
 (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) **A. J. Stratton**
 (Address) **Salmon, Ida.**

15. Filed **5/10-1922** **Chas. E. Bellamy**
 Local Registrar

16. DATE OF DEATH **5-1-1922**
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **May 1, 1922** to **May 1, 1922**
 that I last saw him alive on **May 1, 1922**
 and that death occurred on the date stated above, at **2:30 P.M.**

The CAUSE OF DEATH was as follows:
Prima facie with Smith mouth
 (Duration) Yrs. mos. ds.

Contributory (Secondary)
 (Duration) Yrs. mos. ds.
 (Signed) **A. J. Stratton** M. D.
 1922 (Address) **Salmon, Ida.**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
 At place of death... yrs... mos... days In the State... yrs... mos... days
 Where was disease contracted if not at place of death?
 Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **Salmon Cemetery** DATE OF BURIAL **5-3-1922**

20. UNDERTAKER **W. C. Joebler** ADDRESS **Salmon, Ida.**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

RECEIVED
MAY 23 1922
NOT AT ALL
DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. **38143**Registered No. **80**

1. PLACE OF DEATH

County of **Lewis**City of **Russell**(No. **1016**)

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary Emma Schlander

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Nov 20**1874**

(Month)

(Day)

(Year)

7. AGE

47 yrs. 7 mos. 13 ds.

IF LESS than 1 day
 how many.....hrs.or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Oregon

10. NAME OF FATHER

John P. Wittman

11. BIRTHPLACE OF FATHER

(State or Country)

Ills.

12. MAIDEN NAME OF MOTHER

Catherine Schmidt

13. BIRTHPLACE OF MOTHER

(State or Country)

Ills. Dakota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mr. Guy Shawley

(Address)

Idaho

15.

Filed

5-10 1922**Albert Huff**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

79

16. DATE OF DEATH

May 3

(Month)

3

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to **191**that I last saw her alive on **191**and that death occurred on the date stated above, at **11:00 P.M.**

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease(Duration) **3** yrs. **1** mos. **1** ds.

Contributory (Secondary)

(Duration) **3** yrs. **1** mos. **1** ds.(Signed) **M. J. Fairley** M. D.**May 4 1922** (Address) **Idaho**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... ds. State..... yrs..... mos..... ds.

Where was disease contracted.

If not at place of death?

Former or

usual residence.....

19. PLACE OF BURIAL OR REMOVAL

Russell Idaho

DATE OF BURIAL

5-6 1922

20. UNDERTAKER

Albert Huff

ADDRESS

Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Statistics

38144

1. PLACE OF DEATH

Registration District No. 6
County of Lewis
City of Winchester
Municipal Registration District No. 2129
St.)File No. 4
Registered No. 7

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

ROSE THOMASON

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)6. DATE OF BIRTH April 9 1922
(Month) (Day) (Year)

7. AGE Yrs. 27 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Lewis & Idaho

10. NAME OF FATHER

Carrol D. Thomason

11. BIRTHPLACE OF FATHER

(State or Country) Idaho.

12. MAIDEN NAME OF MOTHER

Aileen Marie Dowd

13. BIRTHPLACE OF MOTHER

(State or Country) Lewiston Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H. L. Thomason
(Address) Craigmont, Ida.

15.

Filed 6/6 1922 P. J. Edwards
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 6 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 4 1922 to May 6 1922 that I last saw him alive on May 6 1922 and that death occurred on the date stated above, at 5:30 AM.

The CAUSE OF DEATH* was as follows:

Mink's Disease

(Duration) Yrs. 3 mos. 3 ds.
Contributory (Secondary) Meningitis(Duration) Yrs. 3 mos. 3 ds.
(Signed) E. H. Langhlin M. D.
May 13 1922 (Address) Winchester, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. 3 mos. 3 days In the State Yrs. 3 mos. 3 days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

1004 Cemetery

DATE OF BURIAL

6/6 1922

20. UNDERTAKER

E. E. Clares

ADDRESS

Craigmont

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

JUN 6 1922
Registration District No.BUREAU OF VITAL STATISTICS
Registration District No.

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male White

Married
(Write the word.)

6. DATE OF BIRTH

7. AGE

78 Yrs. 11 Mos. 6 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

19

Local Registrar

16. DATE OF DEATH

May 26th 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 2nd 1922 to May 26th 1922
that I last saw him alive on May 26th 1922
and that death occurred on the date stated above, at 8:30 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(Duration) Yrs. mos. ds.

Contributory General Arterio Sclerosis
(Secondary)

(Duration) 3 yrs. mos. ds.

(Signed) J. C. Loughlin M. D.

May 27 1922 (Address) Winchester Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

First Cemetery 9/8 1922

20. UNDERTAKER

ADDRESS

Dr. H. V. Duff Co. Coeur d'Alene

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 16
County of Latah Primary Registration District No. 2016
City of Shoshone St.)

File No. 38146
Registered No. 9

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

BUREAU OF VITAL STATISTICS

Lawrence Esterhaedt

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH

May 6 1890
(Month) (Day) (Year)

7. AGE

31 Yrs. 11 Mos. 25 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Farm

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Mrs. Christian Esterhaedt

11. BIRTHPLACE OF FATHER

(State or Country)

Copenhagen, Denmark

12. MAIDEN NAME OF MOTHER

Anna Jensen

13. BIRTHPLACE OF MOTHER

(State or Country)

Copenhagen, Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Olga Payne
Idaho

15.

Filed

1922

J. L. Fair
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 12 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 14 1922 to May 12 1922
that I last saw him alive on May 12 1922
and that death occurred on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:

Perforated Gastric ulcer,
Hemorrhage & Peritonitis

(Duration) about mos. 20 ds.
Contributory (Secondary) Ulcer of stomach

(Duration) 0 mos. 0 ds.
(Signed) Dr. J. L. Fair M. D.

May 12 1922 (Address) Shoshone Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. 20 mos. 32 days. State yrs. 32 mos. 32 days

Where was disease contracted if not at place of death? Home, Idaho

Former or usual residence Idaho

19. PLACE OF BURIAL OR REMOVAL

Idaho

20. UNDERTAKER

O. J. Bruman Shoshone

FORM V. S. No. 5-A-25 M. 1-1

RECEIVED
MAY 23 1922
BUREAU OF VITAL
STATISTICS

CERTIFICATE OF DEATH

1. PLACE OF DEATH *Shoshone*
 County of *Shoshone* Registration District No. *1046*
 City of *Shoshone* (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Rosa Gehrig

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. **38147**
 Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *7* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED
married
 (Write the word.)

6. DATE OF BIRTH *Feb 14 1866*
 (Month) (Day) (Year)

7. AGE *56* Yrs. *2* Mos. *13* ds. IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

Housewife

9. BIRTHPLACE

(State or Country)

Switzerland

10. NAME OF FATHER

Alexander Struchen

11. BIRTHPLACE OF FATHER

(State or Country)

Switzerland

12. MAIDEN NAME OF MOTHER

Mary Mary

13. BIRTHPLACE OF MOTHER

(State or Country)

Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Gotthard Gehrig

(Address)

15. Filed *Jul 26* 1922

J. L. Fuller
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 25 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *April 16 1922* to *April 25 1922*
 that I last saw him alive on *April 25 1922*
 and that death occurred on the date stated above, at *10:25 A.M.*

The CAUSE OF DEATH* was as follows:

Spotted Fever

(Duration) _____ Yrs. _____ mos. *10* ds.
 Contributory (Secondary) *Exposure*

(Duration) _____ Yrs. _____ mos. _____ ds.
 (Signed) *[Signature]* M. D.

4/26 1922 (Address) *Shoshone Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. *10* days. In the State *20* yrs. _____ mos. _____ days

Where was disease contracted *at home*
 if not at place of death?

Former or usual residence *North Wood River*

19. PLACE OF BURIAL OR REMOVAL *Shoshone* DATE OF BURIAL *4-27 1922*

20. UNDERTAKER *W. J. Bruman* ADDRESS *Shoshone*

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **38148**
Registered No. **7**

1. PLACE OF DEATH

County of *Shoshone* Registration District No. *16*
City of *Shoshone* Registration District No. *16* (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ronald Herman John

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*
(Write the word.)6. DATE OF BIRTH *Jan 1920*
(Month) (Day) (Year)7. AGE *15* Yrs. *1* Mos. *1* ds. IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work *nour*
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) *Shoshone*

10. NAME OF FATHER

Anton John

11. BIRTHPLACE OF FATHER

(State or Country) *Susssteinland*

12. MAIDEN NAME OF MOTHER

Catherine Kramer

13. BIRTHPLACE OF MOTHER

(State or Country) *Neb. U.S.A.*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Anton John*
(Address) *Shoshone Idaho*15. *Filed* *Feb 29* 19 *20* *J. L. Suter*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 29 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *Apr 29 1922* to *Apr 29 1922*
that I last saw him alive on *Apr 29 1922*
and that death occurred on the date stated above, at *8:30 P.M.*
The CAUSE OF DEATH* was as follows:*Croup*(Duration) Yrs. *one* mos. *one* ds.
Contributory (Secondary) *Capillary Bronchitis*(Duration) yrs. *2* mos. *2* ds.
(Signed) *Herbert C. Drape* M. D.
4-29-1922 (Address) *Shoshone Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Shoshone

DATE OF BURIAL

5-1-1922

20. UNDERTAKER

O. J. Herman

ADDRESS

FORM V. S. No. 5-25 M. 1-16-13

1. PLACE OF DEATH.

County of Madison
City of Reynolds

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Emma - A. - Barrett

CERTIFICATE OF DEATH.

Registration District No. 100Primary Registration District No. 2178ParkinsonState of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

38149

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widow
(Write the word.)

6. DATE OF BIRTH.

April 30 1922
(Month) (Day) (Year)

7. AGE

Yrs. Mos. 1 ds.IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...Baker

9. BIRTHPLACE

(State or Country)

Reynolds Idaho

10. NAME OF FATHER

Fred Barrett

11. BIRTHPLACE OF FATHER

(State or Country)

Pocahontas Idaho

12. MAIDEN NAME OF MOTHER

Eloise Balgoff

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Fred Barrett

(Address)

Reynolds

15.

Filed

571922 -W. J. Reynolds

Local Registrar

MEDICAL CERTIFICATE OF DEATH

151-b

16. DATE OF DEATH

April 30 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from 4-30 1922, to 4-30 1922.that I last saw her alive on 4-30 1922.and that death occurred on the date stated above, at 11 A. M.

The CAUSE OF DEATH* was as follows:

nasal pneumonia(Duration) Yrs. mos. 1 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. J. Parkinson M. D.

19 (Address)

Reynolds Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Reynolds57 1922

20. UNDERTAKER

ADDRESS

W. J. ReynoldsReynolds

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **38150**
Registered No. **33**

1. PLACE OF DEATH **RECEIVED JUN 5 1922 BUREAU OF VITAL STATISTICS**
County of **Madison** Registration District No. **100**
City of **Rexburg** Primary Registration District No. **2178** St. _____
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Martha Sorensen Nielson**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Married**
(Write the word.)

6. DATE OF BIRTH **February 19th 1871**
(Month) (Day) (Year)

7. AGE **51 Yrs. 2 Mos. 17 ds.** IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION **Housewife**
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE **Utah**
(State or Country)

10. NAME OF FATHER **Jeppa Sorensen**

11. BIRTHPLACE OF FATHER **Denmark**
(State or Country)

12. MAIDEN NAME OF MOTHER **Katherine Johnson**

13. BIRTHPLACE OF MOTHER **Denmark**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) **Joseph W. Nielson**
(Address) **Sugar City, Ida.**

15. **58/22** 19 **1922**
Filed **W. Young** Local Registrar

MEDICAL CERTIFICATE OF DEATH

50

16. DATE OF DEATH **5-6-1922**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **April 10-1922** to **May 5-1922** that I last saw her alive on **May 5-1922** and that death occurred on the date stated above, at **4:30 P.M.**

The CAUSE OF DEATH* was as follows:
Chronic Bronchitis

(Duration) **few** Yrs. mos. ds.
Contributory (Secondary) **Bronchial Asthma**

(Duration) **20** Yrs. mos. ds.
(Signed) **Loring F. Rich** M. D.
58 1922 (Address) **Rexburg Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **Sugar City, Ida.** DATE OF BURIAL **5/9 1922**

20. UNDERTAKER **DAVID R. YOUNG** ADDRESS **REXBURG**

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of MadisonCity of Rexburg

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Maughn

RECEIVED

JUN 5 1922

BUREAU OF VITAL STATISTICS

Registration District No. 100Primary Registration District No. 2178

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

38151

Registered No.

34

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single Babe
(Write the word.)

6. DATE OF BIRTH

May

(Month)

9th

(Day)

1922

(Year)

7. AGE

-- Yrs. 1 Mos. 1 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Child

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

George H. Maughn

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Olive Hansen

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed 5/111922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May
(Month)10
(Day)1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

4-9-1922, to 4-10-1922that I last saw him alive on 4-9-1922and that death occurred on the date stated above, at 5:00 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia(Duration) _____ Yrs. _____ mos. 1 ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) E. J. Parkinson M. D.19 (Address) Rexburg, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

REXBURG, IDA.

DATE OF BURIAL

5/11 19 22

20. UNDERTAKER

DAVID R. YOUNG

ADDRESS

REXBURG.

1. PLACE OF DEATH

County of MadisonCity of Moody Creek

If death occurs away from usual residence, give facts called for under special information.

RECEIVED

JUN 5 1922

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 100Registration District No. 2178

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 38452Registered No. 151-a

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James Oscar Simmons

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDSingle

(Write the word.)

6. DATE OF BIRTH

May17th1922

(Month)

(Day)

(Year)

7. AGE

--- Yrs. --- Mos. + ds.IF LESS than 1 day
how many 1 $\frac{1}{2}$ hrs.
or --- min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Child

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Robert Simmons

11. BIRTHPLACE OF FATHER

(State or Country)

Missouri

12. MAIDEN NAME OF MOTHER

Edith M. Silvester

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James Silvester(Address) Rexburg Idaho

15.

Filed 5/101922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

5-171922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

5-17-1922

to

5-17-2219that I last saw him alive on 5-17-22 19and that death occurred on the date stated above, at 4:40 P.M.

The CAUSE OF DEATH* was as follows:

Premature birth
(not viable)(Duration) Yrs. mos. 1 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

5/171922

(Address)

Rexburg Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

TETON IDA.

DATE OF BURIAL

5/18 1922

20. UNDERTAKER

DAVID R. YOUNG

ADDRESS

REXBURG

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADE INK - THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

38153

File No. **38153**
Registered No. **38153**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Madison
City of RexburgRECEIVED
JUN 5 1922Registration District No. 100Primary Registration District No. 2178

St.)

If death occurs away from usual residence, give facts called for under special information.

BUREAU OF VITAL STATISTICS

2. FULL NAME George Gillis Gunnell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCED
Single

(Write the word.)

6. DATE OF BIRTH

April 24th 1922
(Month) (Day) (Year)

7. AGE

25 yrs. 25 mos. 25 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Child

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Rexburg, Idaho.

10. NAME OF FATHER

George H. Gunnell

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Josephene E. Gillis

13. BIRTHPLACE OF MOTHER

(State or Country)

Colorado

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

George H. Gunnell
(Address) Rexburg, Idaho

15.

Filed 7/18 19 22 J. Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

5 18 19 22
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from 5-16-1922 to 5-17-1922that I last saw him alive on 5-17-1922 and that death occurred on the date stated above, at 5:00 A.M.

The CAUSE OF DEATH* was as follows:

Patulous foramen ovale(Duration) _____ Yrs. _____ mos. 23 ds.Contributory
(Secondary)

(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed)

5/18 1922 (Address) Rexburg, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL
BURTON, IDA.DATE OF BURIAL
5/19 192220. UNDERTAKER
DAVID R. YOUNGADDRESS
REXBURG, IDA

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

JUN 5 1922

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Madison District No. 180
City of Teton (No. 2178 St.)File No. 38154
Registered No. 37

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John W. Tuck

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W.5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Married
(Write the word.)

6. DATE OF BIRTH

July 13 1883
(Month) (Day) (Year)

7. AGE

68 Yrs. 10 Mos. 5 da.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Famer.

9. BIRTHPLACE

(State or Country)

Virginia

10. NAME OF FATHER

Thomas Tuck

11. BIRTHPLACE OF FATHER

(State or Country)

Virginia

12. MAIDEN NAME OF MOTHER

Sally Barker

13. BIRTHPLACE OF MOTHER

(State or Country)

Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Hamie Hawthorn

(Address)

15.

Filed

7/91922J. Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH

92

16. DATE OF DEATH

May 18 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 13 1922 to May 17 1922
that I last saw him alive on May 17 1922
and that death occurred on the date stated above, at 7 a.m.
The CAUSE OF DEATH* was as follows:Pneumonia(Duration) 0 Yrs. 0 mos. 7 ds.Contributory
(Secondary)none

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

5/18/1922 J. A. Gray M. D.
(Address) St. Anthony's

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Teton

DATE OF BURIAL

5/20 1922

20. UNDERTAKER

J. Young

ADDRESS

Boley

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH **RECEIVED**
 County of Madison **JUN 5 1922** Registration District No. 180
 City of Sugar **BUREAU OF VITAL STATISTICS** Primary Registration District No. 2178 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Harriet Aurilia Johnson

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. **38155**
 Registered No. 12

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Widowed
 (Write the word.)

6. DATE OF BIRTH
November 5th 1922
 (Month) (Day) (Year)

7. AGE 67 Yrs. 6 Mos. 19 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
 (a) Trade, profession or particular kind of work None
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE
 (State or Country) Utah.

10. NAME OF FATHER
Nelson S. Hollingshead

11. BIRTHPLACE OF FATHER
 (State or Country) United States

12. MAIDEN NAME OF MOTHER
Harriet A. Hendricks

13. BIRTHPLACE OF MOTHER
 (State or Country) United States

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) W. B. Johnson
 (Address) Rebert, Ida.

15. Filed 5/26 1922 W. Young
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

5 - 24 - 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5 - 18 - 1922, to 5 - 22 - 1922, that I last saw her alive on 5 - 22 - 1922, and that death occurred on the date stated above, at 3:45 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Cecum

(Duration) 3 Yrs. - mos. - ds.
 Contributory (Secondary) Carcinoma of Liver

(Duration) 1 yrs. - mos. - ds.

(Signed) Loring St. Nick M. D.

25 1922 (Address) Rexburg Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Sugar City, Ida. DATE OF BURIAL 5/27 1922

20. UNDERTAKER DAVID R. YOUNG ADDRESS REXBURG

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Minidoka District No. 19
City of Rupert Registration District No. 2015
(No.) (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Francis U. TysonFile No. 38156
Registered No. 98

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED widow
(Write the word.)

6. DATE OF BIRTH

Feb 1 1868
(Month) (Day) (Year)

7. AGE

54 Yrs. 3 Mos. 7 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Housewife

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

Area L. Arnold

11. BIRTHPLACE OF FATHER

(State or Country)

Hont Know

12. MAIDEN NAME OF MOTHER

Pracis G. Arnold

13. BIRTHPLACE OF MOTHER

(State or Country)

Hont Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Anna M. Holloway

(Address)

Rupert

15.

Filed

May 11 1922E. E. Elmore

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 10 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from May 8th 1922 to May 10th 1922
that I last saw him alive on May 9th 1922
and that death occurred on the date stated above, at 5:20 P.M.
The CAUSE OF DEATH* was as follows:
Chronic Brights
disorder(Duration) about 2 Yrs. 0 mos. 0 ds.
Contributory (Secondary) Angina Pectoris
(Duration) 0 yrs. 0 mos. 2 ds.(Signed) Leland Frazier M. D.5-11-1922 (Address) Rupert, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 0 yrs. 0 mos. 0 days. In the State 0 yrs. 0 mos. 0 days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

W. G. Goodman 19

20. UNDERTAKER ADDRESS

Rupert Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH **RECEIVED**
County of *Blaine* Registration District No. *69*
City of *Idaho Falls* Primary Registration District No. *2015*
BUREAU OF VITAL STATISTICS

File No. *38157*
Registered No. *38157*

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME *Robert T. Watson*

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

81

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*
(Write the word.)

6. DATE OF BIRTH *Dec. 11 1852*
(Month) (Day) (Year)

7. AGE *70* Yrs. *5* Mos. *5* ds.
IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work *Farmer*
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) *England*

10. NAME OF FATHER *Robert Watson*

11. BIRTHPLACE OF FATHER
(State or Country) *England*

12. MAIDEN NAME OF MOTHER *Jane Thompson*

13. BIRTHPLACE OF MOTHER
(State or Country) *England*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *J. H. Anderson*
(Address) *Idaho Falls*

15. Filed *May 18 1922* *E. A. Elmore*
Local Registrar

16. DATE OF DEATH *May 16th 1922*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Apr. 2nd 1922* to *May 16th 1922*
that I last saw him alive on *May 7th*
and that death occurred on the date stated above, at *Idaho Falls*

The CAUSE OF DEATH* was as follows:
Arterio Sclerosis
(Duration) *about 5* Yrs. mos.
Contributory (Secondary) *Angina Pectoris*
(Duration) *about 2* yrs. mos. ds.
(Signed) *Leland Frazier* M. D.
5/18/1922 (Address) *Idaho Falls*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Cedar Vale* DATE OF BURIAL *19*

20. UNDERTAKER ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Muskegon Registration District No. 19
City of Plymouth Registration District No. 2015 St.)

File No. 38158Registered No. 2020

If death occurs away from
usual residence, give facts
called for under special
information.

2. FULL NAME

BUREAU OF VITAL
STATISTICS

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

Male White (Write the word.)

6. DATE OF BIRTH.

April 27 1922
(Month) (Day) (Year)

7. AGE

23 Yrs. 23 Mos. 23 ds.
IF LESS than 1 day
how many hrs. or min.

8. OCCUPATION

(a) Trade, profession or
particular kind of work...
(b) General nature of in-
dustry, business, or estab-
lishment in which employ-
ed (or employer)...

9. BIRTHPLACE

(State or Country)

10. NAME OF
FATHER11. BIRTHPLACE
OF FATHER

(State or Country)

12. MAIDEN NAME
OF MOTHER13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15.

Filed June 4 1922

E. H. Elmer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 20 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
April 27 1922 to May 20 1922,
that I last saw him alive on May 20 1922
and that death occurred on the date stated above, at 1 P. M.
The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) mos. ds.

(Signed) W. H. Hooper M. D.5-20-1922 (Address) Plymouth Ida.

*State the DISEASE CAUSING DEATH; or in death from VIOLENT CAUSES, state (1)
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Edwards Cemetery 5-21-1922
20. UNDERTAKER ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **38159**
Registered No. **38159**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH **RECEIVED**
Registration District No. **19**
County of **Minidoka** JUN 6 1922
Primary Registration District No. **2015**
City of **Rupert** BUREAU OF VITAL STATIONS St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Geo. McGonigal

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **male** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **married**
(Write the word.)6. DATE OF BIRTH **May 11 1855**
(Month) (Day) (Year)7. AGE **69** IF LESS than 1 day
how many hrs. or min.?
Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).**Mechanic**

9. BIRTHPLACE

(State or Country)

Scotland

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

Scotland

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Geo. McGonigal
Idaho

15. Filled

Apr. 16 1922**Edith E. E. E.**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 13 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from **Feb 1 1922** to **Feb 13 1922**that I last saw him alive on **Feb 6 1922** and that death occurred on the date stated above, at.....M.

The CAUSE OF DEATH* was as follows:

Fractured

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) **Edith E. E. E.** M. D.**4-1-1922** (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Salt Lake City **Feb 15 1922**

20. UNDERTAKER

ADDRESS

W. A. Woodman **Rupert Ida.**

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. **38167**
Registered No. **777**

1. PLACE OF DEATH **RECEIVED**
Registration District No. **19**
County of **Idaho** Primary Registration District No. **2015**
City of **Reupert** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Charlene Guyer**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **F** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Infant**

6. DATE OF BIRTH **Jan 15 1922**7. AGE **6**

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION **Infant**

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE **Idaho**

(State or Country)

10. NAME OF FATHER **Charles H. Guyer**11. BIRTHPLACE OF FATHER **Pennsylvania**

(State or Country)

12. MAIDEN NAME OF MOTHER **Hulda Replogle**13. BIRTHPLACE OF MOTHER **Penn**

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Chas H Guyer**(Address) **Reupert Idaho**15. Filed **May 1 1922**Local Registrar **Ed E. Edwards**

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **Jan 21 1922**

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from **Jan 14 1922** to **Jan 21 1922**

that I last saw her alive on **Jan 21 1922**

and that death occurred on the date stated above, at **9:00 P.M.**

The CAUSE OF DEATH was as follows:

Symptomatic disease of the new born

7 days (Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) **Jay V. Tenney** M. D.

19 (Address) **Reupert Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **Reupert Cemetery**DATE OF BURIAL **Jan 23 1922**20. UNDERTAKER **W. G. Goodman**ADDRESS **Reupert**

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Shoshone*City of *Paul*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No. *19*Primary Registration District No. *2015*

St.)

File No. *38163*Registered No. *79*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married

6. DATE OF BIRTH

April 12 1900
(Month) (Day) (Year)

7. AGE

21 Yrs. *8* Mos. *27* ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

Farmer

9. BIRTHPLACE

(State or Country)

Colorado

10. NAME OF FATHER

Congus M Mc Donald

11. BIRTHPLACE OF FATHER

(State or Country)

Tennessee

12. MAIDEN NAME OF MOTHER

Julia Simmons

13. BIRTHPLACE OF MOTHER

(State or Country)

Mississippi

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Leon Mc Donald

(Address)

Paul Idaho

15.

Filed *Apr 16 1922*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 9 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 4 1922, to *Jan 9 1922*that I last saw him alive on *Jan 9 1922*and that death occurred on the date stated above, at *6 P* M.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *J B Kennedy* M. D.*4-10-19-22* (Address) *Rupert Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Burley Cemetery Jan 10 1922

20. UNDERTAKER

ADDRESS

W. G. Goodman Rupert

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

Registration District No.

Primary Registration District No.

(No.)

(St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw her alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

19.

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **38165**
Registered No. **9**

1. PLACE OF DEATH

County of *Minidoka*City of *Rupert*Registration District No. *19*Primary Registration District No. *2015*

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Fredrick**Lickson*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married

6. DATE OF BIRTH

*Dec**30**1839*

(Month)

(Day)

(Year)

7. AGE

82

Yrs.

11

Mos.

ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Machinist

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

France

10. NAME OF FATHER

Don't know

11. BIRTHPLACE OF FATHER

(State or Country)

"

12. MAIDEN NAME OF MOTHER

"

13. BIRTHPLACE OF MOTHER

(State or Country)

"

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Lon Dickson

(Address)

Rupert Idaho

15.

Filed

*Apr. 16 1922**E. O. Schumaker*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

19 *22*
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 14 1922 to *Jan 15 1922*that I last saw him alive on *Jan 15 1922*and that death occurred on the date stated above, at *8 P.M.*

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

M. D.

X-1 19 *22* (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Rupert Co. Cem.**Jan 18 1921*

20. UNDERTAKER

ADDRESS

*W. J. Goodman**Rupert*

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

MAY 25 1922
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of BlaineRegistration District No. 19City of from MinidokaPrimary Registration District No. 2016

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Christina SchmiererState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 38166Registered No. _____
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

FemaleWhiteMarried

6. DATE OF BIRTH

Oct131869

(Month)

(Day)

(Year)

7. AGE

5385

Yrs. Mos. ds.

IF LESS than 1 day

how many _____ hrs.

or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

House Wife

9. BIRTHPLACE

(State or Country)

Russia

10. NAME OF FATHER

Mike Solar

11. BIRTHPLACE OF FATHER

(State or Country)

Russia

12. MAIDEN NAME OF MOTHER

Don't know

13. BIRTHPLACE OF MOTHER

(State or Country)

Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Jake Schmierer
Minidoka

15.

Filed

Apr. 16 1922E. E. Elmore
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb81922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 6. 1922 to Feb 6 1922that I last saw him alive on Feb 6 1922and that death occurred on the date stated above, at 2 A.M.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction from strangulated Hernia

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed)

[Signature]

M. D.

4-21-1922

(Address)

[Signature]

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rupert CemeteryFeb 12 1922

20. UNDERTAKER

ADDRESS

W. J. BradmanRupert

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Apr. 16 1922

Local Registrar

RECEIVED

CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

(No. of ...)

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

38167

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 12 1922 to Feb. 26 1922

that I last saw him alive on Feb. 26 1922 and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(Duration) Yrs. 6 mos. 3 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

4-10-1922

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Blaine Registration District No. 19
City of Reupert Primary Registration District No. 2013
(No. 1 St.)File No. 381683
Registered No. 128

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

David E. Ryley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

White White Married

6. DATE OF BIRTH

July 25 1869
(Month) (Day) (Year)

7. AGE

27 Yrs. Mos. ds. IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)Carpenter

9. BIRTHPLACE

(State or Country)

Indiana

10. NAME OF FATHER

William H. Ryley

11. BIRTHPLACE OF FATHER

(State or Country)

Indiana

12. MAIDEN NAME OF MOTHER

Mary E. Wilcoxson

13. BIRTHPLACE OF MOTHER

(State or Country)

Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Emma Ryley
(Address) Clarktown IndFiled Apr. 18 1922 E. E. Moore
Local Registrar

16. DATE OF DEATH

Mar 7 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Febr. 2 1922 to Mar 7 1922that I last saw him alive on Mar 7 1922and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Tuberculosis
General(Duration) 2 Yrs.? mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. B. Kenagy M. D.4-10-1922 (Address) Reupert

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Clarktown Ind DATE OF BURIAL Mar 7 192220. UNDERTAKER W. G. L. L. L. L. ADDRESS Reupert Ind

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

MAY 28 1922

CERTIFICATE OF DEATH

✓

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **38162**
Registered No. _____

1. PLACE OF DEATH

County of *Blaine*City of *Paul*

Registration District No. _____

Primary Registration District No. *2015*

(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Louise Wang

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female *White* *Married*

6. DATE OF BIRTH

May 8 1886
(Month) (Day) (Year)

7. AGE

36 Yrs. *10* Mos. *8* ds.IF LESS than 1 day
how many _____ hrs.
or _____ min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)*House Wife*

9. BIRTHPLACE

(State or Country)

Russia

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

Philip Jungen
Russia

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Catherine Jungen
Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Philip Jungen
Paul Idaho

15.

Filed

*Apr. 16 1922**E. E. Shure*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 16 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____ 19____, to _____ 19____.

that I last saw him _____ alive on _____ 19____.

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Epilepsy

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) *W. G. Goodman Brower* M. D._____ 19____ (Address) *Rupert Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Paul Cemetery**Mar 18 1922*

20. UNDERTAKER

ADDRESS

W. G. Goodman *Rupert Idaho*

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of MinidokaCity of Rupert

If death occurs away from usual residence, give facts called for under special information.

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATHRegistration District No. 19Primary Registration District No. 2013

(No. St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 38170Registered No. 80

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James F. Slusser

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDMale White Single (Write the word.)

6. DATE OF BIRTH

May 15th 1871
(Month) (Day) (Year)

7. AGE

50 Yrs. 10 Mos. 16 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Cabinet Maker

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Indiana

10. NAME OF FATHER

James Slusser

11. BIRTHPLACE OF FATHER

(State or Country) Indiana

12. MAIDEN NAME OF MOTHER

Margaret Biel

13. BIRTHPLACE OF MOTHER

(State or Country) Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Miss J. W. Smith(Address) Rupert Idaho

15.

Filed May 1 1922 E. H. Moore

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 2nd 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from March 28th 1922, to April 2nd 1922 that I last saw him alive on April 2nd 1922 and that death occurred on the date stated above, at 4:30 A. M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris(Duration) Yrs. mos. 10 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Leland Frasier M. D.19..... (Address) Rupert, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL
Rupert Cemetery L D SDATE OF BURIAL
April 2, 1922

20. UNDERTAKER

W. A. Goodman

ADDRESS

Rupert Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of *Shoshone* Registration District No. *19*
City of *Blackfoot* Primary Registration District No. *2015*
(No. St.)

File No. *38171*
Registered No. *6*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Verie Allene Collins*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Child*
(Write the word.)

6. DATE OF BIRTH *Jan 17 1922*
(Month) (Day) (Year)

7. AGE *1* Yrs. *1* Mos. *1* ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION *Child*
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE *Idaho*
(State or Country)

10. NAME OF FATHER *William Collins*

11. BIRTHPLACE OF FATHER *Kentucky*
(State or Country)

12. MAIDEN NAME OF MOTHER *May Harless*

13. BIRTHPLACE OF MOTHER *Missouri*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *William Collins*
(Address) *Shoshone*

15. Filed *May 1 1922* *E. E. Collins*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *Feb 17 1922*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Feb 13 1922*, to *Feb 17 1922* that I last saw him alive on *Feb 13 1922* and that death occurred on the date stated above, at *8:00 A.M.*

The CAUSE OF DEATH* was as follows:
Exhaustion

(Duration) Yrs. *1* mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) *Leland Frazer* M. D.

19. (Address) *Rupert, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Rupert Cemetery* DATE OF BURIAL *Feb 17 1922*

20. UNDERTAKER *W. G. Goodman* ADDRESS

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Myers Registration District No. 92
City of Clifford Registration District No. 2170 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Elizabeth Scheuers

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 38173
Registered No. 45

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH Nov 9 1840
(Month) (Day) (Year)

7. AGE 81 Yrs. 6 Mos. 10 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. House Keeper
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Ohio

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John A Shields

(Address) Penrose Idaho

15. Filed 5-19 1922

E.E. Watts

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 19 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1922 to May 1922

that I last saw h. er alive on May 1922

and that death occurred on the date stated above, at 2 a.m.

The CAUSE OF DEATH* was as follows:

Paralysis

(Duration) Yrs. 1 mos. 3 ds.
Contributory Senile decay
(Secondary)

(Duration) yrs. mos. ds.
(Signed) E.E. Watts M. D.

5-19-1922 (Address) Clifford Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Levinton Idaho

DATE OF BURIAL

5-20-1922

20. UNDERTAKER

H.E. Stoddard

ADDRESS

Clifford

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Nezperce
 City of Lewiston, Ida. (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. _____

Primary Registration District No. _____

2. FULL NAME

Abel Chessah

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 38174Registered No. 828

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-

Male Indian Single
 (Write the word.)

6. DATE OF BIRTH

_____. (Month) _____. (Day) _____. (Year)

7. AGE

15

Yrs. _____ Mos. _____ ds. _____

IF LESS than 1 day
 how many _____ hrs.
 or _____ min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

Student,

9. BIRTHPLACE

(State or Country)

Montana

10. NAME OF FATHER

Unknown (deceased)

11. BIRTHPLACE OF FATHER

(State or Country)

Montana

12. MAIDEN NAME OF MOTHER

Mary Susan C. Lamont

13. BIRTHPLACE OF MOTHER

(State or Country)

Montana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

M. L. Griffithman

(Address)

F. T. Lapwai, Ida.

15. Filed

May 8 1922Susan E Bruce

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Apr 28 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____ 19____, to _____ 19____

that I last saw him _____ alive on _____ 19____

and that death occurred on the date stated above, at 7 A. M.

The CAUSE OF DEATH* was as follows:

Impetigo
gangrenous

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed)

John H. Alley

_____ 19____ (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Blains, Mont.

DATE OF BURIAL

_____ 19____

20. UNDERTAKER

L. B. Warr

ADDRESS

Lewiston, Ida.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **38175**
Registered No. **812**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Myer
City of LeavertonRegistration District No. 96
Primary Registration District No. 1009
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Joseph M. Foster

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male white married
(Write the word.)

6. DATE OF BIRTH

June 10th 1892
(Month) (Day) (Year)

7. AGE

79 Yrs. 9 Mos. 20 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Farmer
Retired

9. BIRTHPLACE

(State or Country)

N.Y.

10. NAME OF FATHER

Chester Foster

11. BIRTHPLACE OF FATHER

(State or Country)

Ut

12. MAIDEN NAME OF MOTHER

Ruth Martin

13. BIRTHPLACE OF MOTHER

(State or Country)

N.Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Spiller
Leaverton, Idaho

15.

Filed May 2 1922 Susan E. Bruce
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 30th 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 12 1922 to March 30 1922that I last saw him alive on March 30 1922and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Semile debility(Duration) Many yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) R. J. Perkins M. D.3/1 1922 (Address) Leaverton Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Leaverton Idaho Apr. 2 1922

20. UNDERTAKER

ADDRESS

Leaverton Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of My Perce
City of Lewiston

Registration District No. 96Primary Registration District No. 1009

(No. _____ St.)

File No. _____

Registered No. 38147

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Albert Edward Higgins

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDSingle
(Write the word.)

6. DATE OF BIRTH

Dec 31 1900
(Month) (Day) (Year)

7. AGE

21 Yrs. 3 Mos. 3 ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of workStudent(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)U. S. M. A.

9. BIRTHPLACE

(State or Country)

Idaho10. NAME OF
FATHEREd. L. Higgins11. BIRTHPLACE
OF FATHER

(State or Country)

Idaho12. MAIDEN NAME
OF MOTHERAugusta M. Benson13. BIRTHPLACE
OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ed. L. Higgins

(Address)

Lewiston, Idaho

15.

Filed May 8 1922 Susan E. Bruce
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Apr 3 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Mar 4th 1922 to Apr 3 1922

that I last saw him alive on Apr 3 1922
and that death occurred on the date stated above, at _____

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous
Nephritis(Duration) _____ Yrs. 6 mos. _____ ds.Contributory
(Secondary)Exposure

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____

W. H. Hume

M. D.

19 _____

(Address)

Lewiston, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted
if not at place of death?

Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Lewiston, Idaho

DATE OF BURIAL

4/5 1922

20. UNDERTAKER

Vassar and Co.

ADDRESS

LewistonIdaho

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *May Perce*
City of *Lewiston*Registration District No. *96*
Primary Registration District No. *1009*
(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Kenneth Ralph White*State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. *38178*
Registered No. *873*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*
(Write the word.)

6. DATE OF BIRTH

Mar 6 1922
(Month) (Day) (Year)

7. AGE

28 Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)*Infant.*

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

T. L. White

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

May Robinson

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Forest G. Roy White

(Address)

401 Snake River Ave

15.

Filed *May 8 1922* *Susan E. Bruce*
Local Registrar

16. DATE OF DEATH

Apr 4 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *April 1 1922* to *April 4 1922*that I last saw him alive on *April 4 1922*and that death occurred on the date stated above, at *6 P.M.*

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. O. Clock M. D.*4/6/22* (Address) *Lewiston Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Lewiston Ida**4/6 1922*

20. UNDERTAKER

ADDRESS

*Cassars and Co**Lewiston**Ida*

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Payson
City of LewistonRegistration District No. 96Primary Registration District No. 1009

(No. _____) (St. _____)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

H. FilbertState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 38179Registered No. 816

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

(Month) _____ (Day) _____ (Year) _____

7. AGE

76 Yrs. _____ Mos. _____ ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Farmer

(b) General nature of industry, business or establishment in which employed (or employer).

Retired

9. BIRTHPLACE

(State or Country)

unknown

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. B. Warr(Address) Lewiston Idaho

15.

Filed May 8 1922Wm. E. Bruce
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 9th 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Mar 27, 1922, to April 9, 1922that I last saw him alive on April 9, 1922

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Aortic Insufficiency(Duration) + Yrs. _____ mos. _____ ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. B. Warr

M. D.

19 _____ (Address) Lewiston Id

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Lewiston Idaho

DATE OF BURIAL

4-11 1922

20. UNDERTAKER

Vassard Co.

ADDRESS

Lewiston Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Boyer
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No.) (St.)

File No.
Registered No. 38180

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary E. Imbler

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED
(Write the word.)

6. DATE OF BIRTH
Feb (Month) 3rd (Day) 1894 (Year)

7. AGE 78 Yrs. 2 Mos. 9 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. at home
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE
(State or Country) mo

10. NAME OF FATHER David McLean

11. BIRTHPLACE OF FATHER
(State or Country) Unknown

12. MAIDEN NAME OF MOTHER Mary Clay

13. BIRTHPLACE OF MOTHER
(State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) D. E. Martin
(Address) Lewiston Idaho

15. Filed May 8 1921 Anna E. Bruce
Local Registrar

16. DATE OF DEATH
April (Month) 12th (Day) 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1 1922 to April 12 1922 that I last saw him alive on April 11 1922 and that death occurred on the date stated above, at 12:00 PM.
The CAUSE OF DEATH* was as follows:
infirmity

(Duration) Yrs. mos. ds.
Contributory (Secondary) General Anemia
(Duration) yrs. mos. ds.
(Signed) W. E. Smith M. D.
412 1922 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Hammah Idaho DATE OF BURIAL Apr 13 1922
20. UNDERTAKER W. E. Smith ADDRESS Lewiston Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **38182**Registered No. **819**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of *Myer*City of *Lewiston*Registration District No. *96*Primary Registration District No. *1009*

(No.)

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Anna M. Conkey*

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female*4. COLOR OR RACE *White*5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Widow*

(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

(Year)

7. AGE

69

Yrs.

Mos.

ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. *at home*

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) *Mass.*10. NAME OF FATHER *unknown*

11. BIRTHPLACE OF FATHER

(State or Country) *Id.*

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country) *Id.*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Ever Brainer*(Address) *Lewiston Ida*15. Filed *May 8 1922**Anna E Bruce*
Local RegistrarMEDICAL CERTIFICATE OF DEATH *28*

16. DATE OF DEATH

*Apr 19*19 *22*
(Year)17. I HEREBY CERTIFY, That I attended deceased from *Feb 22* 19 *22*, to *Apr 19* 19 *22*that I last saw him alive on *Apr 18* 19 *22*

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis(Duration) *7* Yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *O. B. Leason* M. D.19..... (Address) *Lewiston, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Lewiston Idaho*DATE OF BURIAL *4-20 1922*20. UNDERTAKER *Worcester Co.*ADDRESS *Lewiston Ida*

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 1009 95

County of Latah

Primary Registration District No. 1009

City of Lewiston

(No. 95 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Abraham McKee

File No. 38183

Registered No. 822

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M

4. COLOR OR RACE W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married

6. DATE OF BIRTH Feb 13 1892

(Month)

(Day)

(Year)

7. AGE 102 yrs. 2 mos. 7 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE Indiana

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER Not known

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Abraham McKee

(Address) Lewiston, Ida

15.

Filed Mary E. Bruce 1922 Susan E. Bruce Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 20 1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 19 1922 to Feb 20 1922

that I last saw him alive on Feb 19 1922

and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Senility, prostatitis, cystitis,

(Duration) yrs. mos. ds.

Contributory prostatitis, cystitis
(Secondary)

(Duration) yrs. mos. ds.

(Signed) H. J. Smith M. D.

Feb 21 1922 (Address) Lewiston, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Lewiston, Ida DATE OF BURIAL Feb 23 1922

20. UNDERTAKER L. D. Smith ADDRESS Lewiston, Ida

CERTIFICATE OF DEATH

Braddock,
State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **38184**
Registered No. **821**

1. PLACE OF DEATH

Registration District No. **96**County of **Cayuse**Primary Registration District No. **1009**City of **Idaho**(No. **1009**)

St.)

Registered No. **821**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Leona R. Hallingworth

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female white**Single**
(Write the word.)

6. DATE OF BIRTH

Aug 25 1902
(Month) (Day) (Year)

7. AGE

19 Yrs. 7 Mos. 26 ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

**Student
Norman School**

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

R. M. Hallingworth

11. BIRTHPLACE OF FATHER

(State or Country)

Iowa

12. MAIDEN NAME OF MOTHER

Nellie E. Harry

13. BIRTHPLACE OF MOTHER

(State or Country)

Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. E. J. Warner

(Address)

Lewiston Ida.

15.

Filed

May 8 1922 Susan E. Bruce

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 21 1922
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from **April 15 1922** to **April 21 1922** that I last saw him alive on **April 21 1922** and that death occurred on the date stated above, at **6:30 P.M.**

The CAUSE OF DEATH* was as follows:

General Peritonitis

(Duration) _____ Yrs. _____ mos. **6** ds.
Contributory (Secondary) **Sanguine Appendicitis**

(Duration) _____ yrs. _____ mos. **9** ds.
(Signed) **Elmer B. Braddock, M. D.**

422 1922 (Address) **Lewiston Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Norman Idaho**4/22 1922**

20. UNDERTAKER

ADDRESS

Cassius Undertaking Co. Lewiston

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **38185**
Registered No. **822**

1. PLACE OF DEATH

Registration District No. **96**
County of **Myer** Primary Registration District No. **1009**
City of **Rehoboth** (No. _____) (St.) _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jordan Akers

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Single**
(Write the word.)6. DATE OF BIRTH **Feb 9 1918**
(Month) (Day) (Year)7. AGE **4 Yrs. 2 Mos. 15 ds.** IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work **At Home**
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

M J Akers

11. BIRTHPLACE OF FATHER

(State or Country)

Iowa

12. MAIDEN NAME OF MOTHER

Irma Little

13. BIRTHPLACE OF MOTHER

(State or Country)

Neb.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

**W. J. Akers
Rehoboth Idaho**

15.

Filed **May 8 1922** **Irma E. Bruce**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

175-0

16. DATE OF DEATH

April 24 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from **April 24 1922** to **April 24 1922** that I last saw him alive on **April 24 1922** and that death occurred on the date stated above, at **109 M.**
The CAUSE OF DEATH* was as follows:**Fracture of skull
Accidental. Struck by Automobile**
(Duration) _____ Yrs. _____ mos. **30 Mins.**Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) **Ernest B. Broun** D.**4-25-1922** (Address) **Rehoboth Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Rehoboth Idaho **4-26-1922**

20. UNDERTAKER

ADDRESS

Rehoboth Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 96
County of Nezperce Primary Registration District No. 1009
City of Lewiston (No. 100) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Samuel H. MarshallFile No. 38186
Registered No. 38186

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)6. DATE OF BIRTH April 2 1853
(Month) (Day) (Year)7. AGE 69 Yrs. — Mos. 23 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Farmer

9. BIRTHPLACE

(State or Country)

Mo

10. NAME OF FATHER

Newton Marshall

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Saundersland

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Sam Marshall
Nezperce Idaho15. Filed May 8 1922 Simon E Bruce
Local Registrar

16. DATE OF DEATH

April 25 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 22 1922, to April 25 1922
that I last saw him alive on April 25 1922
and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of left lung
and mediastinal glands (29)
(Duration) Yrs. 1 mos. ds.Contributory
(Secondary)(Duration) Yrs. 1 mos. ds.

(Signed)

Edgar L. White M. D.
April 25 1922 (Address) Lewiston 2d

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Lifford 2d 4/27 1922
20. UNDERTAKER H R Merchant ADDRESS Lewiston

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Myer
City of LewistonRegistration District No. 96
Primary Registration District No. 1009
(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Charles W ShiraState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 38187
Registered No. 824

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH

Feb 1st 1860
(Month) (Day) (Year)

7. AGE

62 Yrs. 2 Mos. 25 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Retired Farmer

9. BIRTHPLACE

(State or Country)

Ind

10. NAME OF FATHER

Phillip Shira

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Barley

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

C W Shira
Orangeville IdahoFiled May 8 1922 Susan E Bruce
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 26th 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Apr 21 1922 to Apr 26 1922
that I last saw him alive on Apr 26 1922
and that death occurred on the date stated above, at 1:50 P.M.
The CAUSE OF DEATH* was as follows:Peritonitis(Duration) Yrs. _____ mos. 14 ds.Contributory
(Secondary)Ruptured appendix(Duration) yrs. _____ mos. 18 ds.

(Signed)

O. C. Carson

M. D.

4/27/1922

(Address)

Lewiston Id

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Orangeville Idaho4/27/1922

20. UNDERTAKER

ADDRESS

Lewiston Idaho

FORM V. S. No. 5-25 M. 1-19

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 26

County of Oneida

Primary Registration District No. 2069

City of St John

St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
MAY 26 1922
BUREAU OF VITAL

2. FULL NAME

William S. Lewis

File No.

38188

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

20

3. SEX

Male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDwidowed
(Write the word.)

6. DATE OF BIRTH

July 23

(Month)

(Day)

1896 (Year)

7. AGE

64 yrs. 9 mos. 4 ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

Former

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Lewis Lewis

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Eleanor Davis

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. M. Lewis

(Address)

15.

Filed May 5 1922

Local Registrar

16. DATE OF DEATH

Apr.

27

1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb. 1922 to Apr. 27 1922

that I last saw him alive on Apr. 27 1922

and that death occurred on the date stated above, at 9:30 M.

The CAUSE OF DEATH* was as follows:

Pyorrhea.

(Duration)

Yrs. 4 mos. ds.

Contributory (Secondary)

(Duration)

yrs. mos. ds.

(Signed)

J. M. Lewis, M. D.

4/29/1922 (Address) Malad, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St John

Apr. 30 1922

20. UNDERTAKER

ADDRESS

J. M. Lewis

Malad

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Owyhee,
City of Silver City.

Registration District No. 43.
Primary Registration District No. 2120
(No., St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 38189
Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME FRED A. YOUNG.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH

Unknown

(Month) (Day) (Year)

7. AGE

About 60 years.

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Unemployed

(b) General nature of industry, business or establishment in which employed (or employer)

Escaped prisoner

9. BIRTHPLACE

(State or Country)

United States

10. NAME OF FATHER

George Young

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) R. L. McDonnell
(Address) Silver City, Idaho.

15.

Filed May 8th 19 22.

Local Registrar

MEDICAL CERTIFICATE OF DEATH

159

16. DATE OF DEATH

May 7 19 22.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from after death 19....., to 19....., that I last saw h..... alive on..... 19....., and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Gun shot wound.Coroner's Jury Verdict:"Probably self-inflicted"

..... (Duration) Yrs. mos. ds.

Contributory
(Secondary)

..... (Duration) yrs. mos. ds.

(Signed) Wm. J. Erkenbeck M. D.5/8/19.22 (Address) Grand View, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL
Mountain Home, Idaho

DATE OF BURIAL
..... 19.....

20. UNDERTAKER

Gilbert C. Zaehner

ADDRESS

Mt. Home, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 4

County of Payette

Health Registration District No. 1008

City of Payette

(No.) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Annie A Williams

File No. 38191

Registered No. 38191

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female

White

6. DATE OF BIRTH

Apr 12 1848
(Month) (Day) (Year)

7. AGE

74 yrs. 22 mos. 22 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

Richard Storer

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Elizabeth Bowser

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

A. B. Williams
Payette Ida.

15.

Filed

May 6/1922

J. C. Woodward

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 4 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1922 to May 3 1922,

that I last saw her alive on May 3 1922,

and that death occurred on the date stated above, at 3:30 M.

The CAUSE OF DEATH* was as follows:

Spinal Sclerosis

Intestinal Carcinoma

(Duration) 2 yrs. 2 mos. 2 ds.

Contributory Senility
(Secondary)

(Duration) 2 yrs. 2 mos. 2 ds.

(Signed) J. A. McDonald M. D.

5-6 1922 (Address) Payette, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Payette Ida

5-7 1922

20. UNDERTAKER

ADDRESS

J. A. McDonald Payette Ida

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **38192**
Registered No. **86**

1. PLACE OF DEATH
County of *Payette* Registration District No. *4*
City of *Payette* Primary Registration District No. *1008*
(No. *1008* St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Body of Unknown Infant

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Infant*
(Write the word.)

6. DATE OF BIRTH *Not known*
About May 19 1922
(Month) (Day) (Year)

7. AGE *Not known*
Estimated 1 day
Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) *Near Cemetery, Payette*

10. NAME OF FATHER
Not known

11. BIRTHPLACE OF FATHER
(State or Country) *Not known*

12. MAIDEN NAME OF MOTHER
Not known

13. BIRTHPLACE OF MOTHER
(State or Country) *Not known*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *J. C. Woodward*
(Address) *Payette Id.*

15. *County Physician*
Filed *May 24 1922* *J. C. Woodward*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *about May 19 1922*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 19... to 19... that I last saw him alive on 19... and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Probably ex posed due to abandonment at age of about one day. Found dead near Payette Id.
(Duration) Yrs. mos. ds.

Contributory (Secondary) (Duration) Yrs. mos. ds.

(Signed) *J. C. Woodward* M. D.
6/24/1922 (Address) *County Physician Payette Id.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Payette Id. DATE OF BURIAL *May 23 1922*

20. URBERTAKER

John W. Landry ADDRESS *Payette Id.*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

1. PLACE OF DEATH.

County of **Power**City of **American Falls, Idaho**RECEIVED
Bureau of Vital Statistics
District No. **25**City of **American Falls, Idaho** Registration District No. **2072**

BUREAU OF VITAL

STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Katherin Neu**State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **38194**Registered No. **356**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.**Married**

(Write the word.)

6. DATE OF BIRTH.

Nov**14****852**

(Month)

(Day)

(Year)

7. AGE

69 Yrs. **6** Mos. **1** ds.IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
(b) General nature of in-
dustry, business, or estab-
lishment in which employ-
ed (or employer)**House Wife**

9. BIRTHPLACE

(State or Country)

Russia10. NAME OF
FATHER**Jacob Heer**11. BIRTHPLACE
OF FATHER

(State or Country)

Russia12. MAIDEN NAME
OF MOTHER**J. Baker**13. BIRTHPLACE
OF MOTHER

(State or Country)

Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

John Neu
American Falls, Idaho

15.

Filed **6-5-****1922****R. J. Noth.**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 15 19**22**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 20 1922 to **May 15 1922**that I last saw her alive on **May 15 1922**and that death occurred on the date stated above, at **4 P. M.**

The CAUSE OF DEATH* was as follows:

Fatty heart

(Duration) Yrs. mos. ds.

•Contributory (Secondary) **Edema of lungs**

(Duration) Yrs. mos. ds.

(Signed) **C. F. Schilt** M. D.5/16/1922 (Address) **Amer. Falls, Ida**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)

MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,

Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Plesent Valley Ida

20. UNDERTAKER

A.W. Davis

DATE OF BURIAL

5/17/22 191ADDRESS
Am Falls, Id

RECEIVED

CERTIFICATE OF DEATH.

1. PLACE OF DEATH. **Power** Registration District No. **245**
 County of **American Falls** BUREAU OF VITALS Registration District No. **2072**
 City of **American Falls** (No. **19**) **Stetham Hospital** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Christian Mayer**

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. **38195**Registered No. **355**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED. **Married**
 (Write the word.)

6. DATE OF BIRTH.

May **14** **1862**
 (Month) (Day) (Year)

7. AGE

60 **0** **11**
 Yrs. Mos. ds.

IF LESS than 1 day
 how many hrs. or
 min. 2)

8. OCCUPATION

(a) Trade, profession or particular kind of work... **Retired Farmer**
 (b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country) **Russia**

10. NAME OF FATHER

Christian Mayer

11. BIRTHPLACE OF FATHER

(State or Country) **Russia**

12. MAIDEN NAME OF MOTHER

Carrie Renke

13. BIRTHPLACE OF MOTHER

(State or Country) **Russia**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) **Emil R. Mayer**(Address) **Lodi Cal R. # Box 59**

15.

Filed **6-5-1922** **R. J. Nolt**
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May **25** **1922**
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **May 19 1922** to **May 25 1922**
 that I last saw him alive on **May 25 1922**
 and that death occurred on the date stated above, at **1 P. M.**
 The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) Yrs. mos. **6** ds.

Contributory
 (Secondary)

(Duration) Yrs. mos. ds.

(Signed) **C. F. Adick** M. D.

5/26 1922 (Address) **American Falls, Ida**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted
 if not at place of death?.....

Former or
 usual residence

19. PLACE OF BURIAL OR REMOVAL

Lodi, Cal

DATE OF BURIAL

May 1922

20. UNDERTAKER

A.W. Davis,

ADDRESS

American Falls, Id

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

1. PLACE OF DEATH **Power** Registration District No. **25**
County of **Power** JUN 7 1922 Primary Registration District No. **2072**
City of **Arbon, Idaho** (No.) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Brigham Bowen**

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
38196
File No. **334**
Registered No. **334**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WID-OWED OR DIVORCED. **Single**
(Write the word.)

6. DATE OF BIRTH. **Mar 25 1922**
(Month) (Day) (Year)

7. AGE **28 1 28**
Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min. 2

8. OCCUPATION

(a) Trade, profession or particular kind of work... **Farmer**
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE **Idaho**
(State or Country)

10. NAME OF FATHER **David John Bowen**

11. BIRTHPLACE OF FATHER **Utah**
(State or Country)

12. MAIDEN NAME OF MOTHER **Mary S. Smith**

13. BIRTHPLACE OF MOTHER **Utah**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) **David J. Bowen**
(Address) **Malad, Idaho**

15. Filed **6-5** 1922 **R. J. Nolt**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **May 23 1922**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **191** to **191**,
that I last saw him alive on **191**,
and that death occurred on the date stated above, at **M.**
The CAUSE OF DEATH* was as follows:

Suicide by Shooting

(Duration) Yrs. mos. ds.
Contributory (Secondary)

(Duration) Yrs. mos. ds.
(Signed) **Clarence** Coroner M. D.
May 23 1922 (Address) **American Falls, Idaho**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **Samara, Idaho** DATE OF BURIAL **May 25 1922**

20. UNDERTAKER **Guy J. Benson** ADDRESS **Malad, Ida.**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

1. PLACE OF DEATH. **RECEIVED**
 County of Power **JUN 7 1922** Registration District No. 25
 City of American Falls **BUREAU OF VITAL STATISTICS** Primary Registration District No. 2072
Etham Hospital St.)
 If death occurs away from usual residence, give facts called for under special information.

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 38197
 Registered No. 323
 If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary E. Cooper

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
 (Write the word.)

6. DATE OF BIRTH. Sept 16 1878
 (Month) (Day) (Year)

7. AGE 43 yrs. 7 mos. 21 ds.
 IF LESS than 1 day how many.....hrs. or.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... House Wife
 (b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country) Wis

10. NAME OF FATHER

John Morgan Core

11. BIRTHPLACE OF FATHER

(State or Country) Not known

12. MAIDEN NAME OF MOTHER

MARGARET Not Known

13. BIRTHPLACE OF MOTHER

(State or Country) Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ernest Cooper
 (Address) Roy, Idaho.

15.

Filed 6-5 1922 R. F. Roth
 Local Registrar

MEDICAL CERTIFICATE OF DEATH 57

16. DATE OF DEATH

May 7 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY; That I attended deceased from May 29 1922 to May 7 1922
 that I last saw him or alive on May 7 1922
 and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Exophthalmic goiter(Duration) Don't know yrs. mos. ds.

Contributory (Secondary)

(Duration) 0 yrs. mos. ds.

(Signed)

5/8 1922 (Address) Am. Falls, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

American Falls, Idaho1922

20. UNDERTAKER

ADDRESS

A. J. SmithAm Falls, Ida

FORM V. S. No. 5-25 M. 1-16-18

1. PLACE OF DEATH.

County of Power

City of American Falls,

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Richard Thomas

Parton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

White

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

Single

(Write the word.)

6. DATE OF BIRTH.

March

8

1

1922

(Month)

(Day)

(Year)

7. AGE

Yrs.

Mos.

27

ds.

IF LESS than 1 day
how many hrs. or
min.)

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
(b) General nature of in-
dustry, business, or estab-
lishment in which employ-
ed (or employer)

None

9. BIRTHPLACE

(State or Country)

Power

Ida.

10. NAME OF
FATHER

John Parton

11. BIRTHPLACE
OF FATHER

(State or Country)

N.C.

12. MAIDEN NAME
OF MOTHER

Vera S. Decker

13. BIRTHPLACE
OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

American Falls, Idaho

15.

Filed

6-5

1922

R. J. Nolk

Local Registrar

RECEIVED CERTIFICATE OF DEATH.

Registration District No.

Primary Registration District No.

STATISTICAL

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April

5

1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from
March 2, 1922, to April 5, 1922.

that I last saw him alive on April 1, 1922

and that death occurred on the date stated above, at 3:45 P.M.

The CAUSE OF DEATH* was as follows:

Defect in valves
of heart

(Duration)

Yrs.

7 mos.

ds.

Contributory
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

C. F. Schiefel

M. D.

(Address)

American Falls, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place

of death.....Yrs.....mos.....days

In the

State.....Yrs.....mos.....days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

American Falls, Idaho

April 5, 1922

20. UNDERTAKER

A.W. Davis

ADDRESS

American Falls,
Idaho

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **38109**
Registered No. **157**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of **Power**City of **American Falls Idaho**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Bessie Mae**Hoagland**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.**Single**

(Write the word.)

6. DATE OF BIRTH.

Nov**29****1920**

(Month)

(Day)

(Year)

7. AGE

1 Yrs. **3** Mos. **20** ds.IF LESS than 1 day
how many.....hrs. or
.....min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work...
(b) General nature of in-
dustry, business, or estab-
lishment in which employ-
ed (or employer).....**None**

9. BIRTHPLACE

(State or Country) **Idaho**10. NAME OF
FATHER**(Hoagland)**
William Hoagland11. BIRTHPLACE
OF FATHER(State or Country) **Idaho**12. MAIDEN NAME
OF MOTHER**Clara Bell Walton**13. BIRTHPLACE
OF MOTHER(State or Country) **Idaho**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) **William Hoagland**(Address) **Caldwell, R.F.D. 1 Idaho**

15.

Filed **6-5** **1922****R. K. Roth**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mch
(Month)**20**
(Day)**1922**
(Year)17. I HEREBY CERTIFY, That I attended deceased from
Mch 17 1922 to **Mch 20 1922**that I last saw her alive on **Mch 20 1922**and that death occurred on the date stated above, at **3 P. M.**

The CAUSE OF DEATH* was as follows:

Pneumonia(Duration) Yrs. mos. **6** ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) **C. F. McNeil** M. D.**3/21 1922** (Address) **Amer Falls, Ida.***State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1)
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted
if not at place of death?.....Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

191

20. UNDERTAKER

ADDRESS

1. PLACE OF DEATH.

Registration District No.

County of *Power*Registration District No. *2072*City of *American Falls*

St.)

File No. *9*Registered No. *150*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Augustus Waldemar Thompson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

120

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male *White* *Married*

6. DATE OF BIRTH.

Oct. 3rd 1863
(Month) (Day) (Year)

7. AGE

58 Yrs. *6* Mos. *19* ds.IF LESS than 1 day
how many hrs. or
..... min. 2)

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....*Farmer*

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Waldemar Thompson

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME OF MOTHER

Caroline

13. BIRTHPLACE OF MOTHER

(State or Country)

Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Richard J. N. H.
American Falls

15.

Filed

*5-2*19*22**Richard J. N. H.*

Local Registrar

16. DATE OF DEATH

April 22nd 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
April 7th 1922 to *April 22nd 1922*
that I last saw him alive on *April 21st 1922*
and that death occurred on the date stated above, at *3 P. M.*
The CAUSE OF DEATH* was as follows:*Chronic Nephritis*
(interstitial)

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *Richard J. N. H.* M. D.19 (Address) *American Falls*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rockland 19*22*

20. UNDERTAKER

ADDRESS

Family, American Falls

1. PLACE OF DEATH

County of *Shoshone*City of *Malta*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Elizabeth Furey

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widowed
(Write the word.)

6. DATE OF BIRTH

June

(Month)

16

(Day)

1922

(Year)

7. AGE

59 Yrs.*12* Mos.*13* ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Housewife

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Huntingdon Canada

10. NAME OF FATHER

Ephraim Dunsmore

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Mary Stott

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Estella Furey

(Address)

Malta, Idaho

15. Filed

May 1

19

J. L. Jinks

Local Registrar

PLACE OF DEATH

Registration District No. *70*County Registration District No. *1011*City of *Malta* No. *406 Elm Street* St.)

File No.

Registered No. *42*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Apr 29

(Month)

19

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

1922 to*1922*

that I last saw him alive on

*Apr 29**19*and that death occurred on the date stated above, at *Malta, M.*

The CAUSE OF DEATH* was as follows:

Coronary artery disease & surrounding organs

(Duration)..... mos..... ds.

Contributory (Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed)

Dr. M. W. Jinks

(Address)

Malta, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Wallace Idy

DATE OF BURIAL

5-1 1922

20. UNDERTAKER

Bruce E. Novate

ADDRESS

Wallace

1. PLACE OF DEATH *Shoshone* Registration District No. *70*
 County of *Shoshone* Principal Registration District No. *104*
 City of *Wallace* *Shoshone Hospital* File No. *40*
 If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME *John Benjamin Spencer* If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *married*
 (Write the word)

6. DATE OF BIRTH *May 13 1862*
 (Month) (Day) (Year)

7. AGE *59* Yrs. *11* Mos. *16* ds. 16 IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer)

Enggr.
Held Mining Co.

9. BIRTHPLACE

(State or Country)

Cedar Co. Mo.

10. NAME OF FATHER

Benjamin Spencer

11. BIRTHPLACE OF FATHER

(State or Country)

Kentucky

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs J. B. Spencer
Shoshone Idaho

(Address)

15. Filled *Apr 25 1922* *J L J* Local Registrar

16. DATE OF DEATH *Apr 27 1922*
 (Month) (Day) (Year)

17. I HEREBY CERTIFY That I attended deceased from *Apr 24 1922* to *Apr 27 1922* that I last saw him alive on *Apr 27 1922* and that death occurred on the date stated above, at *5 P.M.* The CAUSE OF DEATH* was as follows
~~Means of Injury~~

(Duration) Yrs. mos. ds.
 Contributory (Secondary) *Empyema & Pleurisy*

(Duration) yrs. mos. ds.
 (Signed) *Dr. Mowry* M. D.

429 1922 (Address) *Wallace Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Wallace Idaho* DATE OF BURIAL *May 1 1922*

20. UNDERTAKER *O. S. Mowstall* ADDRESS *Wallace*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

38203 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration

RECEIVED 70

County of

Primary Registration District No.

File No.

City of

(No.

St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1922

7 27

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

(Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 70

38204

County of Shoshone

Primary Registration District No. 104

File No.

City of Wallace

Primary Registration District No. 104

Registered No.

If death occurs away from usual residence, give facts called for under special information.

MAY 23 1922

FULL NAME, Peter Gregory

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

M.

white

married
(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

(Year)

7. AGE

55 yrs. — mos. — ds.

IF LESS than 1 day
how many hrs. &
..... mins.?

8. OCCUPATION

(a) Trade, profession or

particular kind of work

(b) General nature of industry

business, or establishment in

which employed (or employer)

miner

9. BIRTHPLACE

(State or Country)

Newfoundland

10. NAME OF
FATHER

Peter Gregory

11. BIRTHPLACE
OF FATHER

(State or Country)

Newfoundland

12. MAIDEN NAME
OF MOTHER

no information

13. BIRTHPLACE
OF MOTHER

(State or Country)

no information

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

John Gregory
Burke Idaho

15.

Filed

Mar 14

1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Mar

12

1922

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from

Jan 20 1922 to Mar 12 1922

that I last saw him alive on Mar 11 1922

and that death occurred on the date stated above, at 3:30 PM

The CAUSE OF DEATH* was as follows:

Furunculosis Abscesses

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 3 20M.1-16-12

CERTIFICATE OF DEATH

38205 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. *Shoshone*
County of *Wallace*
City of *Wallace*
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME *Christina Olson*

Registration District No. *70*
Primary Registration District No. *1001*
File No. *12*
Registered No. *12*
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female*
4. COLOR OR RACE *white*
5. SINGLE, MARRIED, WIDOWED OR DIVORCED *married*
(Write the word.)

6. DATE OF BIRTH *Dec 26 1871*
(Month) (Day) (Year)

7. AGE *49* yrs. *0* mos. *26* ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work *housewife*
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE *Norway*
(State or Country)

10. NAME OF FATHER *Larson*

11. BIRTHPLACE OF FATHER *Norway*
(State or Country)

12. MAIDEN NAME OF MOTHER *not known*

13. BIRTHPLACE OF MOTHER *Norway*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *C. F. Olson*
(Address) *1119 Canyon Ave*

15. Filed *Jan 4 1922*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *Jan 22 1922*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Nov 1921* to *Jan 22 1922*
that I last saw *her* alive on *Jan 22 1922*
and that death occurred on the date stated above, at *11:30* P. M.
The CAUSE OF DEATH* was as follows:
discess of liver

(Duration) yrs. mos. ds. *7-8*
Contributory (Secondary) *Chromiaemia*
(Duration) yrs. mos. ds. *several*
(Signed) *Dr. M. D.*
1/25 1922 (Address) *Wallace*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.
Where was disease contracted if not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL *Wallace Ida* DATE OF BURIAL *Jan 25 1922*
20. UNDERTAKER *R. G. Norstall* ADDRESS *Wallace*

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Shoshone*City of *Mullan*

If death occurs away from usual residence, give facts called for under special information.

Registration District No. *70*Primary Registration District No. *101/38206*(No. *Residence* St.)

File No. _____

Registered No. *3*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Halter Meikleham

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

unmarried
(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

(Year)

7. AGE

70 Yrs. — Mos. — ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)*Hatchman at morning news*

9. BIRTHPLACE

(State or Country)

Canada

10. NAME OF FATHER

Brigham Meikleham

11. BIRTHPLACE OF FATHER

(State or Country)

Scotland

12. MAIDEN NAME OF MOTHER

Anna Bellera

13. BIRTHPLACE OF MOTHER

(State or Country)

Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. R. E. King

(Address)

*Butte Mont
511 - 3 Crystal St*

15.

Filed

1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 4

(Month)

(Day)

22
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19

to

*19*that I last saw *him* alive on*19*and that death occurred on the date stated above, at *7 A. M.*

The CAUSE OF DEATH* was as follows:

*Heart failure*Contributory
(Secondary)

(Duration)

ds.

(Duration)

mos.

ds.

(Signed)

1922

(Address)

Wallooedda

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

yrs.

mos.

days

In the

State

yrs.

mos.

days

Where was disease contracted if not at place of death?

Former or usual residence

Mullan Idaho

19. PLACE OF BURIAL OR REMOVAL

Butte Mont

DATE OF BURIAL

Jan 1922

20. UNDERTAKER

Hard Und Co,

ADDRESS

Wallace

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

RECEIVED CERTIFICATE OF DEATH

38207

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.

County of

Primary Registration District No.

City of

(No. 511)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. - FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1912

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw ~~her~~ alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

16 1922 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-42

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

RECEIVED

Registration District No.

70

38208

County of

Shoshone

MAY 2 1922

Registration District No.

City of

Wallace

Buffalo Pacific Hotel

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary E Conrad

File No.

Registered No.

5

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female

White

Married (Write the word)

6. DATE OF BIRTH

April

16

1860

(Month)

(Day)

(Year)

7. AGE

61 yrs. 8 mos. 20 ds.

IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

housewife

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

California

10. NAME OF FATHER

Sam Hayes

11. BIRTHPLACE OF FATHER

(State or Country)

not given

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wm E Guane

(Address)

Wallace

15.

Filed

June

191

Local Registrar

MEDICAL CERTIFICATE OF DEATH

19

16. DATE OF DEATH

Jan

5

1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov

1921, to

Dec 5

1922

that I last saw him alive on

Dec 5

1921

and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Contributory (Secondary)

Encephalitis Rheumatoid

(Signed)

Dr. M. W. E. P. 1/7 1922

(Address)

Wallace

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days.

In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Chico, California

July 7 1922

20. UNDERTAKER

ADDRESS

Bruce & Morrell

Wallace

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of ShoshoneRegistration District No. 70City of WallacePrimary Registration District No. 04

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Charles StanleyState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 38209Registered No. 6

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

single
(Write the word.)

6. DATE OF BIRTH

Mar 21

(Month)

(Day)

1880
(Year)

7. AGE

41 Yrs. 10 Mos. 18 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Hotel Clerk

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Minn.

10. NAME OF FATHER

Charles Stanley

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Augusta Schmidt

13. BIRTHPLACE OF MOTHER

(State or Country)

Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Henry P. Olson

(Address)

Wallace 2da

15.

Filed

19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 6

(Month)

22

(Day)

1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19

to

1922

that I last saw him (alive) on

1922and that death occurred on the date stated above, at 4:57 P.M.

The CAUSE OF DEATH* was as follows:

Heart failure

(Duration)

yrs.

mo.

ds.

Contributory
(Secondary)

(Duration)

yrs.

mo.

ds.

(Signed)

Dr. M. W. M. M.
10 22 (Address) Wallace 2da

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

Wallace 2da

19. PLACE OF BURIAL OR REMOVAL

Wallace 2da

DATE OF BURIAL

Jan 12, 1922

20. UNDERTAKER

Ward Ward

ADDRESS

Wallace 2da

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 8 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH *Shoshone* Registration District No. *70*
County of *Shoshone* Primary Registration District No. *191*
City of *Wallace* (No. *Providence Hosp.* St.)

38210

File No. *7*Registered No. *7*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Ward Henry Batzle*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *single*
(Write the word.)

6. DATE OF BIRTH *Dec 9 1919*
(Month) (Day) (Year)

7. AGE *2 yrs. 1 mos. 0 ds.* IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work *none*
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE *Idaho*
(State or Country)

10. NAME OF FATHER *Paul H Batzle*

11. BIRTHPLACE OF FATHER *N. Y.*
(State or Country)

12. MAIDEN NAME OF MOTHER *Ethel Dunn*

13. BIRTHPLACE OF MOTHER *Mis.*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *W H Batzle*
(Address) *113 Bank St.*

15. Filed *191* Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *Jan 9 1922*
(Month) (Day) (Year)

17. I HEREBY CERTIFY That I attended deceased from *Jan 6 1922* to *Jan 9 1922*
that I last saw him alive on *Jan 9 1922*
and that death occurred on the date stated above, at *11:30 AM*.

The CAUSE OF DEATH* was as follows:

Pneumonia, lobes double

(Duration) *7-8* yrs. mos. ds.
Contributory *asthma*
(Secondary)

(Duration) *7-8* yrs. mos. ds.
(Signed) *Dr. M. W. M. D.*
110 1922 (Address) *Wallace*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Killogg* DATE OF BURIAL *Jan 12 1922*
Ida

20. UNDERTAKER *R. G. Moutell* ADDRESS *Wallace*

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 70

County of Shoshone Primary Registration District No. 1011

City of Wallace Wallace Hospital

File No.

Registered No. 8

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jacob Andreas Peterson Sandness

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

male white single (Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

28 yrs. mos. ds.

IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

miner

9. BIRTHPLACE

(State or Country)

Norway

10. NAME OF FATHER

Peter Aalsen

11. BIRTHPLACE OF FATHER

(State or Country)

Norway

12. MAIDEN NAME OF MOTHER

Caroline Munson

13. BIRTHPLACE OF MOTHER

(State or Country)

Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Peter Sandness
Chateau, Mont.

(Address)

15.

Filed

Jan 15 1922

1922

P. R. Jones

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

January 10 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan. 10 1922 to Jan. 10 1922

that I last saw him alive on 6:30 1922

and that death occurred on the date stated above, at 6:30 PM

The CAUSE OF DEATH* was as follows:

Compound fracture of skull

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. T. Smith M. D.

1-14 1922 (Address) Wallace, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Wallace Idaho Jan 15 1922

20. UNDERTAKER

W. T. Smith Wallace

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Shoshone Registration District No. _____City of Mullan Primary Registration District No. _____St. Mullan

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Peter Pezzetti

File No. _____

Registered No. 2

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

single
(Write the word.)

6. DATE OF BIRTH

(Month) _____ (Day) _____ (Year) 1

7. AGE

40 Yrs. — Mos. — ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

miner

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Italy

10. NAME OF FATHER

not given

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Dr. Donahoe

(Address)

Wallace Idaho

15.

File

Jan 61922P. L. Lee

Local Registrar

MEDICAL CERTIFICATE OF DEATH

173

16. DATE OF DEATH

Jan322
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19____ to 19____

that I last saw him alive on 19____

and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Crushed to death by falling rock(Duration) Yrs. Instant ds.

Contributory (Secondary)

None

(Duration) yrs. mos. ds.

(Signed)

W. C. Mowbray Coroner1922 (Address) Wallace Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

Butte Montana

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Butte MontJan 6 1922

20. UNDERTAKER

ADDRESS

Hard Hard CoWallace Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Shoshone Registration District No. 70
City of Nalla Primary Registration District No. 104
(No. Wallace Hospital St.)

File No.

Registered No. 9

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Blanch Ruth Owens

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F.

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

single
(Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

3 Yrs. — Mos. — ds.IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

none

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

C. P. Owens

11. BIRTHPLACE OF FATHER

(State or Country)

Virginia

12. MAIDEN NAME OF MOTHER

Ella Mae Post

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

C. P. Owens

(Address)

Gen Idaho

15. FILED

Jan 14 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

164

16. DATE OF DEATH

January 12 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 11 1922, to Jan 12 1922that I last saw her alive on Jan 12 1922and that death occurred on the date stated above, at 1 A.M.

The CAUSE OF DEATH* was as follows:

Stroke(Duration) Yrs. mos. 2 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. T. Smith M. D.1/12/22 (Address) Wallace Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

Gen Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wallace IdahoJan 14 1922

20. UNDERTAKER

ADDRESS

Ward and CoWallace
Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

38215

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 70

County of Shoshone

Primary Registration District No. 121

City of Wallace

(No. of) Providence Hosp St.)

File No.

Registered No. 11

If death occurs away from usual residence, give facts called for under special information.

2. FULL STATEMENT OF FACTS

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

single

6. DATE OF BIRTH

January 18 1922
(Month) (Day) (Year)

7. AGE

still born

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

A. T. Smith

11. BIRTHPLACE OF FATHER

(State or Country) Tenn

12. MAIDEN NAME OF MOTHER

Mary O. Andrews

13. BIRTHPLACE OF MOTHER

(State or Country) Tenn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. T. Smith

(Address) 110 Elm St

15.

Filed Jan 20 191

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 18 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191., to 191.,

that I last saw her alive on Jan 18 1922

and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

congenital atelectasis of lungs

(Duration) yrs. mos. ds.

Contributory (Secondary) Premature birth

(Duration) yrs. mos. ds.

(Signed) Dr. Mowery M.D.

1/19 1922 (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wallace Idaho Jan 20 1922

20. UNDERTAKER

ADDRESS

Bruce B. Norstell Wallace

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

38216

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Shoshone*City of *Wallace*

If death occurs away from usual residence, give facts called for under special information.

Registration District No. *70*Primary Registration District No. *124*File No. *124*Registered No. *124*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

John Smith

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

*white*5. SINGLE, MARRIED, WID-
OWED OR DIVORCED*single*
(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

(Year)

7. AGE

54 Yrs.

Mos.

ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

miner

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Texas

10. NAME OF FATHER

not given

11. BIRTHPLACE OF FATHER

(State or Country)

not given

12. MAIDEN NAME OF MOTHER

not given

13. BIRTHPLACE OF MOTHER

(State or Country)

not given

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John Nordquist

(Address)

Wallace Idaho

15.

Filed

Jan 31 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 17 1922 to *Jan 20 1922*that I last saw him alive on *Jan 19 1922*and that death occurred on the date stated above, at *430 p*

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

James R Bran

M. D.

1/31 1922

(Address)

James R Bran

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

Where was disease contracted if not at place of death?

Former or usual residence

Wallace Idaho

19. PLACE OF BURIAL OR REMOVAL

Wallace Ida

DATE OF BURIAL

Feb 1 1922

20. UNDERTAKER

Hart and Co

ADDRESS

Wallace Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Shoshone Registration District No. 79
City of Wallace Registration District No. 184If death occurs away from
usual residence, give facts
called for under special in-
formation.File No. _____
Registered No. 14If death occurred in hos-
pital, institution or camp,
give its NAME instead of
street and number.

2. FULL NAME

Mary Mable Jutila

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDF. white single
(Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

IF LESS than 1 day
how many hrs.
or min.?19 Yrs. 7 Mos. — ds.

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)Student

9. BIRTHPLACE

(State or Country)

Idaho10. NAME OF
FATHERJohn Jutila11. BIRTHPLACE
OF FATHER

(State or Country)

Finland12. MAIDEN NAME
OF MOTHERAnnie Luoma13. BIRTHPLACE
OF MOTHER

(State or Country)

Finland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

John Jutila
Wallace Ida

15.

Filed

Feb 2 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from
Jan 1 1922 to Jan 29 1922that I last saw him alive on Jan 29 1922
and that death occurred on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH* was as follows:

Subacute pulmonary
ary & tubercular(Duration) several mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

1922

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
if not at place of death?Former or
usual residenceWallace Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wallace IdaFeb 10 1922

20. UNDERTAKER

ADDRESS

Hardy & Co Wallace
Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 70

County of

Primary Registration District No. 104

City of

Nalla

File No.

Registered No. 16

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lrene Elizabeth Connolly

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F.

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

single
(Write the word.)

6. DATE OF BIRTH

Nov

6

1921

(Month)

(Day)

(Year)

7. AGE

yrs. 3 mos. 7 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or

particular kind of work

(b) General nature of industry

business, or establishment in

which employed (or employer)

none

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Anna Sullivan

13. BIRTHPLACE OF MOTHER

(State or Country)

Colorado

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs J. Connolly

(Address)

Burke Idaho

15.

Filed

Feb 14-22, 1922 F. L. Jundt

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

92

16. DATE OF DEATH

July 13, 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 11, 1922 to July 13, 1922

that I last saw her alive on July 13, 1922

and that death occurred on the date stated above, at 3:15 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia, Lobar.
Rx.

(Duration) yrs. mos. ds.

Contributory (Secondary) exposure

(Duration) yrs. mos. ds.

(Signed) Dr. M. W. J. M. D.

7-14-22 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence. Burke Idaho

19. PLACE OF BURIAL OR REMOVAL

Wallace Idaho

DATE OF BURIAL

Feb. 15, 1922

20. UNDERTAKER

Hartford Co

ADDRESS

Wallace Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-19

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 70

County of Shoshone

Primary Registration District No. 104

City of Wallace

BUREAU OF WALLACE HOSPITAL ST.
STATISTICS

File No. 38220

Registered No. 17

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Bessie Thompson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F.

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

married
(Write the word.)

6. DATE OF BIRTH

Jan 12 1884
(Month) (Day) (Year)

7. AGE

38 yrs. 1 mos. 6 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

John Eva

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Catherine Boden

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

George Thompson

(Address)

1 Kellogg 2 Idaho

15.

Filed

Jan 21 1922

1922

J. S. Zim

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb 18 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Jan 27 1922, to Feb 18 1922
that I last saw her alive on Feb 17 1922

and that death occurred on the date stated above, at 6:30 A.M.

The CAUSE OF DEATH* was as follows:

Uremia

(Duration) yrs. mos. 4 hours ds.

Contributory (Secondary)

Chr. Nephritis

(Duration) yrs. 15 mos. ds.

2/10/1922 (Signed) James R. Bean M.D.
(Address) Wallace

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence... Kellogg 2 Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wallace Idaho

Feb 21 1922

20. UNDERTAKER

ADDRESS

Hart & Und Co

Wallace

2 day.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH *Threshone* Registration District No. *70*
County of *Threshone* Primary Registration District No. *109*
City of *Wallace* (No. *38222*) File No. *10*
If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME *Emil Takamen* Registered No. *10*
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *married*
(Write the word.)

6. DATE OF BIRTH *1879*
(Month) (Day) (Year)

7. AGE *43* yrs. — mos. — ds. IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work *miner*
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE *Finland*
(State or Country)

10. NAME OF FATHER *David Berg*

11. BIRTHPLACE OF FATHER *Finland*
(State or Country)

12. MAIDEN NAME OF MOTHER *not known*

13. BIRTHPLACE OF MOTHER *Finland*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mrs. Emil Takamen*
(Address) *Finland*

15. Filed *107* 191 *4 I Z...*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *Feb 25 1922*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Feb 10 1922* to *Feb 25 1922*
that I last saw him alive on *Feb 25 1922*
and that death occurred on the date stated above, at *8:00 AM*
The CAUSE OF DEATH* was as follows: *Pneumonia Bronchial*

(Duration) yrs. *several* ds.
Contributory (Secondary) *Influenza*
(Duration) yrs. *several* ds.
(Signed) *J. M. Norstall* M.D.
(Address) *Wallace, Idaho*
*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death... yrs. ... mos. ... days. In the State... yrs. ... mos. ... days.
Where was disease contracted if not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL *Mullan Id* DATE OF BURIAL *2/27 1922*
20. UNDERTAKER *J. M. Norstall* ADDRESS *Wallace*

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

RECEIVED
MAY 23 1922
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Shoshone
City of Burke

District No. 70

Primary Registration District No. Idaho
(No. Burke St.)

File No.

Registered No. 20

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Constance L. Board

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

single (Write the word.)

6. DATE OF BIRTH

July 7 1888
(Month) (Day) (Year)

7. AGE

33 yrs. 7 mos. 18 ds.

IF LESS than 1 day
how many hrs. or
..... mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

housewife

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

Geo H Harrington

11. BIRTHPLACE OF FATHER

(State or Country)

Missouri

12. MAIDEN NAME OF MOTHER

Cordelia Coates

13. BIRTHPLACE OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Royce L. Board
Burke

(Address)

15.

Filed May 4 1922 W. F. L. G. G.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 25 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 25 1922 to Feb 25 1922

that I last saw her alive on 25 1922

and that death occurred on the date stated above, at 12 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) yrs. mos. ds.

Contributory Cardiac failure
(Secondary) Compensated

(Duration) yrs. mos. ds.

(Signed) R. Chas. G. Drake M. D.

19. (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Worstell

DATE OF BURIAL

May 4 1922

20. UNDERTAKER

Worstell
M. C. L.

ADDRESS

Wallace St.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

RECEIVED

Registration District No.

70

County of

Shoshone

Primary Registration District No.

104

City of

Wallace

(No.)

Wallace

Hospital

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Charles Stroble

File No.

22

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married

(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

(Year)

7. AGE

56

yrs.

mos.

ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

miner

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

West Virginia

10. NAME OF FATHER

John Stroble

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

no information

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs Chas. Stroble

(Address)

Gene Idaho

15.

Filed

Mar 7 1922

1922

Ward & Co

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March

(Month)

(Day)

1922

17. I HEREBY CERTIFY, That I attended deceased from

February 24 1922 to

Mar 3 1922

1922

that I last saw him alive on

Mar 3 1922

1922

and that death occurred on the date stated above, at 11:30 PM.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) yrs. mos. ds.

Contributory (Secondary)

Tuberculosis

(Duration) yrs. mos. ds.

(Signed)

Ward T. J. M. D.

3-6-1922 (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence.

Gene Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wallace Ida

Mar 7 1922

20. UNDERTAKER

ADDRESS

Ward & Co

Wallace

Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 70

County of Shoshone

Primary Registration District No. 38226

City of Wallace

File No. 23

Registered No. 23

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Fugene Leslie Lamb

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

6. DATE OF BIRTH

Nov.

(Month)

(Day)

1874

(Year)

7. AGE

47 yrs. 4 mos. ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work

miner

(b) General nature of industry
business, or establishment in
which employed (or employer)

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

Henry Lamb

11. BIRTHPLACE OF FATHER

(State or Country)

Iowa

12. MAIDEN NAME OF MOTHER

Philura M. Brinkerhoff

13. BIRTHPLACE OF MOTHER

(State or Country)

New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Lane, Idaho.

15.

Filed

1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March

5

1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 2

1922

to March 5

1922

that I last saw him alive on March 5 1922

and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Influenza pneumonia

(Duration)

yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

James R. Bean

M. D.

3/6

(Address)

Wallace, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

.....yrs.....mos.....days.

In the

State

.....yrs.....mos.....days.

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wallace, Idaho

March 8, 1922

20. UNDERTAKER

ADDRESS

Blomquist

Wallace

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

RECEIVED CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 70

County of Shoshone

Primary Registration District No. 104

City of Mullan

(No. 104 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarah Fay

File No.

Registered No. 24

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

married (Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

39 yrs. — mos. — ds.

IF LESS than 1 day
how many hrs. or mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Colorado

10. NAME OF FATHER

R. J. McLeod

11. BIRTHPLACE OF FATHER

(State or Country)

Canada

12. MAIDEN NAME OF MOTHER

Sarah McFee

13. BIRTHPLACE OF MOTHER

(State or Country)

Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Belle Preston

(Address)

Spokane Wash

15.

Filed

March 8 1922

1922

G. H. Jumper

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March

6

1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from March 2 1922, to March 6 1922,

that I last saw her alive on March 6 1922

and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) yrs. mos. ds.

Contributory (Secondary)

Myocarditis

(Duration) yrs. mos. ds.

(Signed)

James E. Dean

M. D.

1922

(Address) Wallace Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

Mullan Ida.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Spokane Wash

Mar 8 1922

20. UNDERTAKER

ADDRESS

Ward and Co

Wallace Ida

Form V. S. No. 7 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH *Shoshone* Registry District No. *70*
 County of *Shoshone* Primary Registration District No. *104*
 City of *Wallace* (No. *3rd & Elm* St.)
 If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME *Martha F Hackett*
 Registered No. *38228*
 File No. *64*
 If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. *Widowed*
 (Write the word.)

6. DATE OF BIRTH *Dec 9 1849*
 (Month) (Day) (Year)

7. AGE *72 yrs. 3 mos. 0 ds.* IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION *housewife*
 (a) Trade, profession or particular kind of work
 (b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE *Kentucky*
 (State or Country)

10. NAME OF FATHER *Robt Hackett*

11. BIRTHPLACE OF FATHER *Kentucky*
 (State or Country)

12. MAIDEN NAME OF MOTHER *Nancy M. Cornick*

13. BIRTHPLACE OF MOTHER *Kentucky*
 (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *M. F. Hackett*
 (Address) *606 E 77th St Seattle*

15. Filed *March 11 1922*
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *March 9 1922*
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *March 6 1922* to *March 9 1922*
 that I last saw *her* alive on *March 9 1922*
 and that death occurred on the date stated above, at *M.*

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) *3* yrs. *0* mos. *0* ds.
 Contributory *Atherosclerosis*
 (Secondary)

(Duration) *3-11* yrs. *0* mos. *0* ds.
 (Signed) *Wm T. Smith* M. D.
 (Address) *Wallace, Idaho.*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death *3* yrs. *0* mos. *0* days. In the State *3* yrs. *0* mos. *0* days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL *Seattle* DATE OF BURIAL *March 11, 1922*

20. UNDERTAKER *B. G. Morstall* ADDRESS *Wallace*

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-12-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Shoshone Registration District No. 70

38229

County of Shoshone, Idaho Registration District No. 10

File No.

City of Wallace (No. 10)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Joseph Matt

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OF RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

single (Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

65

yrs. mos. ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

miner

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

Javier Matt

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Mary Matt

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Andrew Matt

(Address)

15.

File

Mar 16 1922 J. L. G. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar

12

1922

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar 7 1922 to Mar 12 1922

that I last saw him alive on Mar 12 1922

and that death occurred on the date stated above, at 8:30 P.M.

The CAUSE OF DEATH* was as follows:

Myocarditis Chronic

(Duration) Several mos. ds.

Contributory (Secondary)

Influenza & Asthma

(Duration) yrs. ds.

(Signed)

J. L. G.

(Address) Wallace

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Wallace Id

DATE OF BURIAL

3-15-22

20. UNDERTAKER

W. H. H. H.

ADDRESS

Wallace

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

RECEIVED CERTIFICATE OF DEATH

38230

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.

County of

Primary Registration District No.

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs. or
..... mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

File

1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

(Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death. yrs. mos. days.

In the

State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

RECEIVED CERTIFICATE OF DEATH

38231

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 70

County of Shoshone

Bureau of Vital Statistics Registration District No. 1011

File No.

City of Wallace

314 Oliver Street St.)

Registered No. 229

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Melaine Sherman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

..... 1.
(Month) (Day) (Year)

7. AGE

53 yrs. mos. ds.

IF LESS than 1 day
how many hrs. or
..... mins.)

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Cook.

9. BIRTHPLACE

(State or Country)

California

10. NAME OF FATHER

Fredrick Sherman

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Mary Long

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Jack Johneatory
Burke Idaho

15.

Filed

Mar 18 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Mar

16

22

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

..... 191....., to 191.....,

that I last saw him alive on 191.....,

and that death occurred on the date stated above, at 4:07 P.

The CAUSE OF DEATH* was as follows:

Gunshot wound of chest

(Duration)

yrs. mos. ds.

Contributory (Secondary)

None

(Duration)

yrs. mos. ds.

(Signed)

3/17 1922

(Address)

Wallace Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence.....Wallace Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wallace Idaho Mar 18 1922

20. UNDERTAKER

ADDRESS

Ward and Co Wallace Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-22

RECEIVED

CERTIFICATE OF DEATH

MAY 23 1922

38232

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH *Shoshone*
County of *Shoshone* Registration District No. *70*
City of *Wallace* (No. *Osborn* St.)
If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME *David Cromie*

File No.

Registered No. *39*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *widowed*
(Write the word.)

6. DATE OF BIRTH
(Month) (Day) (Year)

7. AGE *75* yrs. mos. ds.
IF LESS than 1 day
how many hrs. or
.... mins.?

8. OCCUPATION *Miner*
(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE *Ireland*
(State or Country)

10. NAME OF FATHER *John Cromie*

11. BIRTHPLACE OF FATHER *Ireland*
(State or Country)

12. MAIDEN NAME OF MOTHER *Agnes Gribben*

13. BIRTHPLACE OF MOTHER *Ireland*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *John Cromie*
(Address) *Osborn Ida*

15. *Filed May 22 on FLO*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *May 20 1922*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *1921* to *May 20 1922*
that I last saw him alive on *May 1 1922*
and that death occurred on the date stated above, at *3:30 P.M.*
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(Duration) yrs. mos. ds.
Contributory (Secondary) *Arteriosclerosis*
(Duration) yrs. mos. ds.
(Signed) *Dr. J. W. Wallace*
3/20 1922 (Address) *Wallace Ida*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.
Where was disease contracted if not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL *Wallace Ida* DATE OF BURIAL *3-22-1912*

20. UNDERTAKER *W. W. Warrick* ADDRESS *Wallace*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH **RECEIVED**

Registration District No. 70

38233

County of *Shoshone*

Primary Registration District No. 101

City of *Wallace*(No. *Providence Hospital*)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

George M. Turner

File No.

Registered No. 32

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

*white*5. SINGLE, MARRIED, WID-
OWED OR DIVORCED
married
(Write the word.)

6. DATE OF BIRTH

March 9 1852
(Month) (Day) (Year)

7. AGE

*70 yrs. — mos. 17 ds.*IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of industry
business, or establishment in
which employed (or employer)*Farmer*

9. BIRTHPLACE

(State or Country)

*Iowa*10. NAME OF
FATHER*William Turner*11. BIRTHPLACE
OF FATHER

(State or Country)

*New York*12. MAIDEN NAME
OF MOTHER*Rachel Lee*13. BIRTHPLACE
OF MOTHER

(State or Country)

Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mrs. George Turner*(Address) *Superior Montana*

15.

Filed *Mar 27 1922*

Local Registrar

MEDICAL CERTIFICATE OF DEATH. *qv*

16. DATE OF DEATH

May 26 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
MAY 2 1922 to *MAY 26 1922*
that I last saw him alive on *MAY 26 1922*and that death occurred on the date stated above, at *9 A.M.*

The CAUSE OF DEATH* was as follows:

*Influenza, lobar
pneumonia, both*(Duration) yrs. *3* ds.Contributory
(Secondary) *Influenza*(Duration) yrs. *3* mos. *3* ds.(Signed) *Dr. M. A. Thompson*(Address) *Wallace*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence... *Superior Montana*

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Superior Montana *Mar 28 1922*

20. UNDERTAKER ADDRESS

Hard Und Co *Wallace**Idaho*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

38234 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of *Shoshone*

City of *Mallice*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No. *70*

Primary Registration District No. *1911*

Phoenix Meadhafe

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

M.

white

single
(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

(Year)

7. AGE

56 yrs.

mos.

ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

mines

9. BIRTHPLACE

(State or Country)

Penn.

10. NAME OF FATHER

no Information

11. BIRTHPLACE OF FATHER

(State or Country)

no Information

12. MAIDEN NAME OF MOTHER

no Information

13. BIRTHPLACE OF MOTHER

(State or Country)

no Information

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

*County Infirmary
Brig. Washburn
Mallice Idaho*

15.

Filed

191

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March

27

1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from *March 10 1922* to *March 27 1922*

that I last saw him alive on *March 27 1922*

and that death occurred on the date stated above, at *11:30 A.M.*

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) *1* yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

James R. Brant M. D.

3/19/22 (Address) *Wallace*

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days.

In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence.

Panasack mine

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wallace Ida

Apr 1 1922

20. UNDERTAKER

ADDRESS

Ward Hud Co

Wallace Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 70

County of Shoshone

Primary Registration District No. 1011

City of Wallace

(No. Providence Hospital)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Sam Maki

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED
married
(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

(Year)

7. AGE

38 yrs. — mos. — ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

miner

9. BIRTHPLACE

(State or Country)

Finland

10. NAME OF FATHER

Sam Maki

11. BIRTHPLACE OF FATHER

(State or Country)

Finland

12. MAIDEN NAME OF MOTHER

Rosa Maki

13. BIRTHPLACE OF MOTHER

(State or Country)

Finland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Mrs Sam Maki
Burke Idaho

15.

Filed

Mar 31 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 29 1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 27 1922 to Mar 29 1922

that I last saw him alive on Mar 29 1922

and that death occurred on the date stated above, at 8:30

The CAUSE OF DEATH* was as follows:

Pneumonia
Double

(Duration)

yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

Dr. M. H. M. H.

3/21/1922 (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days.

In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence....Burke Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wallace Ida

April 11 1922

20. UNDERTAKER

ADDRESS

Hart and Co

Wallace

Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12		RECEIVED MAY 23 1922		CERTIFICATE OF DEATH		State of Idaho BOARD OF HEALTH Bureau of Vital Statistics	
1. PLACE OF DEATH		Registration District No. 70		38236		File No.	
County of <u>Shoshone</u>		Primary Registration District No. 1011		38236		Registered No. 35	
City of <u>Wallace</u> (No. <u>Wallace Hospital</u> St. <u>7</u>)		2. FULL NAME <u>Smith Jackson Robertson</u>		If death occurred in a hospital, institution or camp, give its NAME instead of street and number.			
PERSONAL AND STATISTICAL PARTICULARS				MEDICAL CERTIFICATE OF DEATH. 24			
3. SEX <u>Male</u>		4. COLOR OR RACE <u>White</u>		16. DATE OF DEATH <u>March 31st 1922</u> (Month) (Day) (Year)			
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. <u>Single</u> (Write the word.)		6. DATE OF BIRTH <u>March 31 1922</u> (Month) (Day) (Year)		17. I HEREBY CERTIFY, That I attended deceased from <u>March 4 1912</u> to <u>March 31 1922</u> that I last saw him alive on <u>March 31st 1922</u> and that death occurred on the date stated above, at <u>5 A.M.</u>			
7. AGE <u>58</u> yrs. mos. ds.		IF LESS than 1 day how many hrs. or mins.?		The CAUSE OF DEATH* was as follows: <u>Pulmonary Tuberculosis</u>			
8. OCCUPATION (a) Trade, profession or particular kind of work <u>Miner</u> (b) General nature of industry, business, or establishment in which employed (or employer)		9. BIRTHPLACE (State or Country) <u>Missouri</u>		(Duration) <u>3</u> yrs. mos. ds.			
10. NAME OF FATHER <u>John Hopkins</u>		11. BIRTHPLACE OF FATHER <u>Missouri</u> (State or Country)		Contributory (Secondary)			
12. MAIDEN NAME OF MOTHER <u>Mary Barlow Rhine</u>		13. BIRTHPLACE OF MOTHER <u>Missouri</u> (State or Country)		(Duration) yrs. mos. ds.			
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Wallace Hospital</u> (Address) <u>Wallace, Idaho</u>		15. <u>Apr 1 1922</u> Filed <u>1012</u> Local Registrar		(Signed) <u>Max T. Smith</u> M. D. #1/25 19 (Address) <u>Wallace Ida</u>			
				*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.			
				18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) At place of death yrs. mos. days. In the State yrs. mos. days. Where was disease contracted if not at place of death?			
				Former or usual residence <u>Burke Idaho</u>			
				19. PLACE OF BURIAL OR REMOVAL <u>Wallace Idaho</u> DATE OF BURIAL <u>Apr. 3rd 1922</u>			
				20. UNDERTAKER <u>Hard Und Co</u> ADDRESS <u>Wallace Ida</u>			

1. PLACE OF DEATH **RECEIVED** **CERTIFICATE OF DEATH** **90**
 County of Shoshone **MAILED** **125**
 City of Nalla **STATISTICAL** **Primary Registration District No. 1011** **38237** **File No. 36**
 If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Agnes Harry If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F. 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
 (Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

36 Yrs. — Mos. — ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

As Stoner

9. BIRTHPLACE

(State or Country) New Mexico

10. NAME OF FATHER

Jas. P. Blaine

11. BIRTHPLACE OF FATHER

(State or Country) New York

12. MAIDEN NAME OF MOTHER

Jennie Cox

13. BIRTHPLACE OF MOTHER

(State or Country) Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

H. L. Moore

(Address)

Spokane Wash.

15. Filed

Apr 9 1922 J. L. J. J.
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 6 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 13 1922 to April 6 1922
 that I last saw him alive on April 5 1922
 and that death occurred on the date stated above, at 2:50 M.

The CAUSE OF DEATH* was as follows:

Pyemia

(Duration) Yrs. mos. 12 ds.

Contributory (Secondary)

Influenzal pneumonia

(Duration) yrs. mos. 12 ds.

(Signed)

James R. Bean M. D.

(Address)

Wallace

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

Mullan 2da

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mullan 2da Apr 9 1922

20. UNDERTAKER

ADDRESS

Ward Muel Co Wallace
2da

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Shoshone
City of WallaceRegistration District No. 70Primary Registration District No. 1011(No. 38238)File No. 37Registered No. 37

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Anna Nordquist

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F.

4. COLOR OR RACE

white5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDMarried
(Write the word.)

6. DATE OF BIRTH

March 23rd 1860
(Month) (Day) (Year)

7. AGE

62 Yrs. — 16 Mos. 16 ds.

IF LESS than 1 day

how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

As Steward

9. BIRTHPLACE

(State or Country)

Sunder

10. NAME OF FATHER

John Johnson

11. BIRTHPLACE OF FATHER

(State or Country)

Sunder

12. MAIDEN NAME OF MOTHER

No Information

13. BIRTHPLACE OF MOTHER

(State or Country)

Sunder

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mr. H. A. Belding

(Address)

Prescott Ariz.

15. Filed

Apr 14 1922F. L. Juntz

Local Registrar

MEDICAL CERTIFICATE OF DEATH

40

16. DATE OF DEATH

Apr 8 1922
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from Mar 1 1922 to Apr 8 1922that I last saw him alive on Apr 8 1922 and that death occurred on the date stated above, at 12:45 P.M.

The CAUSE OF DEATH* was as follows:

Californian of Court
Wallace(Duration) several yrs. 16 mos. 16 ds.

Contributory (Secondary)

(Duration) several yrs. 16 mos. 16 ds.

(Signed)

Dr. M. J. Belding
Wallace

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

Wallace Idaho

19. PLACE OF BURIAL OR REMOVAL

Wallace Ida

DATE OF BURIAL

Apr 14 1922

20. UNDERTAKER

Nordquist Co

ADDRESS

Wallace
Idaho

CERTIFICATE OF DEATH

38239
State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Boise*City of *Eagle*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No. *70*Primary Registration District No. *104*(No. *Eagle Idaho* St.)File No. *38*Registered No. *38*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widowed
(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

(Year)

7. AGE

77

Yrs.

Mos.

ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

miner

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

New York

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

unknown

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed *apr 21* 19 *22*

Local Registrar

16. DATE OF DEATH

Apr 14

(Month)

(Day)

19 *22* (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19..... to 19.....

that I last saw him (alive) on 19.....

and that death occurred on the date stated above.

The CAUSE OF DEATH* was as follows:

Heart failure

(Duration)

Yrs.

Mos.

ds.

Contributory
(Secondary)

(Duration)

Yrs.

Mos.

ds.

(Signed)

19 *22*

(Address)

Wallace Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

Yrs.

Mos.

Days.

In the

State

Yrs.

Mos.

Days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wallace Idaho 4-21-22

20. UNDERTAKER

ADDRESS

W. S. Moretall Wallace

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Shoshone Registration District No. 70City of Wallace Registration District No. 104 St. Wallace HospitalFile No. 38240Registered No. 39

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Laurence N. Pudas

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male white

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

October 18 1871
(Month) (Day) (Year)

7. AGE

50 Yrs. 4 Mos. 24 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Mine

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Sweden

10. NAME OF FATHER

Lease Pudas

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME OF MOTHER

Annis Pudas

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wallace Hospital
(Address) Wallace, Idaho

15.

Filed Apr 25 1922 J L J

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH.

April 24 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 6 1922 to April 24 1922
that I last saw him alive on April 24 1922
and that death occurred on the date stated above, at 4 A. M.

The CAUSE OF DEATH* was as follows:

Pneumonia Tuberculosis

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. T. J. J. M. D.
4-5 1922 (Address) Wallace, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Butte, Mont. 4-15 1922

20. UNDERTAKER

B. Morrell Wallace

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. _____
Registered No. 4

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Shoshone
City of Wallace

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Julia C Roy

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

married
(Write the word.)

6. DATE OF BIRTH

June 1st 1875
(Month) (Day) (Year)

7. AGE

46 Yrs. 10 Mos. 22 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Housewife

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

New York

10. NAME OF FATHER

Fred Keiser

11. BIRTHPLACE OF FATHER

(State or Country)

Not Known

12. MAIDEN NAME OF MOTHER

Henrietta Keiser

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

6 Roy
Wallace Id

15.

Filed

april 25 1922J L Jumper
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 23 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 19 1922, to April 23 1922
that I last saw her alive on Apr 23 1922
and that death occurred on the date stated above, at 49 M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage(Duration) Yrs. mos. 1 ds.Contributory Arteriosclerosis
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Wm T. Jumper M. D.4/25 1922 (Address) Wallace Id

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Spokane Wn4/25 1922

20. UNDERTAKER

ADDRESS

BS MartellWallace

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

38242

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Teton*City of *Grange*

If death occurs away from usual residence, give facts called for under special information.

RECEIVED

JUN 5 1922

BUREAU OF VITAL STATISTICS

Registration District No. *77*Primary Registration District No. *2176*

File No. _____

Registered No. *8*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Fredrick S. Reichert

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

169

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WID-OWED OR DIVORCED

Single (Write the word.)

6. DATE OF BIRTH

March 18
(Month) (Day) (Year)

7. AGE

2 Yrs. *2* Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).*Infant*

9. BIRTHPLACE

(State or Country)

Washington

10. NAME OF FATHER

Karl A. Reichert

11. BIRTHPLACE OF FATHER

(State or Country)

Washington

12. MAIDEN NAME OF MOTHER

Gertrude Barmann

13. BIRTHPLACE OF MOTHER

(State or Country)

Washington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wm. H. Evans

(Address)

Grange, Id.

15.

Filed *May 20 - 1922**Martha Marker*
Local Registrar

16. DATE OF DEATH

May 18
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 18 1922 to *May 18 1922*that I last saw him alive on *May 18 1922*and that death occurred on the date stated above, at *7:15* M.

The CAUSE OF DEATH* was as follows:

Strained, Crown

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *Chas. Martin* M. D.(Address) *Grange, Id.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Idaho Coal mine.

DATE OF BURIAL

5/19 1922

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

38243 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Leton
City of Driggs

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
JUN 5 1922
BUREAU OF VITAL STATISTICSRegistration District No. 77Primary Registration District No. 2176

File No.

Registered No. 7

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Mary Ann Eddington

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female white

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDwidow
(Write the word.)

6. DATE OF BIRTH

August 24 1847
(Month) (Day) (Year)

7. AGE

74 Yrs. 8 Mos. 20 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)at home

9. BIRTHPLACE

(State or Country) England

10. NAME OF FATHER

Joseph Littlefield

11. BIRTHPLACE OF FATHER

(State or Country) England

12. MAIDEN NAME OF MOTHER

Mary Ann Toomer

13. BIRTHPLACE OF MOTHER

(State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mary Eddington

(Address)

Driggs Idaho

15.

Filed 5/16/ 1922 Mrs. Martha Marker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

120

16. DATE OF DEATH

May 14 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 1 1920, to May 14 1922
that I last saw her alive on May 14 1922
and that death occurred on the date stated above, at 10:10 P.

The CAUSE OF DEATH was as follows:

Chronic Interstitial Nephritis

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Chas J. Martin M. D.(Address) Driggs, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place 28 yrs. 0 mos. 0 days. In the 28 yrs. 0 mos. 0 days. State

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Salt Lake, Utah, May 18 1922

20. UNDERTAKER

409

ADDRESS

John Phillips Perburg, Ida.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Letow Registration District No. 77
City of Letow Primary Registration District No. 2176
St. Idaho

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Carline RammellFile No. 38244
Registered No. 7

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Widow
(Write the word.)

6. DATE OF BIRTH

August 21 1922
(Month) (Day) (Year)

7. AGE

75 Yrs. 9 Mos. 7 ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Housekeeper
"

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

Frederick Burger

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

do not know

13. BIRTHPLACE OF MOTHER

(State or Country)

do not know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

P. J. Rammell
Letow, Idaho

(Address)

15.

Filed June 1st 1922 Martha Markes
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 24 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 21 1922, to May 24 1922
that I last saw her alive on May 24 1922
and that death occurred on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia complicated by
acute endocarditis

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas. Martin M. D.(Address) Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Letow, Ida. 5/26/ 1922

20. UNDERTAKER

ADDRESS

Ed. King Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

38245

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Idaho*

City of *Idaho*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Emil Johnson

RECEIVED
JUN 2 1922
BUREAU OF VITAL STATISTICS

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH.

Jan 31 1908
(Month) (Day) (Year)

7. AGE

14 Yrs. *3* Mos. *11* ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

School Student

9. BIRTHPLACE

(State or Country)

Minnesota

10. NAME OF FATHER

Eloing Johnson

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME OF MOTHER

Emma H. Johnson

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Emma H. Johnson

(Address)

Idaho

15.

Filed

May 10 1922

A. A. Newberry

Local Registrar.

38
2086

St.)

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 8 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 2 1922 to *May 8 1922*
that I last saw him alive on *May 8 1922*
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Gangrenous Appendicitis.
(Duration) Yrs. mos. *8* ds.

Contributory (Secondary)

Peritonitis

(Signed) Yrs. mos. ds.

(Address) M. D.

May 9 1922 (Address) *Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days, State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Idaho Cemetery
SE Corner

DATE OF BURIAL

May 10 1922

20. UNDERTAKER

ADDRESS

Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Butte Registration District No. 2-087City of Butte (St.)File No. 38246Registered No. 39

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Eugene

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single (Write word.)

6. DATE OF BIRTH

Feb 18 1920
(Month) (Day) (Year)

7. AGE

2 Yrs. 2 Mos. 12 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Butte

10. NAME OF FATHER

Chas Mc Kelly

11. BIRTHPLACE OF FATHER

(State or Country) Minn

12. MAIDEN NAME OF MOTHER

Iva Hart

13. BIRTHPLACE OF MOTHER

(State or Country) Minn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dr. J. B. Bate(Address) Butte, Idaho

15.

Filed May 1 1922Local Registrar J. H. Murphy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 30 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

4/27 1922 to 4/30 1922that I last saw him alive on 4/29 1922and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Scarlet Fever(Duration) Yrs. mos. 4 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) W. H. B. Bate M. D.4/30 1922 (Address) Butte, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Butte Cemetery

DATE OF BURIAL

5/2 1922

20. UNDERTAKER

Howells & Rugg

ADDRESS

Butte, Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Lincoln* Registration District No. *39*
City of *Buhl* Primary Registration District No. *2087*
St. *Buhl*

38247

File No. _____
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Abner Fox

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *married*
(Write the word.)

6. DATE OF BIRTH

March 16 1855
(Month) (Day) (Year)

7. AGE

67 Yrs. *1* Mos. *18* ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)*Retired*

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

Wm Scott Fox

11. BIRTHPLACE OF FATHER

(State or Country)

Virginia

12. MAIDEN NAME OF MOTHER

Melissa Hickory

13. BIRTHPLACE OF MOTHER

(State or Country)

Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs J. A. Fox

(Address)

Buhl Ida

15.

Filed *May 5 1922*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

40

16. DATE OF DEATH

May 4 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *3-8 1922* to *May 4 1922*that I last saw him alive on *May 4 1922*and that death occurred on the date stated above, at *5 P. M.*

The CAUSE OF DEATH* was as follows:

Cancer of the Liver

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *H. J. Jennings* M. D.*5-4 1922* (Address) *Buhl, Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Buhl Ida

DATE OF BURIAL

5/5 1922

20. UNDERTAKER

L. J. Johnson

ADDRESS

Buhl Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Idaho* Registration District No. *39*
City of *Buhl* Primary Registration District No. *2087* St. *38248*

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Eileen May Warner

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

Sept 1 1921
(Month) (Day) (Year)

7. AGE

8 Yrs. *4* Mos. *4* ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Buhl

10. NAME OF FATHER

H. Warner

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Beatrice Mary Allen

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

H. Warner

(Address)

Buhl Ida

15.

Filed *5-5* 19*22*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 5 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 20 1922 to *May 5 1922*that I last saw *her* alive on *May 4 1922*and that death occurred on the date stated above, at *7:30 PM*

The CAUSE OF DEATH* was as follows:

Enteric Colitis

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *J. H. Murphy* M. D.*5-5 1922* (Address) *Buhl Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Buhl Ida

DATE OF BURIAL

5/6 1922

20. UNDERTAKER

L. Johnson

ADDRESS

Buhl Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

38249

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Swain
City of BuhlRegistration District No. 39Registration District No. 2087

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

W. G. Carson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

Oct (Month) 1836 (Year)

7. AGE

85 Yrs. 7 Mos. X ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Farmer

9. BIRTHPLACE

(State or Country)

Va.

10. NAME OF FATHER

Andy Carson

11. BIRTHPLACE OF FATHER

(State or Country)

Not known

12. MAIDEN NAME OF MOTHER

Not known

13. BIRTHPLACE OF MOTHER

(State or Country)

Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Paul C Carson
Buhl Idaho

15.

Filed 5-6 1922J. H. Murphy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

5-5-22
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from 3-1-1922 to 5-5-1922that I last saw him alive on 5-5-1922and that death occurred on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Geo. Jennings M. D.5-5-1922 (Address) Buhl, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Galax Va. 1922

20. UNDERTAKER

ADDRESS

Newville & Sons
Buhl Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Blaine Registration District No. 39
City of Buhl Primary Registration District No. 38250
St. Idaho

File No. _____
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Raymond Brewer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-OWED OR DIVORCED Single

6. DATE OF BIRTH

Feb 16 1922
(Month) (Day) (Year)

7. AGE

2 Yrs. 19 Mos. 19 ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

C. A. Brewer

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Lottie McCaffins

13. BIRTHPLACE OF MOTHER

(State or Country)

Wash

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

P. M. Wilton
Buhl Idaho

15.

Filed May 6 1922

J. H. Murphy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

104

16. DATE OF DEATH

May 5 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5/5 1922 to 5/5 1922
that I last saw him alive on 5/5 1922
and that death occurred on the date stated above, at 3 P. M.
The CAUSE OF DEATH* was as follows:
Acute Illness

(Duration) _____ Yrs. _____ mos. 2 ds.

Contributory
(Secondary)

(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed)

A. F. Melchior M. D.
5/5 1922 (Address) Buhl Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Buhl Cemetery 5/7 1922
20. UNDERTAKER McEvilly & Huff ADDRESS Buhl Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

RECEIVED

JUN 7 CERTIFICATE OF DEATH

38251

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of *Lewin Falls* Registration District No. *39*
City of *Buhl* (No. *2087* St.)

File No. _____
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *F* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*
(Write the word.)

6. DATE OF BIRTH *May 6 1922*
(Month) (Day) (Year)

7. AGE _____
IF LESS than 1 day how many _____ hrs. or _____ mins.
_____ yrs. _____ mos. _____ ds.

8. OCCUPATION
(a) Trade, profession or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9. BIRTHPLACE *Buhl Ida RD #1*
(State or Country)

10. NAME OF FATHER *L M Hayden*

11. BIRTHPLACE OF FATHER *Idaho*
(State or Country)

12. MAIDEN NAME OF MOTHER *Chas Jackson*

13. BIRTHPLACE OF MOTHER *Idaho*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *L M Hayden*

(Address) *Buhl Ida RD #1*

15. _____

Filed *May 6 1922* *J. H. Hengley*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *May 6 1922*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *5/6 1922* to *5/6 1922*, that I last saw her alive on *5/6 1922* and that death occurred on the date stated above, at *8 AM*

The CAUSE OF DEATH* was as follows:

Spontaneous Birth
Mother has influenza
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory *Mother's Influenza*
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) *J. H. Hengley* D.

5/6 1922 (Address) *Buhl Ida*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Buhl Ida *May 7 1922*

20. UNDERTAKER ADDRESS

Hengley

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Trinity Falls* Registration District No. *39 38252*
City of *Buhl* Primary Registration District No. *2087*
(No. St.)File No.
Registered No.If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

*Pyithia Haskell*If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

64

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED*Female**white**Widowed*
(Write the word.)

6. DATE OF BIRTH

Sept
(Month)*16*
(Day)*1844*
(Year)

7. AGE

77 Yrs.*8* Mos.*2* ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work(b) General nature of in-
dustry, business or estab-
lishment in which employ-
(or employer).*Retired*

9. BIRTHPLACE

(State or Country)

*Pennsylvania*10. NAME OF
FATHER*Henry Harrison Hall*11. BIRTHPLACE
OF FATHER

(State or Country)

*Don't know*12. MAIDEN NAME
OF MOTHER*Emily Whitehill*13. BIRTHPLACE
OF MOTHER

(State or Country)

Don't know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs E. Goaly

(Address)

Buhl, Idaho

15.

Filed

5-16-1922

Local Registrar

16. DATE OF DEATH

May
(Month)*16*
(Day)*1922*
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 16 1922, to *19*that I last saw him alive on *19*and that death occurred on the date stated above, at *12:20 P.M.*

The CAUSE OF DEATH was as follows:

apoplexy

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. H. Murphy

M. D.

5-16-1922

(Address)

*Buhl, Ida**State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Reynolds, Ill.**19*

20. UNDERTAKER

ADDRESS

*L. Johnson**Buhl, Ida*

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

38254

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Twin Falls*
City of *Twin Falls*Registration District No. *36*Primary Registration District No. *MA 23*(No. *36* St.)File No. *5*Registered No. *5*If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

*Apal Sartwell*If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED*he* *white* *Single*
(Write the word.)

6. DATE OF BIRTH

March 2
(Month) (Day) (Year)

7. AGE

16 Yrs. *1* Mos. *27* ds.
IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)*School Girl*

9. BIRTHPLACE

(State or Country) *MO*10. NAME OF
FATHER*adlak Sartwell*11. BIRTHPLACE
OF FATHER(State or Country) *ark*12. MAIDEN NAME
OF MOTHER*Emma A. Sartwell*13. BIRTHPLACE
OF MOTHER(State or Country) *MO*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mrs Emma Sartwell*
(Address) *Kimberly, Idaho.*

15.

Filed *April 30* 19 *22* *J. M. Davis*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 28 19 *22*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 28 19 *22* to *April 29* 19 *22*
that I last saw her alive on *April 29* 19 *22*
and that death occurred on the date stated above, at *9* P.M.

The CAUSE OF DEATH* was as follows:

fracture of skull
Cerebral Hemorrhage

(Duration) Yrs. mos. ds.

Contributory (Secondary) *fracture of skull*
and accident

(Duration) Yrs. mos. ds.

(Signed) *J. M. Davis* M. D.*4-30* 19 *22* (Address) *Kimberly**State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Twin Falls

DATE OF BURIAL

May 1, 1922

20. UNDERTAKER

J. E. Roberts

ADDRESS

*Twin Falls*WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Jun Falls*

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No.

Primary Registration District No.

St.)

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed *May 1* 19 *22*

Local Registrar

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

38255

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 30 19 *20*
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *April 22 1922* to *Apr 30 1922*
that I last saw him alive on *Apr 30 1922*
and that death occurred on the date stated above, at *11* A.M.

The CAUSE OF DEATH* was as follows:

*Septic Embolism
in Brain*
(Duration) Yrs. mos. ds.Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

5-1 1922 (address) *Kimberly Id.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Jun Falls Id. *1st 1922*

20. UNDERTAKER

ADDRESS

J. E. Devil *T. F.*

CERTIFICATE OF DEATH

38256

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Twin Falls*
City of *Artistic City*

Registration District No.

Primary Registration District No.

(No.)

St.)

File No.

Registered No. *4*If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

*Mrs Mary Harroth*If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

*White*5. SINGLE, MARRIED, WID-
OWED OR DIVORCED*Widowed*
(Write the word.)

6. DATE OF BIRTH

Sept
(Month)*9*
(Day)*1897*
(Year)

7. AGE

74 Yrs.*6* Mos.*20* ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)*Retired*

9. BIRTHPLACE

(State or Country)

*Ind*10. NAME OF
FATHER*Geo Balin*11. BIRTHPLACE
OF FATHER

(State or Country)

*Ky.*12. MAIDEN NAME
OF MOTHER*Mary Woods*13. BIRTHPLACE
OF MOTHER

(State or Country)

Ky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

V. G. Swanson

(Address)

Murdough, Ida

15.

Filed

Apr 30 1922

Local Registrar

J. M. Davis

MEDICAL CERTIFICATE OF DEATH

118

16. DATE OF DEATH

Apr
(Month)*29*
(Day)*1922*
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 13 1922 to *April 29 1922*that I last saw him alive on *April 28 1922*

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

*Hemorrhage into
lungs.*(Duration)..... Yrs..... mos. *4* ds.Contributory (Secondary) *Chronic organic heart disease*(Duration) *Chronic nephritis*..... mos..... ds.(Signed) *J. M. Davis* M. D.*4/30/22* (Address) *Kimberly, Ida**State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Artistic City Ida

DATE OF BURIAL

May 3 1922

20. UNDERTAKER

P. J. Grossman Co

ADDRESS

Twin Falls Ida

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Twin Falls*Registration District No. *37*

38257

City of

(No. *1013*)

(St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Thomas Childer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

M

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

married
(Write the word.)

6. DATE OF BIRTH

July 21
(Month) (Day) (Year)

7. AGE

67 Yrs. *8* Mos. *11* ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).*School teacher*

9. BIRTHPLACE

(State or Country)

MO

10. NAME OF FATHER

Thomas Childer

11. BIRTHPLACE OF FATHER

(State or Country)

not known

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. M. Childer

(Address)

238 - 3 - East

15.

Filed

May 7 - 1922

Local Registrar

16. DATE OF DEATH

May
(Month)*4*
(Day)*1922*
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 1920 to *May 4* 1922.
that I last saw him alive on *May 3* 1922
and that death occurred on the date stated above, at *6:15 AM*.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(Duration) Yrs. mos. ds.

Contributory
(Secondary)*Arterio Sclerosis*

(Duration) Yrs. mos. ds.

(Signed)

Joseph Segal

M. D.

May 1922 (Address) *Twin Falls, Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Mullan are**19*

20. UNDERTAKER

ADDRESS

*J. E. De Witt**Twin Falls*

FORM V. S. No. 5-A—25 M. 1-19.

1. PLACE OF DEATH

County of *Twin Falls*

City of " " (No. " " St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No. *37*Primary Registration District No. *1085*State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *38258*

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

*white*5. SINGLE, MARRIED, WID-
OWED OR DIVORCED*married*

(Write the word.)

6. DATE OF BIRTH

February 2nd 1964
(Month) (Day) (Year)

7. AGE

58 Yrs. *2* Mos. *26* ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).*Building Contractor*

9. BIRTHPLACE

(State or Country)

Kentucky

10. NAME OF FATHER

Milton Lansberry

11. BIRTHPLACE OF FATHER

(State or Country)

Kentucky

12. MAIDEN NAME OF MOTHER

Eliza Jane Gravenor

13. BIRTHPLACE OF MOTHER

(State or Country)

Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Alice Shiffer

(Address)

Kimberly Idaho

15.

Filed

May 7 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 28 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19*19*, to *4/28* 19*22*
that I last saw him alive on *4/28* 19*22*
and that death occurred on the date stated above, at *4:30 P.* M.

The CAUSE OF DEATH* was as follows:

Myelogenous Leukemia(Duration) *4* Yrs. mos. ds.Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

C. D. Weaver M. D.

19

(Address)

Twin Falls, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Twin Falls, Ida

DATE OF BURIAL

19*22*

20. UNDERTAKER

R. J. Grossman

ADDRESS

Twin Falls Ida

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Lincoln Registration District No. 37City of Lincoln (No. 1085)City of Lincoln (No. 1085)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Susan M. FergusonFile No. 38259Registered No. 38259

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widowed

6. DATE OF BIRTH

Oct. 5 1844
(Month) (Day) (Year)

7. AGE

77 Yrs. 0 Mos. 0 ds. IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Retired at home

9. BIRTHPLACE

(State or Country)

Mo.

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

Kentucky

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm. Walker(Address) Lincoln Falls15. Filed May 9 1922 John T. Ferguson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Apr. 28 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 16 1922 to April 28 1922that I last saw him alive on April 28 1922and that death occurred on the date stated above, at 10 M.

The CAUSE OF DEATH* was as follows:

Paralysis Apitaur(Duration) 20 Yrs. 0 mos. 0 ds.

Contributory (Secondary)

(Duration) 0 yrs. 0 mos. 0 ds.(Signed) H. C. Wilson M. D.(Address) Lincoln Falls, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 0 yrs. 0 mos. 0 days. In the State 0 yrs. 0 mos. 0 days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lincoln Falls 19 1922

20. UNDERTAKER

ADDRESS

J. P. Grossman Lincoln Falls

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Turn Falls* Registration District No. *37*
City of *Turn Falls* Primary Registration District No. *1085*
St. *Idaho*File No. _____
Registered No. _____If death occurs away from
usual residence, give facts
called for under special in-
formation.If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

2. FULL NAME

Samuel Lats

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED*male white married*
(Write the word.)

6. DATE OF BIRTH

Jun 17 1868
(Month) (Day) (Year)

7. AGE

*75- Yrs. 2 Mos. 24 ds.*IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer).*Farmer*

9. BIRTHPLACE

(State or Country)

*Ohio*10. NAME OF
FATHER*Samuel Lats*11. BIRTHPLACE
OF FATHER

(State or Country)

*Ohio*12. MAIDEN NAME
OF MOTHER*Elizabeth Perry*13. BIRTHPLACE
OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

T. H. Fouts

(Address)

Stirling Colorado

15.

Filed *May 9- 1922**John Stoughton*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 10 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

*1920 to Apr 10 1922*that I last saw him alive on *Apr 10 1922*and that death occurred on the date stated above, at *9 P.M.*

The CAUSE OF DEATH* was as follows:

Aortic Aneurism(Duration) *2* Yrs. _____ mos. _____ ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) *Chas. R. Scott* M. D.*Apr. 11, 1922* (Address) *Turn Falls Idaho**State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)At place In the
of death _____ yrs. _____ mos. _____ days. State _____ yrs. _____ mos. _____ daysWhere was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Turn Falls

DATE OF BURIAL

4-13-1922

20. UNDERTAKER

J. E. DeWitt

ADDRESS

Turn Falls

1. PLACE OF DEATH

County of *Twins Falls* District No. *37*
 City of *Twins Falls* Primary Registration District No. *1085*
 (City of *Idaho* County Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Elizabeth Venable

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*

6. DATE OF BIRTH

May 7 19*22*
 (Month) (Day) (Year)

7. AGE

44 Yrs. *11* Mos. *9* ds.

IF LESS than 1 day
 how many..... hrs.
 or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

Nursewife

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

Earnest Fennebold

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Sophia Schoenberg

13. BIRTHPLACE OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. C. Venable

(Address)

Hansen, Ida

15. Filed

May 9 - 1922

John Houghlin
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Apr 11 19*22*
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Jan 1* 19*22* to *April 11* 19*22* that I last saw her alive on *Apr 11* 19*22* and that death occurred on the date stated above, at *10:10 A.M.*

The CAUSE OF DEATH* was as follows:

Cholecyctitis

Contributory (Secondary)

(Duration) *20* Yrs. mos. ds.

Hysterectomy Operation

(Duration) yrs. mos. *8* ds.

(Signed)

J. M. Davis

M. D.

4/11/1922 (Address) *Kimberly Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Appleton City Mo.

19

20. UNDERTAKER

ADDRESS

J. Grossman *Twins Falls*

1. PLACE OF DEATH		CERTIFICATE OF DEATH		State of Idaho BOARD OF HEALTH Bureau of Vital Statistics	
Juniata		Registration District No. 37		38262	
County of Juniata		Registration District No. 085		File No.	
City of Juniata		St.)		Registered No.	
If death occurs away from usual residence, give facts called for under special information.		2. FULL NAME		If death occurred in a hospital, institution or camp, give NAME instead of street and number.	
Rose B. Rutherford					
PERSONAL AND STATISTICAL PARTICULARS					
3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED			
Female	White	Married			
6. DATE OF BIRTH					
Sep 11 1874					
7. AGE					
48 Yrs. 7 Mos. 9 ds.					
8. OCCUPATION					
Housewife					
9. BIRTHPLACE					
Calo					
10. NAME OF FATHER					
Geo Bear					
11. BIRTHPLACE OF FATHER					
England					
12. MAIDEN NAME OF MOTHER					
Not known					
13. BIRTHPLACE OF MOTHER					
England					
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE					
(Informant) C. C. Rutherford					
(Address)					
15. May 7 1922 John St. Cloughen					
Local Registrar					
MEDICAL CERTIFICATE OF DEATH					
16. DATE OF DEATH					
April 18 1922					
17. I HEREBY CERTIFY, That I attended deceased from April 1 1922, to April 18 1922					
that I last saw her alive on April 18 1922					
and that death occurred on the date stated above, at 8:00 A.M.					
The CAUSE OF DEATH* was as follows:					
Hibrid uterine hypertrophy					
10 days postoperative					
(Duration) 2 Yrs. mos. ds.					
Contributory (Secondary)					
(Duration) Yrs. mos. ds.					
(Signed) H. Wilson M. D.					
(Address) Juniata, Idaho					
*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.					
18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)					
At place of death Yrs. mos. days. In the State Yrs. mos. days					
Where was disease contracted if not at place of death?					
Former or usual residence					
19. PLACE OF BURIAL OR REMOVAL					
Juniata					
DATE OF BURIAL					
4 21 1922					
20. UNDERTAKER					
J. E. Rutherford					
ADDRESS					
Juniata					

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Registration District No. 37

Primary Registration District No. 208538263

(No.)

St.)

File No.

Registered No.

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Male

White

Single
(Write the word.)

6. DATE OF BIRTH

Nov - 8 1922
(Month) (Day) (Year)

7. AGE

2 Yrs. 5 Mos. 11 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country)

Iowa.

10. NAME OF
FATHER

Joe Gasser.

11. BIRTHPLACE
OF FATHER

(State or Country)

Wis.

12. MAIDEN NAME
OF MOTHER

Leola Hutchins

13. BIRTHPLACE
OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Joe Gasser
1344 E. 2da

15.

Filed

May - 9 - 1922 James J. Knapp
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 18 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

4/15/1922 to 4/18/1922
that I last saw him alive on 4/18/1922
and that death occurred on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:

Dysentery

(Duration) Yrs. mos. 3 ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) W. G. Fisher M. D.

4/19/22 (Address) Twin Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

Twin Falls
J. J. Crossman
Twin Falls

FORM V. S. No. 5-A—20 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

38264

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

Registration District No.

Primary Registration District No.

(No.)

(St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him..... alive on.....
and that death occurred on the date stated above, at..... A. M.

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Signed)

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former of usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

FORM V. S. No. 5-A-25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

38265

Wilson
State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Swain Falls

Registration District No. 37

County of

Primary Registration District No. 2885

City of

(No. St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Elvie Chamberlain

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Feb 21 1906
(Month) (Day) (Year)

7. AGE

6 Yrs. 29 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Wyo.

10. NAME OF FATHER

A.R. Chamberlain

11. BIRTHPLACE OF FATHER

(State or Country)

Ind.

12. MAIDEN NAME OF MOTHER

Anna Green

13. BIRTHPLACE OF MOTHER

(State or Country)

Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A.R. Chamberlain

(Address)

Kimbrey Fla.

15. Filed

May-7-1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Apr - 20 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 2 1922 to Apr 20 1922
that I last saw her alive on Apr 17 1922
and that death occurred on the date stated above, at 9¹⁰ M.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

(Duration) 1 Yrs. mos. ds.

Contributory Chronic nephritis

(Duration) yrs. 6 mos. ds.

(Signed) H.W. Wilson M. D.

Apr 22 1922 (Address) Swain Falls, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Swain Falls 4/22/1922

20. UNDERTAKER

ADDRESS

J. J. Roseman Swain Falls

RECEIVED

CERTIFICATE OF DEATH

38266

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Trimble*
City of *Idaho Falls*Registration District No. *37*Primary Registration District No. *1085*

(No. St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Robert Wilson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male *White* *Married*

6. DATE OF BIRTH

March 19 1887
(Month) (Day) (Year)

7. AGE

85 Yrs. *1* Mos. *14* ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)*Retired Farmer.*

9. BIRTHPLACE

(State or Country)

New York

10. NAME OF FATHER

Robert Wilson

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Washburn

13. BIRTHPLACE OF MOTHER

(State or Country)

New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. S. M. Henderson

(Address)

Trimble Idaho Falls

15.

Filed *May 6 - 1922**John F. Coughlin*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 3 - 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

*Apr. 24 1922 to May 3 1922*that I last saw him alive on *May 3 - 1922*

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

*Int. relation of heart,
Senility*

(Duration) Yrs. mos. ds.

Contributory
(Secondary)*Pneumonia*

(Duration) Yrs. mos. ds.

(Signed)

*John F. Coughlin - M. D.**5/6 - 1922*(Address) *Trimble*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

127 - 2d Ave. N. O.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Trimble**May 6 - 1922*

20. UNDERTAKER

ADDRESS

J. F. Coughlin *Trimble*

FORM V. S. No. 5-A-25 M. 1-19.

1. PLACE OF DEATH

County of *Chimney Falls*City of *Chimney Falls*

If death occurs away from usual residence, give facts called for under special information.

RECEIVED CERTIFICATE OF DEATH

Registration District No. *37*Primary Registration District No. *1085*

(No. St.)

38267

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

William G Evans

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED*Male* *White* *Married*

6. DATE OF BIRTH

April 20 1856
(Month) (Day) (Year)

7. AGE

66 Yrs. *0* Mos. *12* ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).*Latrover*

9. BIRTHPLACE

(State or Country)

Ill.

10. NAME OF FATHER

James C. Evans

11. BIRTHPLACE OF FATHER

(State or Country)

Kentucky

12. MAIDEN NAME OF MOTHER

Mary E Hopkins

13. BIRTHPLACE OF MOTHER

(State or Country)

Mass.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Albert G. Evans

(Address)

Chimney Falls

15.

Filed *May-9-1922* *John H. Long*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

46

16. DATE OF DEATH

May 2 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

april 30 1922 to *May 2 1922*
that I last saw him alive on *april 30 1922*and that death occurred on the date stated above, at *9 P. M.*

The CAUSE OF DEATH* was as follows:

Brain Tumor(Duration) *3* Yrs. mos. ds.Contributory *paralysis (hemiplegia)*
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *L. W. Wilson* M. D.*May 4 1922* (Address) *Twins Falls*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Chimney Falls Ida. *May 6 1922*

20. UNDERTAKER

ADDRESS

J. J. Crossman *Chimney Falls*

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

Registration District No.

Primary Registration District No.

(No. County Hospital St.)

File No.

Registered No.

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF
FATHER11. BIRTHPLACE
OF FATHER

(State or Country)

12. MAIDEN NAME
OF MOTHER13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

April 30 1922, to April 30 1923
that I last saw him alive on April 30 1922
and that death occurred on the date stated above, at 3:57 P.M.
The CAUSE OF DEATH* was as follows:

Gun shot wound

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

May 1922 (Address) Twin Falls, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)At place In the
of death Yrs. mos. days. State Yrs. mos. daysWhere was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
MAY 23 1922

CERTIFICATE OF DEATH

State of Idaho
38270 BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Idaho Falls*

Registration District No. *37*

City of

Primary Registration District No. *1085*

(No. *Idaho Falls Hospital*)

St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

G. M. Dearing

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Divorced
(Write the word.)

6. DATE OF BIRTH

Don't Know

(Month)

(Day)

(Year)

7. AGE

76

Yrs.

Mos.

ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Constable

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Mo.

10. NAME OF FATHER

Don't Know

11. BIRTHPLACE OF FATHER

(State or Country)

Id.

"

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

"

"

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Signed

Mary F.

19

John Houghlin

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Apr 24

(Month)

(Day)

19 *22*
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 23 19*22*, to *April 24* 19

that I last saw him alive on *April 24* 19*22*

and that death occurred on the date stated above, at *11 am* M.

The CAUSE OF DEATH* was as follows:

Stomach Poisoning

(Duration)

Yrs.

mos.

1 1/2 ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

Hurvilson

M. D.

April 26 19*22* (Address) *Idaho Falls, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

yrs.

mos.

days

In the State

yrs.

mos.

days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Idaho Falls, Idaho

DATE OF BURIAL

Apr 26 19*22*

20. UNDERTAKER

P. J. Grossman

ADDRESS

Idaho Falls, Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 37
County of Quinn Registration District No. 1083
City of Idaho Falls (No. Idaho Falls St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Bull

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDMale White Single
(Write the word.)

6. DATE OF BIRTH

Don't know
(Month) (Day) (Year)

7. AGE

52 Yrs. Mos. ds.
IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Mason
Stone

9. BIRTHPLACE

(State or Country) Don't know

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country) ..

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country) ..

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) County Hospital Record
(Address) Idaho Falls, Ida15. Mar. 9 1922 John H. Houghton
Filed John H. Houghton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 24 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
April 1, 1922, to April 23, 1922
that I last saw him alive on April 21, 1922
and that death occurred on the date stated above, at 7 A M.

The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease
Pulmonary tuberculosis(Duration) ? Yrs. mos. ds.
Contributory Arteriosclerosis
(Secondary)(Duration) ? Yrs. mos. ds.(Signed) Joseph Sigal, M. D.5/24/1922 (Address) Idaho Falls, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Idaho Falls Ida Apr 25 19 22

20. UNDERTAKER

J. J. Grossman ADDRESS Idaho Falls

CERTIFICATE OF DEATH

1. PLACE OF DEATH **RECEIVED**
 Registration District No. **37** **38273**
 County of **Twin Falls** Primary Registration District No. **1085**
 City of **Idaho** (No. **County Hospital** St.)

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No.

Registered No.

If death occurs away from
 usual residence, give facts
 called for under special in-
 formation.

2. FULL NAME

J. G. Wilson

If death occurred in a hos-
 pital, institution or camp,
 give its NAME instead of
 street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED

Male **White** **Married**
 (write the word.)

6. DATE OF BIRTH

Jan 2 1863
 (Month) (Day) (Year)

7. AGE

59 Yrs. **3** Mos. **19** ds.

IF LESS than 1 day
 how many..... hrs.
 or..... min.?

8. OCCUPATION

(a) Trade, profession or
 particular kind of work.
 (b) General nature of in-
 dustry, business or estab-
 lishment in which employ-
 ed (or employer).

Grain Dealer

9. BIRTHPLACE

(State or Country)

Ida

10. NAME OF FATHER

Thomas Wilson

11. BIRTHPLACE OF FATHER

(State or Country)

Ida

12. MAIDEN NAME OF MOTHER

Sager

13. BIRTHPLACE OF MOTHER

(State or Country)

Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs J. G. Wilson

(Address)

Eden, Ida

15.

Filed

May-9- 1922 John F. Loughman

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Apr 28 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

4/11 1922 to **4/21 1922**
 that I last saw him alive on **4/20 1922**
 and that death occurred on the date stated above, at **59** M.

The CAUSE OF DEATH* was as follows:

Carcinoma of esophagus(Duration) Yrs. **4 1/4** mos. ds.

Contributory (Secondary)

Gastrostomy

(Duration) yrs. mos. ds.

(Signed)

W. G. Fike M. D.(Address) **Twin Falls, Ida**

*State the Disease Causing Death; or in deaths from Violent Causes, state
 (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted
 if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Twin Falls Ida **4/23 1922**

20. UNDERTAKER

ADDRESS

P. J. Grossman **Twin Falls**

RECEIVED
MAY 23 1922

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

Registration District No.

Primary Registration District No.

City of

(No.

St.)

File No.

Registered No.

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF
FATHER11. BIRTHPLACE
OF FATHER

(State or Country)

12. MAIDEN NAME
OF MOTHER13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19..... to 19.....

that I last saw her alive on 19.....

and that death occurred on the date stated above, at 2:00 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of bowels.

(Duration) Several mos. — ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

M. D.

4-15-1922 (Address) Twin Falls Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)At place In the
of death..... yrs..... mos..... days. State..... yrs..... mos..... daysWhere was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

RECEIVED
MAY 23 1922
BURIAL

CERTIFICATE OF DEATH

38275

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Juniper Falls* Registration District No. *37-*
City of *Juniper Falls* (No. *Juniper Falls* St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant Ponderpool

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male white Infant (Write the word.)

6. DATE OF BIRTH

April 13 1922
(Month) (Day) (Year)

7. AGE

3 hr IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Infant

9. BIRTHPLACE

(State or Country) *Idaho*

10. NAME OF FATHER

Pete Ponderpool

11. BIRTHPLACE OF FATHER

(State or Country) *Kentucky*

12. MAIDEN NAME OF MOTHER

Ruth Hansen

13. BIRTHPLACE OF MOTHER

(State or Country) *Idaho*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Pete Ponderpool*

(Address) *Juniper Falls*

15. *May 9 - 1922* *John T. Boughen*

Filed *May 9 - 1922* Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 13 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 13 1922 to *April 13 1922*
that I last saw him alive on *April 13 1922*
and that death occurred on the date stated above, at *3 P.M.*

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *John T. Boughen* M. D.

4/14 1922 (Address) *Juniper Falls, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Juniper Falls, Idaho

DATE OF BURIAL

4 - 15 - 1922

20. UNDERTAKER

J. E. Stewart

ADDRESS

Juniper Falls

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

MAY 23 1922

Registration District No. 37

38276

County of

Twin Falls

Vital Statistics
Tertiary Registration District No. 1085

File No.

City of

(No. St.)

Registered No.

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Virginia Carter

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF
FATHER11. BIRTHPLACE
OF FATHER

(State or Country)

12. MAIDEN NAME
OF MOTHER13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

April 10th 1922, to April 17th 1922,
that I last saw her alive on April 17th 1922,
and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) Yrs. mos. ds.

Contributory Broncho-Pneumonia
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Gilbert J. Jelford D.P.

4/18, 1922 (Address) Twin Falls, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

(No.)

St.)

File No.

Registered No.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

April 14, 1922, to April 17, 1922
that I last saw him alive on April 17, 1922
and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Myocarditis Lobar Pneumonia
Atherosclerosis of

(Duration) Yrs. mos. ds.

Contributory (Secondary) Lobar Pneumonia Myocarditis

(Duration) Yrs. mos. ds.

(Signed) Joseph Orzul, M. D.

5/19/22 (Address) Twin Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B. - Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

38278

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Twin Falls* Registration District No. *37*
City of *Twin Falls* Primary Registration District No. *1085*
(No. *37* St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Sarah Gruwell

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female *White* *Married*
(Write the word.)

6. DATE OF BIRTH

July 8 1 (Year)
(Month) (Day)

7. AGE

75 Yrs. *9* Mos. *27* ds. IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work *house wife*
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) *Iowa*

10. NAME OF FATHER

James Bohanen

11. BIRTHPLACE OF FATHER

(State or Country) *Nebraska*

12. MAIDEN NAME OF MOTHER

not known

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *C O Gruwell*

(Address) *7th Idaho*

15. Filled *May 9* 19*22* *John P. Bohanen*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 5 19*22*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 1 19*22*, to *May 5* 19*22*
that I last saw him alive on *May 4* 19*22*
and that death occurred on the date stated above, at *8:30 AM*

The CAUSE OF DEATH* was as follows:

Dilatation, cardiac

(Duration) Yrs. mos. *4* ds.

Contributory (Secondary) *Arteriosclerosis*

(Duration) *10* yrs. mos. ds.

(Signed) *Hal Bieder* M. D.

May 5 1922 (Address) *Twin Falls, Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Billing, Montana 19*22*

20. UNDERTAKER ADDRESS

J E Dewitt *Twin Falls*

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH Home Registration District No. 15
 County of Valley Primary Registration District No. 38279
 City of Cascade (No. 1) St.

File No.
 Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Mrs. Mattie Dukes

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widowed
 (Write the word.)

6. DATE OF BIRTH October 15 1854
 (Month) (Day) (Year)

7. AGE 67 Yrs. 5 Mos. 2 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Housework
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE Missouri
 (State or Country)

10. NAME OF FATHER O. G. Harris

11. BIRTHPLACE OF FATHER Not known
 (State or Country)

12. MAIDEN NAME OF MOTHER Not known

13. BIRTHPLACE OF MOTHER Not known
 (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dr. J. F. Rutledge
 (Address) Cascade Idaho

15. Stella Cain
 Filed 19 copy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 30 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 25 1921, to March 30 1922, that I last saw her alive on March 30 1922 and that death occurred on the date stated above, at 30 P.M.

The CAUSE OF DEATH* was as follows:

Bright's Disease

(Duration) 7 Yrs. mos. ds.

Contributory
 (Secondary)

(Duration) yrs. mos. ds.

(Signed) Dr. J. F. Rutledge M. D.

3/30 1922 (Address) Cascade Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence Cascade Idaho

19. PLACE OF BURIAL OR REMOVAL Cascade Idaho (Crown Point) DATE OF BURIAL 4/1 1922

20. UNDERTAKER D. M. Cox ADDRESS Cascade Ida.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED

JUN 19 1922

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

District No.

Registration District No.

(No.)

38280

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married

(Write the word.)

6. DATE OF BIRTH

Dec.

24

1881

(Month)

(Day)

(Year)

7. AGE

40

Yrs.

4

Mos.

5

ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Farmer

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Finland

10. NAME OF FATHER

Henry Juntti

11. BIRTHPLACE OF FATHER

(State or Country)

Finland

12. MAIDEN NAME OF MOTHER

No information

13. BIRTHPLACE OF MOTHER

(State or Country)

Finland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Charles Juntti

(Address)

Kingston, Idaho.

15.

Filed

June 14 - 1922

E. E. Hardy

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May

2

1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

..... 19....., to

..... 19.....

that I last saw him alive on

..... 19.....

and that death occurred on the date stated above, at 11:45 A.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis
pneumonia with lungs
septicaemia

(Duration)

..... yrs.

..... mos.

..... ds.

Contributory (Secondary)

(Duration)

..... yrs.

..... mos.

..... ds.

(Signed)

1922

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hunt's Cemetery, Kingston May 3, 22

20. UNDERTAKER

M. C. Thornhill

ADDRESS

Kellogg, Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of AdaCity of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2Primary Registration District No. 1004(No. 214 E. Jefferson, St.)File No. 38281Registered No. 147

2. FULL NAME

George H. Roberts

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

July - 13 - 1841
(Month) (Day) (Year)

7. AGE

81 Yrs. 11 Mos. 13 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Lawyer

9. BIRTHPLACE

(State or Country)

Penn

10. NAME OF FATHER

George H. Roberts

11. BIRTHPLACE OF FATHER

(State or Country)

Penn

12. MAIDEN NAME OF MOTHER

Margaret Stevenson

13. BIRTHPLACE OF MOTHER

(State or Country)

Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wm. E. Bratney

(Address)

Boise Idaho

15.

Filed 6-17 1922 R. H. Pratt

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June - 16 - 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Reverend
that I last saw him alive on June 15 1922
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

6/17/22
19H. B. Bratney M. D.
(Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Morris Hill Cemetery

DATE OF BURIAL

6/17 1922

20. UNDERTAKER

Wm. E. Bratney

ADDRESS

Boise Idaho

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH
in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 38282
Registered No. _____

1. PLACE OF DEATH

County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. 1610 Washington St.)

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Thomas B. Williams

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Married

6. DATE OF BIRTH

Sep 23 1984
(Month) (Day) (Year)

7. AGE

77 Yrs. 9 Mos. 13 ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

Stockman

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

Thomas Bennett Williams

11. BIRTHPLACE OF FATHER

(State or Country)

Waller, Iowa

12. MAIDEN NAME OF MOTHER

Mary Elizabeth Griffith

13. BIRTHPLACE OF MOTHER

(State or Country)

Waller, Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Earl Hatfield
(Address) _____

15.

Filed 7-6 1922

R. H. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 6 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
July 1st 1922 to July 5th 1922
that I last saw him alive on July 5th 1922
and that death occurred on the date stated above, at 3 A.M.

The CAUSE OF DEATH* was as follows:

Senility and Chronic
Rheumatism

(Duration) 10 yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Jos. R. Neumgers M. D.

7-6 1922 (Address) Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted
if not at place of death?

Former or usual residence Boise, Emmett

19. PLACE OF BURIAL OR REMOVAL

Morris Hill Cemetery July 7 1922

20. UNDERTAKER

Summers & Kels Boise, Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH JUL 6 1922
County of Ada Registration District No. 2
City of Boise Primary Registration District No. 1004
(No. Soldier Home Hospital)
If death occurs away from usual residence, give facts called for under special information.

File No. 38283
Registered No. 120

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jess W. Wagoner

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-OWED OR DIVORCED Unknown

6. DATE OF BIRTH 1834
(Month) (Day) (Year)

7. AGE 88 Yrs. - Mos. - ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Retired Veteran
(b) General nature of industry, business or establishment in which employed (or employer). Civil War.

9. BIRTHPLACE (State or Country) Unknown.

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Unknown.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) E. G. Burned.
(Address) Boise Id.

15. Filled 6-2 1922 R. H. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 1 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3/26 1922 June 1 1922 that I last saw him alive on May 31 1922 and that death occurred on the date stated above, at 5 A.M.
The CAUSE OF DEATH* was as follows:

Senility

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Fred A. Pungent M. D.
6/2 1922 (Address) Boise Id.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Morris Steel Cem. DATE OF BURIAL June 2 1922

20. UNDERTAKER Summers & Co. ADDRESS Boise Id.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **38284**
Registered No. **131**

1. PLACE OF DEATH **RECEIVED**
County of **Ada** JUL 6 1922
City of **Boise** (No. **R.F.D. 5 South Boise** St.)
Registration District No. **7**
Primary Registration District No. **1004**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Sarah Wilson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **F.** 4. COLOR OR RACE **White.** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Widow.**

6. DATE OF BIRTH

Aug 31

7. AGE

78 Yrs.

Mos.

ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

At Home.

9. BIRTHPLACE

(State or Country)

Iowa.

10. NAME OF FATHER

— Dash.

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown.

12. MAIDEN NAME OF MOTHER

Unknown.

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Harry Strobe.

(Address)

Boise, Idaho.

15.

Filed

6-3

1922

R. H. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

79

16. DATE OF DEATH

June 2

(Month)

(Day)

1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 2 1922 to **June 2** 1922
that I last saw her alive on **June 2** 1922

and that death occurred on the date stated above, at **11:10** M.

The CAUSE OF DEATH* was as follows:

Chronic cardiac disease.

(Duration) **several** yrs. mos. ds.

Contributory (Secondary) **Cardiac compensation**

(Duration) yrs. mos. ds.

(Signed) **R. L. McCalla** M. D.

19 (Address) **Boise, Idaho.**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cem.

June 4 1922

20. UNDERTAKER

ADDRESS

Sumner Strobe.

Boise, Idaho.

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH JUL 6 1922
Registration District No. 2
County of Ada
Primary Registration District No. 1004
City of Boise (No. 110 East Broadway St.)

File No. 38285
Registered No. 132

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Douglas Gordon Carter

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word)

6. DATE OF BIRTH Jan 23 1922
(Month) (Day) (Year)

7. AGE 4 Yrs. Mos. ds. IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Unemployed

9. BIRTHPLACE

(State or Country)

Boise

10. NAME OF FATHER

Raymond E. Carter

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Hazel Morrison

13. BIRTHPLACE OF MOTHER

(State or Country)

Boise Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Raymond E. Carter

(Address)

Boise Ida

15. Filed 6-7-1922 G. H. Pratt
Local Registrar

16. DATE OF DEATH

June 5 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4:45 pm 1922, to 5:45 pm 1922, that I last saw him alive on June 4 1922 and that death occurred on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Typhoid Spasm

(Duration) Yrs. mos. ds.
Contributory (Secondary) Typhoid Hypertrophy

(Duration) yrs. mos. ds.
(Signed) H. H. Pratt M. D.

June 7 1922 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Mormon Hill Cemetery 6/7 1922

20. UNDERTAKER ADDRESS
Schreiber & Sons Boise Ida

1. PLACE OF DEATH

County of AdaCity of Boise

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No. 2Primary Registration District No. 1004(No. St Lukes Hospital St.)

2. FULL NAME

Mary M. McConleyState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 38286Registered No. 133

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F.

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widow (write one word.)

6. DATE OF BIRTH

July 17 - 1845

(Month)

(Day)

(Year)

7. AGE

76 Yrs. 10 Mos. 21 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

At Home.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Kentucky

10. NAME OF FATHER

Martin

11. BIRTHPLACE OF FATHER

(State or Country)

Virginia

12. MAIDEN NAME OF MOTHER

Mary M. Casland

13. BIRTHPLACE OF MOTHER

(State or Country)

Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Harry Webb

(Address)

Boise Idaho

15.

Filed

6-1019 22P. G. Rath

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 8

(Month)

(Day)

19 22 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 18 1922 to June 8 1922that I last saw her alive on June 8 1922and that death occurred on the date stated above, at 8:30 A.M.

The CAUSE OF DEATH* was as follows:

Paralysis(Duration) Yrs. mos. 2 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

P. P. French

M. D.

June 9 1922 (Address) Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Morris Skies Cemetery

DATE OF BURIAL

June 11 1922

20. UNDERTAKER

Summer Webb

ADDRESS

Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 38288
Registered No. 135

1. PLACE OF DEATH JUL 6 1922
County of Ada
City of Boise
Registration District No. 2
Primary Registration District No. 1004
(No. 87 x 30 St.)
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME William M. Mitchell.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX m. 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married

6. DATE OF BIRTH July 1 1867
(Month) (Day) (Year)

7. AGE 59 Yrs. 11 Mos. 9 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION (a) Trade, profession or particular kind of work merchant (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE Illinois (State or Country)

10. NAME OF FATHER Daniel Mitchell

11. BIRTHPLACE OF FATHER Kentucky (State or Country)

12. MAIDEN NAME OF MOTHER Annath Mullan

13. BIRTHPLACE OF MOTHER Indiana (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) W. M. Mitchell (Address) 1403 N-10 St Boise Ida

15. Filed June 22 1922 P. H. Parker Local Registrar

16. DATE OF DEATH June 10 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 1922, to June 10 1922 that I last saw him alive on June 10 1922 and that death occurred on the date stated above, at 12:30 P.M.

The CAUSE OF DEATH* was as follows: Angina Pectoris

(Duration) Yrs. 4 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) O. H. Parker M. D.

19. (Address) 303 McCarty Bldg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Morris Hill Cem. DATE OF BURIAL June 13 1922

20. UNDERTAKER Summers & Son. ADDRESS Boise Ida.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 38289

Registered No. 136

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

1. PLACE OF DEATH

County of Ada Registration District No. 7
City of Boise Primary Registration District No. 1004
(No. St. Lukes Hospital St.)If death occurs away from
usual residence, give facts
called for under special in-
formation.2. FULL NAME Iruman Lee Catlin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Widow

6. DATE OF BIRTH

Dec 21 1889
(Month) (Day) (Year)

7. AGE

82 Yrs. 5 Mos. 19 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work Stockman(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country) Illinois10. NAME OF
FATHERIruman M. Catlin11. BIRTHPLACE
OF FATHER(State or Country) Connecticut12. MAIDEN NAME
OF MOTHERRhoda Bond13. BIRTHPLACE
OF MOTHER(State or Country) Connecticut

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harry St. L.(Address) Boise Idaho

15.

Filed June 12 1922 R. B. Pratt

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 10 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 1920 to June 10 1922
that I last saw him alive on June 10 1922
and that death occurred on the date stated above, at 10:30 A.M.

The CAUSE OF DEATH* was as follows:

arteris Sclerosis

(Duration) Yrs. mos. ds.

Contributory
(Secondary)Dilatation of heart

(Duration) yrs. mos. ds.

(Signed)

6/12/22 J. S. Springer M. D.
(Address) Boise Idaho*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Star Cemetery June 12 1922

20. UNDERTAKER

ADDRESS

Summers & St. L. Boise Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

Registration District No.

Primary Registration District No.

(No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19

that I last saw him alive on June 11 1922

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

19 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Ada
 City of Boise

Registration District No. 7
 Primary Registration District No. 1094
 (No. 410 Washington St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Albert Reade

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 38291
 Registered No. 138

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male White Single
 (Write the word.)

6. DATE OF BIRTH

June 9 1922
 (Month) (Day) (Year)

7. AGE

IF LESS than 1 day
 how many hrs.
 or min.?

Yrs. Mos. 3 ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Boise

10. NAME OF FATHER

Ralph L. Reade

11. BIRTHPLACE OF FATHER

(State or Country) Idaho

12. MAIDEN NAME OF MOTHER

Alice L. Sprague

13. BIRTHPLACE OF MOTHER

(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ralph L. Reade
 (Address) Boise, Ida.

15.

Filed 6-12 1922

R. L. Reed
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 12 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 9 1922 June 12 1922
 that I last saw him alive on June 12 1922
 and that death occurred on the date stated above, at 2 A.M.

The CAUSE OF DEATH* was as follows:

Emphysema

(Duration) Yrs. mos. 4 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. H. Salzman D.

June 12 (Address) Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Monroe Hill Cemetery 6/12/1922

20. UNDERTAKER ADDRESS

Schmidt & Schindler Boise

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Ada
City of Boise

If death occurs away from usual residence, give facts called for under special information.

RECEIVED

JUL 6 1922

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 2Registration District No. 1004City of Boise St. Lukes Hospital (St.)

2. FULL NAME

Eyeko SedinState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 38293Registered No. 140

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single

6. DATE OF BIRTH

1898
(Month) (Day) (Year)

7. AGE

29 Yrs. — Mos. — ds.
IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Laborer

9. BIRTHPLACE

(State or Country)

Sweden

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Harry Schels
Boise, Idaho

15.

Filed

6-13 1922R. H. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 5 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 1 1922 to June 5 1922
that I last saw him alive on June 5 1922
and that death occurred on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis(Duration) Yrs. 5 mos. — ds.Contributory
(Secondary)(Duration) yrs. — mos. — ds.

(Signed)

Harold W Stone M. D.19. (Address) 413 Cleveland Bldg. Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. — mos. — days. In the State yrs. — mos. — days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Morris Hill Cemetery

DATE OF BURIAL

June 15 1922

20. UNDERTAKER

Summers & Schels

ADDRESS

Boise, Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada
City of Boise, IdahoRegistration District No. 2Primary Registration District No. 1904
(No. St. Alphonsus Hospital St.)File No. 38294Registered No. 141

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Pearl J. McCabe

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)6. DATE OF BIRTH Nov. 8-1885
(Month) (Day) (Year)7. AGE 36 Yrs. 11 Mos. 8 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Housewife

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

Newton Webb

11. BIRTHPLACE OF FATHER

(State or Country)

Iowa

12. MAIDEN NAME OF MOTHER

Mary E. Butler

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. McBratney

(Address)

Boise, Idaho15. Filed June 14, 1922 R. A. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June, 12, 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

6/12 1922 to 6/12 1922
that I last saw her alive on 6/12 1922
and that death occurred on the date stated above, at 2:10 M.

The CAUSE OF DEATH was as follows:

Shock following operation
Pelvic abscess

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

Paul A. Tuttle M. D.6/12, 1922 (Address) Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Knoxville, Tenn1922

20. UNDERTAKER

ADDRESS

W. McBratneyBoise, Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **38295**
Registered No. **142**

1. PLACE OF DEATH

County of **Ada** Registration District No. **2**
City of **Boise** Primary Registration District No. **1004**
BUREAU OF VITAL STATISTICS JUL 6 1922

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Rosa E. Morfitt

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **M.** 4. COLOR OR RACE **W.** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Married
(Write the word.)

6. DATE OF BIRTH

Aug - 13 - 1858
(Month) (Day) (Year)

7. AGE

63 Yrs. **10** Mos. **1** ds.If LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)**Housewife**

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

J. D. Hoffstatter

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Eliza Anna White

13. BIRTHPLACE OF MOTHER

(State or Country)

Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

W. McBratney
Boise, Idaho.

15.

Filed **6-16** 19 **22**

Local Registrar

R. H. Rall

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June - 14 19 **22**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 12 19 **21**, to **June 14** 19 **22**
that I last saw h. or alive on **June 12** 19 **21**,
and that death occurred on the date stated above, at **2 P.** M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis.(Duration) **10** Yrs. **10** mos. **10** ds.Contributory (Secondary) **Senile dementia.**(Duration) **3** yrs. **3** mos. **3** ds.(Signed) **M. H. T. T. T. M. D.****6/15** 19 **22** (Address) **Boise, Idaho.**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death **10** yrs. **10** mos. **10** days. In the State **10** yrs. **10** mos. **10** days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Morris Hill Cemetery

DATE OF BURIAL

6/16 19 **22**

20. UNDERTAKER

W. McBratney

ADDRESS

Boise, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 38296
Registered No. 143

1. PLACE OF DEATH
County of Ada
City of Boise
Registration District No. 2
Primary Registration District No. 1004
(No. 410 State St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Gertrude German Wyskoff

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH Oct 4 1884
(Month) (Day) (Year)

7. AGE 37 Yrs. 9 Mos. 9 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION housewife
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE Idaho City, Idaho
(State or Country)

10. NAME OF FATHER John German

11. BIRTHPLACE OF FATHER Utah.
(State or Country)

12. MAIDEN NAME OF MOTHER Lena German

13. BIRTHPLACE OF MOTHER Wash. D.C.
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. A. German
(Address)

15. Filed 6-16 1922

R. L. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 13 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6/13 1922 to 6/13 1922
that I last saw her alive on 6/13 1922
and that death occurred on the date stated above, at 8 P.M.
The CAUSE OF DEATH* was as follows:

Takes.

(Duration) Yrs. mos. ds.
Contributory (Secondary) Myocarditis
(Duration) yrs. mos. ds.
(Signed) Fred A. Pittinger M. D.
6/15 1922 (Address) Boise Id

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence Boise Idaho

19. PLACE OF BURIAL OR REMOVAL St. Johns Cemetery
DATE OF BURIAL 6/14 1922

20. UNDERTAKER Schreiber & Sidenfaden
Dr. Pittinger

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of *Ada*
City of *Boise*

Registration District No. *2*
Primary Registration District No. *1004*
(*St. Alphonsus Hosp.*)

File No. *38297*
Registered No. *144*

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME *Maria Eilenberg Ecklund*

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *F* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*
(Write the word.)

6. DATE OF BIRTH *June 3 1878*
(Month) (Day) (Year)

7. AGE *44* Yrs. *11* Mos. *11* ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. *housewife*
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE *Monmouth Ills.*
(State or Country)

10. NAME OF FATHER *Eilenberg*

11. BIRTHPLACE OF FATHER *Germany*
(State or Country)

12. MAIDEN NAME OF MOTHER *Don't Know*

13. BIRTHPLACE OF MOTHER *Germany,*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *J. T. Ecklund*
(Address)

15. Filled *6-16* 19*22*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *June 14 1922*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *May 29 1922* to *June 14 1922* that I last saw him alive on *June 14 1922* and that death occurred on the date stated above, at *11:30 A.M.*
The CAUSE OF DEATH* was as follows:

Exophthalmic Goiter
(Duration) Yrs. mos. ds.
Contributory (Secondary) *Surgical Shock*
(Duration) yrs. mos. ds.
(Signed) *Paul Hittinger* M. D.
19. (Address) *Boise Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days.
Where was disease contracted if not at place of death?
Former or usual residence *Boise Idaho*

19. PLACE OF BURIAL OR REMOVAL *Morris Hill cemetery* DATE OF BURIAL *6/15 1922*

20. UNDERTAKER *Schreiber & Eidenfaden* ADDRESS *Boise Ida*
Pittinger

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of

Ada

City of

Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No.)

110 East Ramona

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

38298

Registered No.

146

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Edna Penner Tibblad

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

married
(Write the word.)

6. DATE OF BIRTH

Sept

27

1890

(Month)

(Day)

(Year)

7. AGE

31

Yrs.

8

Mos.

17

ds.

IF LESS than 1 day

how many

Yrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

Housewife

9. BIRTHPLACE

(State or Country)

Boise Idaho

10. NAME OF FATHER

Jos Penner

11. BIRTHPLACE OF FATHER

(State or Country)

Belleville Canada

12. MAIDEN NAME OF MOTHER

Kate A Kelly

13. BIRTHPLACE OF MOTHER

(State or Country)

Monroe Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Jos Penner

(Address)

Boise Idaho

15.

Filed

6-16

1922

R. L. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 13

(Month)

(Day)

1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 8 1922 to June 13 1922

that I last saw her alive on July 13 1922

and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Caesarean operation
(Duration) Yrs. mos. ds.Contributory
(Secondary)Sepsis
(Duration) yrs. mos. ds.

(Signed)

Chas. A. Peterson M. D.

6/15/22 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

Boise, Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery 6/15/22

20. UNDERTAKER

ADDRESS

Schnecker & Videnshagen Boise Id

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 38300
Registered No. 148

1. PLACE OF DEATH RECORD
County of Ada
City of Battle

Registration District No. 2
Primary Registration District No. 1004
(No. 410 State St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ester L. Acuff

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED widowed.
(Write the word.)

6. DATE OF BIRTH Nov. 28, 1858
(Month) (Day) (Year)

7. AGE 63 Yrs. 6 Mos. 21 ds. IF LESS than 1 day how many.....hrs. or.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

housewife

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Arvid N. Hall

11. BIRTHPLACE OF FATHER

(State or Country)

N. H.

12. MAIDEN NAME OF MOTHER

Louisa Chippin

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. M. Acuff

(Address)

W.

Rupert Ida

15.

Filled

June 19, 1922

R. L. Pratt

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 18, 1922
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from Jan 10, 1922 to June 18, 1922 that I last saw him alive on Jan 18, 1922 and that death occurred on the date stated above, at 7:00 M.

The CAUSE OF DEATH* was as follows:

Chorea for
Heart Disease

(Duration) Yrs. 6 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) James Stewart M. D.

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

Rupert Idaho

19. PLACE OF BURIAL OR REMOVAL Rupert Idaho DATE OF BURIAL 6/22/22

20. UNDERTAKER Shirley Widupman Boise ADDRESS Boise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed 6-24 1922

Local Registrar

CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

No.

St.

BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Strangulated Inguinal Hernia
Operations

(Duration) Yrs. mos. 5 ds.

Contributory (Secondary) Elbow Anomalous

(Duration) yrs. mos. 3 ds.

(Signed) H. N. Braxton M. D.

1922 (Address) Boise Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

McCull Idaho. 6-27-22

20. UNDERTAKER

ADDRESS

Wm. Braxton Boise Idaho.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 38302
Registered No. 150

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Ada
City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2
Primary Registration District No. 1004
(No. St. Lukes Hospital St.)2. FULL NAME Gustaf Shallman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male White Married (in the word.)

6. DATE OF BIRTH

Sept 16 1887
(Month) (Day) (Year)

7. AGE

54 Yrs. 9 Mos. 6 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Life Insurance
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Sweden

10. NAME OF FATHER

Gustaf Shallman

11. BIRTHPLACE OF FATHER

(State or Country) Sweden

12. MAIDEN NAME OF MOTHER

Hilda M. Johnson

13. BIRTHPLACE OF MOTHER

(State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harry Krebs(Address) Boise, Idaho.15. Filed June 24 1922 R. H. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 22 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 19 1922 to June 22 1922
that I last saw him alive on June 22 1922
and that death occurred on the date stated above, at 11: P. M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) Yrs. mos. ds.

Contributory Fracture
(Secondary)

(Duration) yrs. mos. ds.

(Signed) James H. Stewart M. D.(Address) Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Morris Hill Cemetery

DATE OF BURIAL

Jun 25 1922

20. UNDERTAKER

Summer Krebs

ADDRESS

Boise, Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **38303**
Registered No. **157**

1. PLACE OF DEATH **RECEIVED**
County of **Ada** JUL 6 1922
City of **Boise** BUREAU OF VITAL STATISTICS
Registration District No. **2**
Primary Registration District No. **1004**
No. **614** No. 5th St. St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME **Maggie King**

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX **F** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Married**
(Use the word.)

6. DATE OF BIRTH **Jan 13 1881**
(Month) (Day) (Year)

7. AGE **41** Yrs. **5** Mos. **10** ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work **Housewife**
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) **Kentucky**

10. NAME OF FATHER
Dudley Parker

11. BIRTHPLACE OF FATHER
(State or Country) **Kentucky**

12. MAIDEN NAME OF MOTHER
Sis Anderson

13. BIRTHPLACE OF MOTHER
(State or Country) **Kentucky**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) **Harry Hebe**
(Address) **Boise Idaho**

15. Filed **June 24 1922** **R. H. Pratt**
Local Registrar

16. DATE OF DEATH **June 23 1922**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **June 12 1922** to **June 23 1922**
that I last saw him alive on **June 23 1922**
and that death occurred on the date stated above, at **M.**

The CAUSE OF DEATH* was as follows:
Phlebitis with embolism + arthritis (Within 30 days following suspected miscarriage)
(Duration) Yrs. mos. **20** ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) **C. L. Armstrong** M. D.
June 23 1922 (Address) **Boise Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **New Plymouth Ida.** DATE OF BURIAL **June 25 1922**
20. UNDERTAKER **Sumner Hebe** ADDRESS **Boise Ida.**

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Ada
 City of Boise JUL 6

Registration District No. 2
 Primary Registration District No. 1004
 (No. 1377 Date Boise St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Bessie P. Jones.

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 38304
 Registered No. 152

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F. 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED Married

6. DATE OF BIRTH

May 7, 1889
 (Month) (Day) (Year)

7. AGE

33 Yrs. 1 Mos. 18 ds.

IF LESS than 1 day
 how many _____ hrs.
 or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

Housewife.

9. BIRTHPLACE

(State or Country)

Utah.

10. NAME OF FATHER

John R. Price

11. BIRTHPLACE OF FATHER

(State or Country)

Wales.

12. MAIDEN NAME OF MOTHER

Sarah M. Keane

13. BIRTHPLACE OF MOTHER

(State or Country)

Scotland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. C. E. Stuart

(Address)

1377 State Boise.

15.

Filed 6-26

1922

R. L. Pratt
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 7, 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19

that I last saw him alive on 19

and that death occurred on the date stated above, at 10:30 P. M.

The CAUSE OF DEATH* was as follows:

Was dead when I arrived. History of advanced pulmonary tuberculosis. Probably tuberculosis cause.

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
 (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

For. R. Summers, M. D.

6-26-1922

(Address)

Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Salt Lake City, Utah

19

20. UNDERTAKER

ADDRESS

Summers & Webb.

Boise Ida.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 38305
Registered No. 753

1. PLACE OF DEATH

County of Ada Registration District No. 4
City of Boise Primary Registration District No. 1004
(No. St Luke's Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Horace Drake Smith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widower
(write the word.)

6. DATE OF BIRTH

July 27 1850
(Month) (Day) (Year)

7. AGE

71 Yrs. 11 Mos. ds.
IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Farmer

9. BIRTHPLACE

(State or Country)

Warren Co., Ohio

10. NAME OF FATHER

Jacob H Smith

11. BIRTHPLACE OF FATHER

(State or Country)

Penn

12. MAIDEN NAME OF MOTHER

Stedham

13. BIRTHPLACE OF MOTHER

(State or Country)

Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs L. S. Lanning
(Address) _____

15.

Filed 6-26 1922 R. L. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 25 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from June 23 1922 to June 25 1922
that I last saw him alive on June 24 1922
and that death occurred on the date stated above, at 7:20 A.M.

The CAUSE OF DEATH was as follows:

acute distention(Duration) Yrs. 6 mos. ds.
Contributory (Secondary) acute peritonitis due to perforation of wall of stomach.
(Duration) yrs. 4 mos. ds.
(Signed) M. S. Tallman M. D.
(Address) Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence Ecce Lander

19. PLACE OF BURIAL OR REMOVAL

Star Cemetery

DATE OF BURIAL

7/25/22

20. UNDERTAKER

Schreiber & Sidingaden Boise, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Ada*City of *Boise*

If death occurs away from usual residence, give facts called for under special information.

Registration District No. *2*Primary Registration District No. *1004*
(No. *1149 1/2 River* St.)State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *38306*Registered No. *154*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Ed Varga

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

6. DATE OF BIRTH

*march**1856*

(Month)

(Day)

(Year)

7. AGE

66

Yrs.

Mos.

ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Retired Miner

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Switzerland

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Harry Krebs

(Address)

Boise Idaho

15.

Filed

*6-28*19 *22**R. H. Rath*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 26

(Month)

(Day)

19 *22*
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 *—*

to

19 *—*that I last saw him alive on 19 *—*and that death occurred on the date stated above, at *—* M.

The CAUSE OF DEATH* was as follows:

Found dead. Probably Cerebral Hemorrhage.

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

Harry Krebs

(Address)

Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Morris Hill Cemetery*19 *—*

20. UNDERTAKER

ADDRESS

*Sumner Krebs**Boise Idaho*

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 38307
Registered No. 155

1. PLACE OF DEATH

County of Idaho
City of BoiseRegistration District No. _____
Primary Registration District No. _____
(No. 410 State _____ St.)If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Edgar HaynesIf death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH

July 11 1922
(Month) (Day) (Year)

7. AGE

9 Yrs. _____ Mos. _____ ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer).Student

9. BIRTHPLACE

(State or Country)

Midvale Ida10. NAME OF
FATHERJ. W. Haynes11. BIRTHPLACE
OF FATHER

(State or Country)

Idaho12. MAIDEN NAME
OF MOTHERLena Young13. BIRTHPLACE
OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. W. Haynes Eagle

15.

Filed 6-29-1922R. H. Pratt
Local Registrar

16. DATE OF DEATH

6-29-22
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
6-20-22 to 6-29-22
that I last saw him alive on 6-29-22
and that death occurred on the date stated above, at 6:30 A.M.

The CAUSE OF DEATH* was as follows:

Renal or Septic(Duration) Yrs. _____ mos. 12 ds.
Contributory Heart Disease
(Secondary)(Duration) yrs. _____ mos. _____ ds.
(Signed) C. S. Titus M. D.6-29-1922 (Address) Boise*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Star Cemetery July 22

20. UNDERTAKER

ADDRESS

Schneiber Midvale Idaho BoiseTitus

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada
City of BoiseRegistration District No. 2
Primary Registration District No. 1004
(No. 410 late St.)

If death occurs away from usual residence, give facts called for under special information.

File No. 38308
Registered No. 156

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edmund S. Watters

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED single6. DATE OF BIRTH February 22nd 1896
(Month) (Day) (Year)7. AGE 26 Yrs. 4 Mos. 6 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).accountant-stalicious9. BIRTHPLACE Little Rock Ark.
(State or Country)10. NAME OF FATHER Edmund James Watters11. BIRTHPLACE OF FATHER Needham Wis
(State or Country)12. MAIDEN NAME OF MOTHER Anna McInerney13. BIRTHPLACE OF MOTHER Burlington Iowa
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Anna S. Watters
(Address) 604 1/2 Hwy. St.15. Filed June 29 1922 R. H. Prax
Local RegistrarMEDICAL CERTIFICATE OF DEATH 2016. DATE OF DEATH June 28 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from June 14 1922 to June 28 1922, that I last saw him alive on June 28 1922, and that death occurred on the date stated above, at 11 A. M.

The CAUSE OF DEATH* was as follows:

Carbuncle on neck. and
resulting infection of sinuses
of trans
(Duration) Yrs. mos. 14 ds.Contributory (Secondary) _____
(Duration) yrs. mos. ds.(Signed) L. P. McCulloch M. D.
6/28/1922 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death? _____

Former or usual residence Boise19. PLACE OF BURIAL OR REMOVAL St. John's Cemetery DATE OF BURIAL 6/30/192220. UNDERTAKER Schreibler & Wideman ADDRESS Boise

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **38309**
Registered No. **157**

1. PLACE OF DEATH

County of **Ada**
City of **Boise**

Registration District No.
Primary Registration District No.
(No. **1012** **Lincoln St.** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Sarah Mead

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **F.** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Widow**
(Write the word.)

6. DATE OF BIRTH

April 8 1829
(Month) (Day) (Year)

7. AGE

93 Yrs. **2** Mos. **21** ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Retired

9. BIRTHPLACE

(State or Country)

Harrison Co. Ohio

10. NAME OF FATHER

J. Jenkins

11. BIRTHPLACE OF FATHER

(State or Country)

Nova Scotia Canada

12. MAIDEN NAME OF MOTHER

Catherine Johnson

13. BIRTHPLACE OF MOTHER

(State or Country)

Don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

L. J. Redell
60 Boise, Idaho

15.

Filed **6-29** 19**22**

Local Registrar

R. H. Pratt

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 29th 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **June 28** 19**22**, to **19**

that I last saw her alive on **June 28** 19**22**, and that death occurred on the date stated above, at **5 P.M.**

The CAUSE OF DEATH* was as follows:

apoplexia

(Duration) Yrs. mos. ds.

Contributory (Secondary)

old age

(Duration) **2** yrs. mos. ds.

(Signed)

J. W. Cannon M. D.
Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Dry Creek Cem **7/2** 19**22**

20. UNDERTAKER

ADDRESS

Schreibers & Sidenfaden **Boise**

D. Cannon

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Ada
City of BoiseRegistration District No. 2Primary Registration District No. 1004(No. 247 Warm Springs Ave St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Theo. A SloanState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 38310Registered No. 158

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

Oct171853

(Month)

(Day)

(Year)

7. AGE

68

Yrs.

Mos.

ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Hardware Merchant

(b) General nature of industry, business or establishment in which employed (or employer)

N

9. BIRTHPLACE

(State or Country)

Kingstony N.Y.

10. NAME OF FATHER

Not obtainable

11. BIRTHPLACE OF FATHER

(State or Country)

""

12. MAIDEN NAME OF MOTHER

""

13. BIRTHPLACE OF MOTHER

(State or Country)

""

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

L. A. Sloan

(Address)

249 W. 8 Ave

15.

Filed

June 3019 22R. N. Pratt

Local Registrar

SYNOPSIS CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June2919 22

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

1917

to

June 2819 22that I last saw him alive on June 28 19 22

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis(Duration) 10 Yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Joseph R. Runyars

M. D.

6-29-1922

(Address)

Boise, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Monis Hill Cemetery6/30/1922

20. UNDERTAKER

ADDRESS

Schweitzer & WidensfordBoiseDr. Numbers

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **38311**
Registered No. **159**

1. PLACE OF DEATH

County of **Ada**
City of **Boise**

Registration District No. **2**
Primary Registration District No. **1004**
(No. **310 Barnock** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Francis S. Ranney

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **M.** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED **Widow**
(Write the word.)

6. DATE OF BIRTH

Dec 31st 1842
(Month) (Day) (Year)

7. AGE

79 Yrs. Mos. ds. IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Retired

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

Leo Clinton Ranney

11. BIRTHPLACE OF FATHER

(State or Country)

Vir

12. MAIDEN NAME OF MOTHER

Purell

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Una Estella Bean

(Address)

15.

Filed **6-30** 19**22**

R. H. Rath
Local Registrar

MEDICAL CERTIFICATE OF DEATH

126

16. DATE OF DEATH

June 29th 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Dec 8** 19**17**, to **June 29** 19**22**

that I last saw him alive on **June 29** 19**22**
and that death occurred on the date stated above, at **M.**

The CAUSE OF DEATH* was as follows:

Cancer of Prostate

(Duration) **1** Yrs. mos. ds.

Contributory
(Secondary)

(Duration) **1** Yrs. mos. ds.

(Signed) **James L. Stewart** M. D.
(Address) **Boise Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery 7/1st 1922

20. UNDERTAKER

ADDRESS

Schubert & Sidenfaden Boise

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

Registration District No.

Primary Registration District No.

(No. of)

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many... hrs
or... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at 7:15 P.M.

The CAUSE OF DEATH* was as follows:

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

June 29, 1922 (Address) Boise, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH Ada
 County of Ada
 City of Boise
 Registration District No. 2
 Primary Registration District No. 1004
 (No. 410 State Idaho St.)

File No. 38313
 Registered No. 161

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Alma Cecelia Ballot

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

94

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
 (Write the word.)

6. DATE OF BIRTH

Oct-10-1886
 (Month) (Day) (Year)

7. AGE

35 Yrs. 9 Mos. 10 ds.

IF LESS than 1 day
 how many..... hrs.
 or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Montana

10. NAME OF FATHER

George W. Voss

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Marie Anna Schnautz

13. BIRTHPLACE OF MOTHER

(State or Country)

Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Lyle M. Powell(Address) 1419 N. 20th St. Boise

15.

Filed

July 1 19 22R. H. Padgug

Local Registrar

16. DATE OF DEATH

June 28th 19 22
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 21st 19 22, to June 28th 19 22, that I last saw her alive on June 28 19 22, and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Edema of lungs, due to pneumonia

(Duration) Yrs. mos. ds.

Contributory (Secondary)

Pregnancy (9th mo)

(Duration) yrs. mos. ds.

(Signed)

L. P. McCalla

M. D.

6/29/1922 (Address) Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. John's Cemetery July 1 19 22

20. UNDERTAKER

ADDRESS

Schmeider & Hidenfaden Boise

Dr. McCalla

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH **RECEIVED**
 County of **Ada** JUL 6 1922
 City of **Boise** BUREAU OF VITAL STATISTICS
 Registration District No. **2008**
 Primary Registration District No. **8**
 (No. of **Boise Near Baxter Foundry** St.)
 File No. **38314**
 Registered No. **36**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Charles Smith**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX **M.** 4. COLOR OR RACE **W.** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Single**
 (Write the word.)

6. DATE OF BIRTH **Don't know**
 (Month) (Day) (Year)

7. AGE **76** Yrs. — Mos. — ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
 (a) Trade, profession or particular kind of work **Laundry Employee.**
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE
 (State or Country) **Don't know**

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER
 (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
 (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) **W. McBratney**
 (Address) **Boise, Idaho.**

15. Filed **6-15** 19 **22** **R. H. Pratt**
 Local Registrar

16. DATE OF DEATH **79**
June 12 - 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Mar 1922** to **June 12 1922**
 that I last saw him alive on **June 12 1922**
 and that death occurred on the date stated above, at **8:15 P.M.**

The CAUSE OF DEATH* was as follows:
Chronic Myocarditis

(Duration) **3** Yrs. mos. ds.
 Contributory (Secondary) **Heart Block.**
 (Duration) yrs. mos. ds. **15**
 (Signed) **T. N. Brantner** M. D.
6/13 1922 (Address) **Boise Idaho.**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **Morris Hill Cemetery** DATE OF BURIAL **6/15 1922**

20. UNDERTAKER **W. McBratney** ADDRESS **Boise Idaho.**

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No.

2. FULL NAME

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many.....hrs.
or.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

6-19

19.22

R. H. Pratt

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

Feb 3 1922 to June 18th 1922

that I last saw him alive on June 18th 1922

and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Colon
and valvular heart disease

(Duration) Yrs. 6 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. R. Murray M. D.

6/19 19.22 (Address) Boise, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery June 20th 1922

20. UNDERTAKER

ADDRESS

Summers & Webb Boise, Ida

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Ada*City of *Boise*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Edith Laveen Bybee

JUL 6 1922

Registration District No. *8*

BUREAU OF VITAL STATISTICS

Registration District No. *2008*City of *Boise*St. *High School*File No. *38316*Registered No. *57*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

If LESS than 1 day
how many.....hrs.
or.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed *6-20* 19*22*

Local Registrar

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

June 11 19*22* to *June 18* 19*22*
that I last saw her alive on *June 17* 19*22*

and that death occurred on the date stated above, at.....M.

The CAUSE OF DEATH* was as follows:

Enterocolitis (Bottle feeding)(Duration).....Yrs.....mos. *7* ds.Contributory.....*Meningitis*
(Secondary)(Duration).....Yrs.....mos. *1* ds.(Signed) *T. N. Braxton* M. D.*6/19/22* (Address) *Boise, Idaho.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....Yrs.....mos.....days In the State.....Yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Morris Hill Cemetery**9-30* 19*22*

20. UNDERTAKER

ADDRESS

*Wm. Bratney**Boise, Idaho.*

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH
in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Ada

City of Eagle

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Claudia R. Carter

CERTIFICATE OF DEATH

38317

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. _____

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed June 1 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 26th 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 22nd 1922, to May 26th 1922
that I last saw him alive on May 25th 1922,
and that death occurred on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:

Probably Pulmonary or
Coronary Embolus - died
suddenly 79 hours after
onset of illness
(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

J. M. Taylor M. D.
5/26/22 (Address) Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Boise, Idaho June 1 1922

20. UNDERTAKER

ADDRESS

W. McBratney Boise, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

38318

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Barnack
City of McCannanRegistration District No. 28Primary Registration District No. 216File No. 51Registered No. 3859

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Unknown man

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.Male white Not Known

6. DATE OF BIRTH.

Not Known
(Month) (Day) (Year)

7. AGE

between 25 & 40 yrs
about 48
Yrs. Mos. ds.IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)unknown

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Sheriff Geo. Mober
Sheriff of Barnack County

15.

Filed

June 17 1922J. R. Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Thursday June 16, 22. Evidently
had been in River 6 miles.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to 191
that I last saw him alive on 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH was as follows:

Found in river with
skull fractured

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) J. S. Izquierdo Coroner6-17-1922 (Address) Pocatello Id

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death....yrs....mos....days In the State....yrs....mos....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

mt View Cem June 17, 1922

20. UNDERTAKER

ADDRESS

McHan Undertaking Pocatello

RECEIVED
JUN 20 1922

CERTIFICATE OF DEATH

38319

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Bannock*City of *Basin*Registration District No. *1*Primary Registration District No. *1*(No. *1*)St. *Basin*File No. *51*Registered No. *5860*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Brathwaite Charles

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant *Rev Eugene P. Burke*)(Address *Basin, Idaho*)

15.

Filed *6/20* 1922Local Registrar *James Schumacher*

16. DATE OF DEATH

June (Month)*20* (Day)19 *22* (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19....., to

19.....

that I last saw him alive on 19.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *A. J. Marshall* M. D.*June 20 - 22* (Address) *Act Coronor*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

2838320
State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 52
Registered No. 3861

1. PLACE OF DEATH

County of Bannock

Registration District No.

City of Boise

Primary Registration District No.

(No. 30 N. 3rd St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Welch

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Male

4. COLOR OF RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

Mar 11th 1845
(Month) (Day) (Year)

7. AGE

77 Yrs. 3 Mos. 9 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

Retired
Sabara

9. BIRTHPLACE

(State or Country)

Canada

10. NAME OF FATHER

John Welch

11. BIRTHPLACE OF FATHER

(State or Country)

unknown

12. MAIDEN NAME OF MOTHER

Elizabeth Orvil

13. BIRTHPLACE OF MOTHER

(State or Country)

unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs John Welch

(Address)

Boise, Ida

15.

Filed

6/21

1922

Local Registrar

16. DATE OF DEATH

June 20 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 19 1922 to June 20 1922
that I last saw him alive on June 20 1922
and that death occurred on the date stated above, at 11 P.M.

The CAUSE OF DEATH was as follows:

Cerebral hemorrhage resulting in complete paralysis of right side and coma.

(Duration) 0 Yrs. 0 mos. 1 1/2 ds.

Contributory (Secondary) Chronic nephritis and arteriosclerosis

(Duration) unknown mos. 0 ds.

(Signed) H. H. Hughes M. D.

6/21 1922 (Address) 400 Kane Bldg. Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mountain View June 22 1922

20. UNDERTAKER

ADDRESS

Schumacher & Sons Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

28 38321 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 52
 Registered No. 3862

1. PLACE OF DEATH *San Francisco*
 County of *Proskett*
 City of *Proskett*
 If death occurs away from usual residence, give facts called for under special information.
 2. FULL NAME *Ralph Newcomb*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Widower*
 (Write the word.)

6. DATE OF BIRTH *July 3 1874*
 (Month) (Day) (Year)

7. AGE *48* Yrs. *6* Mos. *21* ds.
 IF LESS than 1 day
 how many hrs. or min.?

8. OCCUPATION *Retired*
 (a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE *Orange County Vermont*
 (State or Country)

10. NAME OF FATHER *Walter Newcomb*

11. BIRTHPLACE OF FATHER *New Hampshire*
 (State or Country)

12. MAIDEN NAME OF MOTHER *Marriet Dean*

13. BIRTHPLACE OF MOTHER *New Hampshire*
 (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) *Walter Newcomb*
 (Address) *Proskett*

15. *Yes*
 Filed *7/5/22* 19 *22*
J. H. Young
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *June 24 1922*
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *April 25 1922* to *June 24 1922*
 that I last saw him alive on *June 24 1922*
 and that death occurred on the date stated above, *3:20* P. M.

The CAUSE OF DEATH* was as follows:

Gastric ulcer

(Duration) Yrs. *2* mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) *John J. Roaf* M. D.

6/25/19 (Address) *Proskett Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Colorado Springs* DATE OF BURIAL *6/25 1922*

20. UNDERTAKER *J. H. Roaf* ADDRESS *Proskett*

CERTIFICATE OF DEATH

1. PLACE OF DEATH *Home*
 County of *San Juan*
 City of *Pocatello*

Registration District No. *283832*
 Primary Registration District No. *2461*
 (No. *2461* St.)

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. *52*
 Registered No. *3863*

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

W. C. Daugherty

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*
 (Write the word.)

6. DATE OF BIRTH *April 1842*
 (Month) (Day) (Year)

7. AGE *80* Yrs. Mos. ds.
 IF LESS than 1 day
 how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

Retired

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *See Information*
 (Address)

15. Filed *6/27* 19*22* *J. P. Young*
 Local Registrar

16. DATE OF DEATH

June 24 19*22*
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *April 5th* 19*22*, to *June 24* 19*22*, that I last saw him alive on *June 24* 19*22*, and that death occurred on the date stated above, at *1:30* P. M.

The CAUSE OF DEATH* was as follows:

Senility - Uræmia

(Duration) Yrs. mos. ds.

Contributory *Enlarged prostate gland with a varicose vein*

(Duration) yrs. mos. ds.

(Signed) *J. P. Young* M. D.

June 27 19*22* (Address) *Pocatello, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Burton New York* DATE OF BURIAL *6/28* 19*22*

20. UNDERTAKER *W. W. Cracker* ADDRESS *Pocatello*

CERTIFICATE OF DEATH

38322

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County

Registration District No.

Primary Registration District No.

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from June 23, 1922, to June 24, 1922, that I last saw him alive on June 24, 1922, and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Signed)

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

38324

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. *Barroch*County *Barroch* Primary Registration District No. *413*City *Bozate* (No. *413* St. *4th*)

If death occurs away from usual residence, give facts called for under special information.

File No. *52*
Registered No. *5865*

If death occurred in a hospital, institution or camp, give the NAME instead of street and number.

2. FULL NAME

Marianna Bertasso

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *Female* 4. COLOR OR RACE *Italian* 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED *married*

(Write the word.)

6. DATE OF BIRTH *Feb 9th 1884*
(Month) (Day) (Year)7. AGE *38 3 16*
Yrs. Mos. ds. IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work *Housewife*
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) *Italy*

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country) *Italy*

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country) *Italy*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Angelo Bertasso*
(Address) *250 S. 3rd*

15.

Filed *6/27 1922*

16. DATE OF DEATH

6/26 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

6/26 1922 to *6-26 1922*
that I last saw him alive on *6-26 1922*
and that death occurred on the date stated above, at *11 P.*

The CAUSE OF DEATH* was as follows:

Uraemic poisoning

(Duration) Yrs. mos. ds.

Contributory (Secondary) *Pregnancy*

(Duration) Yrs. mos. ds.

(Signed) *J. P. Young M. D.**6/27 1922* (Address) *Bozate*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully applied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

38325

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Pocatello
City of POCATELLO, IDAHO

Registration District No. 28Primary Registration District No. 2161File No. 52Registered No. 3866

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Dan Little dike

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single (Write in word.)

6. DATE OF BIRTH.

Not Known
(Month) (Day) (Year)

7. AGE his Chum Scott Nelson says
42 Yrs. Mos. ds.

If less than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)

Common Laborer on farm and in mine

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

Little dike

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

not known

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Scott Nelson
Smithfield, Utah

15.

Filed June 23 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

175-a

16. DATE OF DEATH

June 23 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to 191

that I last saw him alive on 191

and that death occurred on the date stated above, at 3. a. M.

The CAUSE OF DEATH* was as follows:

Accidentally struck by a s. t. train

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

S. S. Ferguson
POCATELLO, IDAHO

6/23/22 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

Smithfield Utah

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Smithfield Utah June 24 1922

20. UNDERTAKER

ADDRESS

H. L. McHAN

POCATELLO, IDAHO

CERTIFICATE OF DEATH.

1. PLACE OF DEATH.

Registration District No. 28
 County of Bannock Primary Registration District No. 2161
 City of Pocatello (No. 1404 N. Grant St.)

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 52
 Registered No. 3867

If death occurs away from
 usual residence, give facts
 called for under special
 information.

2. FULL NAME

Juhana Christensen

If death occurred in a hos-
 pital, institution or camp,
 give its NAME instead of
 street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

Female white Widowed

6. DATE OF BIRTH.

Nov 17 1898
 (Month) (Day) (Year)

7. AGE

84 Yrs. 7 Mos. 12 ds.

IF LESS than 1 day
 how many.....hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or
 particular kind of work...
 (b) General nature of in-
 dustry, business, or estab-
 lishment in which employ-
 ed (or employer)

house keeper

9. BIRTHPLACE

(State or Country)

Denmark

10. NAME OF
FATHER

Rasmus Holm

11. BIRTHPLACE
OF FATHER

(State or Country)

Denmark

12. MAIDEN NAME
OF MOTHER

Hall

13. BIRTHPLACE
OF MOTHER

(State or Country)

Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

E. M. Schlademan

(Address)

1404 N. Grant

15.

Filed June 29 1922

W. Young
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 28 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Feb 10 1922 to June 27 1922
 that I last saw her alive on June 27 1922
 and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) 5 Yrs. mos. ds.

Contributory
 (Secondary)

Pneumonia

(Duration) yrs. 15 mos. ds.

(Signed)

Carl N. Clark M. D.

June 19 22 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
 MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death 13 yrs. mos. days. In the State 13 yrs. mos. days

Where was disease contracted
 if not at place of death?

Former or
 usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mt View Cem June 29 1922

20. UNDERTAKER

ADDRESS

McFarland & Co Pocatello

CERTIFICATE OF DEATH.

38327
State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 52
Registered No. 3869

1. PLACE OF DEATH. Registration District No. 28
County of Benrock Primary Registration District No. 2161
City of Pocatello No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Sallie Stewart

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

Female white Divorced
(Write the word.)

6. DATE OF BIRTH.

not known 1855
(Month) (Day) (Year)

7. AGE

67

Yrs. — Mos. — ds.

IF LESS than 1 day
how many hrs. or
min. 2

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

Housekeeper
Housekeeper.

9. BIRTHPLACE

(State or Country)

N. Carolina.

10. NAME OF FATHER

Shade Scott.

11. BIRTHPLACE OF FATHER

(State or Country)

N. Carolina.

12. MAIDEN NAME OF MOTHER

Louisa Payne.

13. BIRTHPLACE OF MOTHER

(State or Country)

N. Carolina.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Lucy M. Scott.

(Address)

Silverton Oregon

15.

Filed

6 - 3

1922

Deceased

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 2, 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 2, 1922, to June 2, 1922,
that I last saw her alive on June 2, 1922,
and that death occurred on the date stated above, at 1922 M.

The CAUSE OF DEATH* was as follows:

Cerebral syphilis
- diagnosis obtained from
sister-in-law
(Duration) 20 Yrs. mos. ds.

Contributory
(Secondary)

(Duration) 20 Yrs. mos. ds.

(Signed)

June 2, 1922 M. D.

(Address)

Pocatello

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place Enroute to Smith Arkansas
of death Yrs. mos. days State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

Silverton Oregon

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Joplin Mo. June 7, 1922

20. UNDERTAKER

V. F. McMan Pocatello, Ida.

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statements of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

38328
State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

RECEIVED

Registration District No.

County of

Bannock

Registration District No.

City of

Pocatello

BUREAU OF VITAL STATISTICS

File No.

51

Registered No.

3852

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Dorothy Elizabeth Bayl

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

7

white

Single

6. DATE OF BIRTH.

June 1

(Month)

1922

(Day)

(Year)

7. AGE

lived 24 hours

IF LESS than 1 day how many 24 hrs. or min.

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

none

9. BIRTHPLACE

(State or Country)

Pocatello, Idaho

10. NAME OF FATHER

Joseph Perry Bayl

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Nasmi R. Devore

13. BIRTHPLACE OF MOTHER

(State or Country)

New York State

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Joseph P. Bayl

(Address)

Pocatello, Idaho

15.

Filed

June 2, 1922 J. R. Young

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 2

(Month)

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

6-1

1922 to

6-2

1922

that I last saw her alive on

6-1

1922

and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Premature birth at 6 1/2 m. m.

(Duration)

Yrs.

mos.

ds.

Contributory (Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

J. R. Young

M. D.

June 2, 1922 (Address) Pocatello, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

yrs.

mos.

days

In the

State

yrs.

mos.

days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mt View Cem

June 2, 1922

20. UNDERTAKER

ADDRESS

McName Undertaking Pocatello, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

38329

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Bannock
City of Bozelle

RECEIVED
JUL 1 1922

Registration District No. 28
Primary Registration District No. 2161
(No. 2161 St.)

File No. 51
Registered No. 3853

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Shea

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

not known
(Write the word.)

6. DATE OF BIRTH.

not known
(Month) (Day) (Year)

7. AGE

apparently 40
Yrs. Mos. ds.

IF LESS than 1 day
how many hrs. or min. >|

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

Labor. (?)

9. BIRTHPLACE

(State or Country)

not known

10. NAME OF FATHER

not known

11. BIRTHPLACE OF FATHER

(State or Country)

not known

12. MAIDEN NAME OF MOTHER

not known

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Sheriff Mabey
Bannock County

15.

Filed

6-6 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

not known 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to 191
that I last saw h. alive on 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

unknown

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

D. S. Johnson

(Address)

Bozelle, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

St. Clair Cemetery June 6, 1922

20. UNDERTAKER

ADDRESS

W. H. McLean Bozelle, Idaho

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Bannock*City of *Pocatello*

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Leda V. Way

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

*White*5. SINGLE MARRIED, WID-
OWED OR DIVORCED*Single*
(Write the word.)

6. DATE OF BIRTH

Sept 1st 1922
(Month) (Day) (Year)

7. AGE

1 Yrs. *9* Mos. *4* ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) *Montana*

10. NAME OF FATHER

Wack J. Way

11. BIRTHPLACE OF FATHER

(State or Country) *Oklahoma*

12. MAIDEN NAME OF MOTHER

Leda Triplet

13. BIRTHPLACE OF MOTHER

(State or Country) *Montana*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address) *1532 N. Harrison*

15.

Filed

2 *6* 19*22*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 6 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 30 1922 to *June 6 1922*
that I last saw him alive on *June 6 1922*
and that death occurred on the date stated above, at *7:30 P.M.*

The CAUSE OF DEATH* was as follows:

Infectious Diarrhea(Duration) Yrs. mos. *17* ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

June 7 1922

(Address)

Idaho Falls M. D.
Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mountain View Cemetery *June 7 1922*

20. UNDERTAKER

ADDRESS

Schumacher & Co *Idaho Falls*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

38333

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 28
County of Bannock Primary Registration District No. 2161
City of Pocatello (No. 340 M. Hayes St.)

File No. 51
Registered No. 3857

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Emma Myers

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widow

6. DATE OF BIRTH.

Mar 21 1856
(Month) (Day) (Year)

7. AGE

66 Yrs. 2 Mos. 26 ds.

IF LESS than 1 day
how many.....hrs. or
.....min.]

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

house wife

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

Philip Held

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Phelipen

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Henry C. Myers

(Address)

340 N. Hayes St. Pocatello, Idaho

15.

Filed June 16 1922J. R. Young

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 16 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 13th 1922 to June 16th 1922
that I last saw her alive on June 14th 1922
and that death occurred on the date stated above, at 5:30 A. M.

The CAUSE OF DEATH* was as follows:

cancer of the stomach(Duration) Yrs. 4 mos. ds.

Contributory (Secondary)

none

(Duration) Yrs. mos. ds.

(Signed)

Dr. L. J. Young M. D.6/16 1922 (Address) Pocatello, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDE or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 7 yrs.....mos.....days In the State 7 yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

Utah

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mt View Cem June 17 1922

20. UNDERTAKER

ADDRESS

McKean Undert Co Pocatello

CERTIFICATE OF DEATH

2838334

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County

Bannock

City of

Preston

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No.)

347 N. 3rd

St.)

File No.

51

Registered No.

3858

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Frank Williams

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

Male Colored Single
Infant date 1874
unknown (Month) (Day) (Year)

7. AGE

48 years as known
Yrs. Mos. ds. or min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Laborer

9. BIRTHPLACE

(State or Country)

Kansas

10. NAME OF FATHER

Unknown Williams

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mary Bradsher

(Address)

25th St. 1st

15.

Filed 6-18 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 3rd 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19..... to 19.....
that I last saw h..... alive on 19.....
and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Myocarditis

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Duration) Yrs. mos. ds.

4/22/22 (Signed) J. J. Ferguson Coroner
5/1/22 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mountain View June 19 1922

20. UNDERTAKER

ADDRESS

Schumacher & Sons Pocatello

CERTIFICATE OF DEATH

38335

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

If death occurs away from
usual residence, give facts
called for under special in-
formation.

Registration District No.

Primary Registration District No.

(No.)

File No.

Registered No.

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF
FATHER11. BIRTHPLACE
OF FATHER

(State or Country)

12. MAIDEN NAME
OF MOTHER13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
May 3 - 1922 to May 5 - 1922
that I last saw him alive on May 5 - 1922
and that death occurred on the date stated above, at 10:30 A.M.

The CAUSE OF DEATH* was as follows:

accidental automobile

(Duration) Yrs. mos. 2 ds.

Contributory
(Secondary)

(Duration) yrs. mos. 2 ds.

(Signed)

M. D.

May 5 - 1922 (Address) 2222 2222

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. 2 days. In the State 7 yrs. mos. 2 days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

38336

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock
City of PocatelloRegistration District No. 28Primary Registration District No. 2161(No. 744 S. Main St.)File No. 51Registered No. 3836

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Rachel Poppleton Elk

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female American

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

Jan 5 1873
(Month) (Day) (Year)

7. AGE

49 Yrs. 3 Mos. 29 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Housewife

9. BIRTHPLACE

(State or Country)

Wellsville Utah

10. NAME OF FATHER

Garth William Poppleton

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Leah Perkes

13. BIRTHPLACE OF MOTHER

(State or Country)

Dudley - England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

M. M. Elk

(Address)

744 South Main Pocatello

15.

Filed

7/81922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 4 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Apr 1922 to May 4 1922
that I last saw h. er alive on May 3 1922
and that death occurred on the date stated above, at 8:30 P.M.

The CAUSE OF DEATH* was as follows:

Biliary Septicemia(Duration) Yrs. mos. ds.
Contributory (Secondary) Chronic Cholecystitis(Duration) 3 yrs. mos. ds.(Signed) Chas. S. Ray M. D.5:6.1922 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mountain View May 7 1922

20. UNDERTAKER

ADDRESS

Schumacher & Sons curj

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

38337

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of *Bannock*
City of *Pocatello*Registration District No. *28*
Primary Registration District No. *2161*
(No. *AL* St.)File No. *51*
Registered No. *3837*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Samuel M Autra*If death occurred in a hospital, institution or camp, give its NAME instead of street and number. *79*

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WID-OWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH.

July *10* *1854*
(Month) (Day) (Year)

7. AGE

67 Yrs. *7* Mos. *10* ds.IF LESS than 1 day
how many.....hrs. or
.....min.?)

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....*Farmer.*

9. BIRTHPLACE

(State or Country)

Tennessee.

10. NAME OF FATHER

Samuel Autra.

11. BIRTHPLACE OF FATHER

(State or Country)

Not Known.

12. MAIDEN NAME OF MOTHER

Narcissis Roberts

13. BIRTHPLACE OF MOTHER

(State or Country)

Tennessee.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Chas L. Autra.

(Address)

207 So Garfield.

15.

Filed

5/8 *1922**J. P. Young*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May *7* *1922*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

5/4 *1922* to *5-7* *1922*
that I last saw him alive on *5-7* *1922*
and that death occurred on the date stated above, at *11:30 P.M.*

The CAUSE OF DEATH* was as follows:

Myocarditis(Duration) Yrs. *6* mos. ds.Contributory
(Secondary)(Duration) Yrs. *5* mos. ds.

(Signed)

5/8 *1922* (Address) *Pocatello*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Pocatello Ida.**191*

20. UNDERTAKER

ADDRESS

*J. F. McHaw.**Pocatello*
215 So Main

CERTIFICATE OF DEATH

38338 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Camanche*City of *Pocatello*

If death occurs away from usual residence, give facts called for under special information.

Registration District No. *2116*Primary Registration District No. *2116*File No. *81*Registered No. *38338*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Mr. E. C. Shack

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

1856
(Month) (Day) (Year)

7. AGE

66

Yrs. Mos. da.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

Nursewife

9. BIRTHPLACE

(State or Country)

Holland Utah

10. NAME OF FATHER

Wm Gardner

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Angelina Gould

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

E. C. Shack
132 So 1st Ave Pocatello

15.

Filed

*5-12*19*22**E. C. Shack*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 11 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY That I attended deceased from

*April 29 1922 to May 11 1922*that I last saw her alive on *May 11 1922*and that death occurred on the date stated above, at *10:30 P.M.*

The CAUSE OF DEATH* was as follows:

Carcinoma rectum(Duration) Yrs. *10* mos. *7* ds.

Contributory (Secondary)

Pulmonary tuberculosis(Duration) yrs. *10* mos. *10* ds.

(Signed)

*H. F. Howard M. D.**5/11/22* (Address)*Pocatello Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Bingham City, Utah**5/17 1922*

20. UNDERTAKER

H. F. Howard

ADDRESS

Pocatello

CERTIFICATE OF DEATH

38339

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

RECEIVED

Primary Registration District No.

JUN 10 1922

HOSPITAL

2. FULL NAME

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from
May 5th 1922 to May 11th 1922
that I last saw her alive on May 11th 1922
and that death occurred on the date stated above, at 3:30 P. M.

The CAUSE OF DEATH* was as follows:

acute nephritis
urine incontinence
complication

(Duration) Yrs. mos. 5 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

May 13th 1922 (Address) Coocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. 6 days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

38340

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Ramsey*City of *Pocatello*

If death occurs away from usual residence, give facts called for under special information.

Registration District No. *28*Primary Registration District No. *2181*(No. *10*)

St.)

File No. *1*Registered No. *3811*If death occurred in a hospital, institution or camp, give its NAME instead of street and number. *170*

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed *10* *10* 19 *22*

Local Registrar

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on _____ 19 *22*and that death occurred on the date stated above, at *10* A. M.

The CAUSE OF DEATH was as follows:

Contributory
(Secondary)

(Signed)

5/15/22

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

28 38341

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock
City of BoiseRegistration District No. 2Primary Registration District No. 2(No. 2)(St. Idaho)File No. 51Registered No. 3842

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Maggie Ellen BarnardIf death occurred in hospital, institution or camp, give its NAME instead of street and number. 42

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female4. COLOR OR RACE White5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married

(Write the word)

6. DATE OF BIRTH

July 17 1878
(Month) (Day) (Year)

7. AGE

47 Yrs. 9 Mos. 29 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

Joseph C. Barnard

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Maggie Munden

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) D. W. Barnard(Address) Armed

15.

Filed 5-17 1922Dr. J. W. Baker
Local Registrar

16. DATE OF DEATH

May 16 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from May 9 1922 to May 16 1922that I last saw him alive on May 16 1922 and that death occurred on the date stated above, at 1:30 P. M.

The CAUSE OF DEATH* was as follows:

pneumonia - double(Duration) Yrs. 7 mos. 11 ds.Contributory (Secondary) Influenza(Duration) Yrs. 7 mos. 14 ds.(Signed) J. W. Baker M. D.May 19 22 (Address) Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. 7 days. In the State..... yrs. mos. 7 daysWhere was disease contracted if not at place of death? ArmedFormer or usual residence Armed

19. PLACE OF BURIAL OR REMOVAL

St. Lawrence Cemetery

20. UNDERTAKER

Dr. J. W. Baker

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

1. PLACE OF DEATH.

County of Bannock
City of Pocatello

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Walter Henry Clark

CERTIFICATE OF DEATH.

Registration District No.

Primary Registration District No.

(No.)

38342

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

male

white

married

(Write the word.)

6. DATE OF BIRTH.

Dec 2 1851
(Month) (Day) (Year)

7. AGE

70 Yrs. 5 Mos. 16 ds.

IF LESS than 1 day
how many.....hrs. or
.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

Teacher &
Confectioner

9. BIRTHPLACE

(State or Country)

Canton Ohio

10. NAME OF FATHER

Maskel Clark

11. BIRTHPLACE OF FATHER

(State or Country)

Catharine Gibson

12. MAIDEN NAME OF MOTHER

Catharine Gibson

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. Walter Henry Clark

(Address)

935 West Lewis

15.

Filed

5-18 1922

Day Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 18 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-15 1922, to 5-18 1922.

that I last saw him alive on 5-16 1922.

and that death occurred on the date stated above, at 12:30 A.M.

The CAUSE OF DEATH* was as follows:

Diabetic Coma

(Duration) Yrs. mos. ds. 1 ds.

Contributory
(Secondary)

Diabetes

(Duration) Yrs. mos. ds. 6 mos.

(Signed)

18.1922 (Address) Pocatello M. D.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 2 yrs. mos. days In the State 2 yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mt New Cemetery May 20 1922

20. UNDERTAKER

ADDRESS

H. F. McFar 215 So Main

38343

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

1. PLACE OF DEATH.

Registration District No. 28
County of Bannock Primary Registration District No. 2161
City of Pocatello, (No. _____ St.)File No. 51Registered No. 3843

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Germa Coronas

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.male mexican not known
(Write the word.)

6. DATE OF BIRTH.

not known
(Month) (Day) (Year)

7. AGE

not known
Yrs. Mos. ds.IF LESS than 1 day
how many hrs. or
..... min. >]

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)Not known

9. BIRTHPLACE

(State or Country)

Not known

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Miss Pond
Pocatello Gen Hospital

15.

Filed

5-20-1922

Def. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 19 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from May 16, 1922 to May 19, 1922
that I last saw him alive on May 19, 1922
and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Tuberculosis of
bowels, with
General peritonitis(Duration) Yrs. 6 mos. — ds.Contributory (Secondary) Chronic Pulmonary Tuberculosis(Duration) not known Yrs. — mos. — ds.(Signed) C. W. Clark M. D.May 19, 1922 (Address) Pocatello, Idaho

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.. 6 mos.....days. In the State.....yrs.. 6 mos.....daysWhere was disease contracted if not at place of death? not knownFormer or usual residence Mexico for 9 years

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. New Cemetery May 20, 1922

20. UNDERTAKER

ADDRESS

J. F. McFar 215 So Main
Pocatello
Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

38344 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 51
Registered No. 3846

1. PLACE OF DEATH

County of BannockCity of Pocatello

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 23Primary Registration District No. 2161(No. General Hospital

St.)

2. FULL NAME H. A. Beswick

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDDivorced
(Write the word.)

6. DATE OF BIRTH

Unknown

(Month)

(Day)

(Year)

7. AGE

58

Yrs.

Mos.

ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Farmer

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Unknown

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) D. C. W. Clark(Address) Pocatello

15.

Filed 5 22 19 22Local Registrar L. R. Young

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 20 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 16 1922, to May 20 1922that I last saw him alive on May 20 1922and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Spotted Fever (Rocky Mountain type).(Duration) Yrs. 8 mos. 8 ds.Contributory (Secondary) Overwork and underfed.(Duration) yrs. 6 mos. 8 ds.(Signed) Carl W. Clark M. D.May 22 1922 (Address) Pocatello 2 drs

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mountain View Cem 9 May 27 1922

20. UNDERTAKER

ADDRESS

Schumacher & Hall Pocatello

CERTIFICATE OF DEATH

38345 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Blaine Registration District No. 28
City of Pocatello Primary Registration District No. 2161
BUREAU (No. 1 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mr. Arthur SammsFile No. 51
Registered No. 3850

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married

6. DATE OF BIRTH

March 15 1866
(Month) (Day) (Year)

7. AGE

56 Yrs. 2 Mos. 10 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Civil Engineer

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

John Samms
Indiana

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Vergil Samms
Boise, Ida.

15.

Filed

5-27-1922G. O. Samms

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 25 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from May 17 1922 to May 25 1922 that I last saw him alive on May 25 1922 and that death occurred on the date stated above, at 7:00 P. M.

The CAUSE OF DEATH* was as follows:

Hypertension

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Chas. H. Sprague M. D.
Pocatello, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

St. Lawrence Cemetery 5/28 1922
20. UNDERTAKER H. M. Macker Pocatello

CERTIFICATE OF DEATH

38346

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County *Bannock*
City of *Pocatello*

Registration District No. _____

Primary Registration District No. _____

(No. *450 S. Third* St.)

File No. _____

Registered No. *3851*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William Jephard

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED, OR DIVORCED*Male* *White* *Single*
(Write the word.)

6. DATE OF BIRTH

*February 27**Unknown*

(Month)

(Day)

(Year)

7. AGE

about 78 yrs

Yrs. Mos. ds.

IF LESS than 1 day

how many _____ hrs.

or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

Retired

9. BIRTHPLACE

(State or Country)

Unknown

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

D. L. Morrison

(Address)

450 S. Third

15.

Filed *5-31-1922*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May

(Month)

27

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 19____, to _____ 19____,

that I last saw him _____ alive on _____ 19____,

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

*S. S. Johnson, Coroner**5/31/1922*(Address) *Pocatello, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

*Mountain View**May 31, 1922*

20. UNDERTAKER

Schumacher & Sons

ADDRESS

Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

28 38348

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock
City of Pocatello

Registration District No. _____

Primary Registration District No. _____

(No. St. Anthony Hospital)

File No. _____

Registered No. 3844

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jim Pulor

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

May 17 1922
(Month) (Day) (Year)

7. AGE

1 Yrs. 1 Mos. 1 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Infant

9. BIRTHPLACE

(State or Country)

Pocatello

10. NAME OF FATHER

Dan Pulor

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Rena Hordogian

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Dan Pulor

(Address)

Pocatello, Ida.

15.

Filed

5-18 1922Jim Pulor
Dep. Local Registrar

16. DATE OF DEATH

May 18 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 17 1922 to May 18 1922that I last saw him alive on May 17 1922and that death occurred on the date stated above, at 5 A. M.

The CAUSE OF DEATH* was as follows:

Lines Congenital(Duration) _____ Yrs. _____ mos. 2 ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

W. F. Howard M. D.
Pocatello, Idaho

19 _____ (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mountain View CemMay 19 1922

20. UNDERTAKER

ADDRESS

Schumacher & HallPocatello

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

38349

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Bannock Registration District No. 28
City of Pocatello Primary Registration District No. 2161
(No. Pocatello Idaho St.)

File No. 52
Registered No. 3868

If death occurs away from
usual residence, give facts
called for under special
information.

2. FULL NAME

Infant Grable

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female white

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.Single
(Write the word.)

6. DATE OF BIRTH.

May 25 1922
(Month) (Day) (Year)

7. AGE

Yrs. 6 Mos. 6 ds.

IF LESS than 1 day
how many hrs. or
min.

8. OCCUPATION

(a) Trade, profession or
particular kind of work...
(b) General nature of in-
dustry, business, or estab-
lishment in which employ-
ed (or employer)

None

9. BIRTHPLACE

(State or Country)

Pocatello Ida10. NAME OF
FATHERGuy Grable11. BIRTHPLACE
OF FATHER

(State or Country)

Texas12. MAIDEN NAME
OF MOTHERLilas Hamby13. BIRTHPLACE
OF MOTHER

(State or Country)

Arkansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Guy Grable
Pocatello Ida

15.

Filed

May 31 1922

Wm. H. H. H.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 30 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
May 28 1922 to May 30 1922
that I last saw h. Er alive on May 29 1922
and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Idiopathic graver

(Duration) Yrs. 2 mos. 2 ds.

Contributory
(Secondary)

(Duration) Yrs. 2 mos. 2 ds.

(Signed) J. J. Rast D.
1922 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death... yrs. 2 mos. 2 days In the State... yrs. 2 mos. 2 days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Pocatello Ida May 31 1922

20. UNDERTAKER

ADDRESS

McHan Undert Co. Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

38350

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 28

County of *Cannock*
City of *Pocatello*

Primary Registration District No. *2161*
(No. St.)

File No. *51*
Registered No. *3848*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant Kanomata

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-OWED, OR DIVORCED.

male Japanese

Single
(Write the word.)

6. DATE OF BIRTH.

May 5 1922
(Month) (Day) (Year)

7. AGE

Yrs. Mos. *7* ds.

IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...

None

9. BIRTHPLACE

(State or Country)

Pocatello Ida.

10. NAME OF FATHER

Chas Kanomata

11. BIRTHPLACE OF FATHER

(State or Country)

Japan

12. MAIDEN NAME OF MOTHER

Mase

13. BIRTHPLACE OF MOTHER

(State or Country)

Japan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Chas Kanomata
254 So Main St

15.

Filed

5-13

19122

Free

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 12 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 11 1922 to *May 12 1922*
that I last saw him alive on *May 12 1922*
and that death occurred on the date stated above, at *11:15 PM*

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) Yrs. mos. *7* ds.

Contributory (Secondary)

Forcep delivery

(Duration) Yrs. mos. ds.

(Signed) *W. W. Brothers* M. D.

May 31 1922 (Address) *Pocatello, Idaho*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....*life*...days In the State.....yrs.....*life*...mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

Pocatello

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Pocatello Ida Mt View *May 16 1922*

20. UNDERTAKER

ADDRESS

V. F. McFar *Pocatello Idaho*

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

(No.)

38352

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

5-24

1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 23 1922 to May 23 1922

that I last saw him alive on May 23 1922

and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Premature birth

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Am. Newton

M. D.

May 23 1922 (Address) Pocatello, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

20. UNDERTAKER

ADDRESS

1. PLACE OF DEATH.

County of BannockCity of Lava Hot SpringsIf death occurs away from
usual residence, give facts
called for under special
information.RECEIVED
JUN 27 1922

Registration District No.

Primary Registration District No.

BUREAU OF VITAL
STATISTICS

File No.

Registered No.

If death occurred in a hos-
pital, institution or camp,
its NAME instead of
street and number.

2. FULL NAME

Samuel Blaine Williams

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.(Write in English)
Single

6. DATE OF BIRTH.

July 16, 1913
(Month) (Day) (Year)

7. AGE

8 Yrs. 10 Mos. 17 ds.
IF LESS than 1 day
how many hrs. or
..... min. 2)

8. OCCUPATION

(a) Trade, profession or
particular kind of work...
(b) General nature of in-
dustry, business, or estab-
lishment in which employ-
ed (or employer).....Student

9. BIRTHPLACE

(State or Country)

St Anthony, Ida10. NAME OF
FATHERDavid E Williams11. BIRTHPLACE
OF FATHER

(State or Country)

Utah12. MAIDEN NAME
OF MOTHEROlue E Ashcraft13. BIRTHPLACE
OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

David E Williams
(Address) Lava Hot Springs, Ida

15.

Filed

May 30 1922Walter R. Bond
Local Registrar

MEDICAL CERTIFICATE OF DEATH

9

16. DATE OF DEATH

May 30 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
5-25 1922, to 5-30 1922.that I last saw him alive on 5-29 1922.and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

Diphtheria(Duration) Yrs. mos. 5 ds.Contributory
(Secondary)(Signed) D. H. Lewis M. D.19. (Address) Lava Hot Springs*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)At place of death 3 yrs. mos. days In the State yrs. mos. daysWhere was disease contracted
if not at place of death?Former or usual residence Victor Basin, Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St Anthony, IdaMay 31, 1922

20. UNDERTAKER

ADDRESS

H. L. McPhersonBoise, Idaho

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH
in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

RECEIVED
JUN 2 1922

CERTIFICATE OF DEATH

38355

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock
City of Lund

Registration District No. 84

Primary Registration District No. 2131

(No. _____ St.)

File No. _____

Registered No. _____

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME Carolina Frederica Isaacson

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number. 79

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

F

W

Widow write the word.)

6. DATE OF BIRTH

Dec 31 1845
(Month) (Day) (Year)

7. AGE

78 Yrs. 4 Mos. 20 ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min. ?

8. OCCUPATION

(a) Trade, profession or
particular kind of work

housewife

(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country)

Malno Sweden

10. NAME OF
FATHER

???

%

11. BIRTHPLACE
OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME
OF MOTHER

?????

13. BIRTHPLACE
OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(Address) _____

15.

Filed 6-1-22 19 _____

Walter Bach
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 20, 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____ 19 _____, to _____ 19 _____

that I last saw h. _____ alive on _____ 19 _____,

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Myocarditis

_____ (Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

_____ 19 _____ (Address) _____

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted
if not at place of death? _____

Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

38357

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH RECEIVED
 County of Bennett Registration District No. 32
 City of St. Maries Primary Registration District No. 2049
 (No. _____) (St.) _____

File No. _____
 Registered No. 28

If death occurs away from
 usual residence, give facts
 called for under special in-
 formation.

2. FULL NAME

Charles Herbert Hoisington

If death occurred in a hos-
 pital, institution or camp,
 give its NAME instead of
 street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED married
 (Write the word.)

6. DATE OF BIRTH Sept 7 1871
 (Month) (Day) (Year)

7. AGE 50 Yrs. 8 Mos. 28 ds.
 IF LESS than 1 day
 how many _____ hrs.
 or _____ min.?

8. OCCUPATION

(a) Trade, profession or
 particular kind of work.
 (b) General nature of in-
 dustry, business or estab-
 lishment in which employ-
 ed (or employer).

Farmer

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

W. W. Hoisington

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Kate Elizabeth Smith

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Lottie P. Hoisington
 (Address) St. Maries, Ida.

15.

Filed June 6 1922

H. E. Hunt
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

28

16. DATE OF DEATH

June 5 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 18 1922 to June 8 1922
 that I last saw him alive on May 18 1922
 and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Tubercular Laryngitis

(Duration) _____ Yrs. 6 mos. _____ ds.
 Contributory (Secondary) Chronic Tuberculosis

(Duration) 2 yrs. _____ mos. _____ ds.
 (Signed) E. D. Platt M. D.

June 19 22 (Address) St. Maries, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state
 (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted
 if not at place of death? _____

Former or
 usual residence _____

19. PLACE OF BURIAL OR REMOVAL Cover, Valeno, Ida. DATE OF BURIAL June 19 22

20. UNDERTAKER Mitchell & Menager ADDRESS St. Maries, Ida.

CERTIFICATE OF DEATH

38358

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bennett
City of St. MarieRegistration District No. 32Primary Registration District No. 2049File No. 29

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Sarah Elizabeth Bennett

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

married
(Write the word.)

6. DATE OF BIRTH

Nov 12 1847
(Month) (Day) (Year)

7. AGE

74 Yrs. 7 Mos. 2 ds.IF LESS than 1 day
how many.....hrs.
or.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).House-wife

9. BIRTHPLACE

(State or Country)

Kentucky

10. NAME OF FATHER

Henry Bruner

11. BIRTHPLACE OF FATHER

(State or Country)

Indiana

12. MAIDEN NAME OF MOTHER

not known

13. BIRTHPLACE OF MOTHER

(State or Country)

Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

James S. Bennett
St Marie, Ida.

15.

Filed 6/16 1922 CG Miller

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 14 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from June 11 1922, to June 14 1922that I last saw her alive on June 13 1922and that death occurred on the date stated above, at 9:30 A.M.

The CAUSE OF DEATH* was as follows:

General Senility(Duration) 7 Yrs. 0 mos. 0 ds.Contributory Arterio Sclerosis
(Secondary)(Duration) 5 yrs. 0 mos. 0 ds.(Signed) Owen D. Hall M. D.June 12 (Address) Bennett, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

Woodlawn Cem.

DATE OF BURIAL

6/16 1922

20. UNDERTAKER

Mitchell & McLaughlin

ADDRESS

St Marie, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **38359**
Registered No. **30**

1. PLACE OF DEATH

County of **Benedict**
City of **St. Maries**Registration District No. **32**
Primary Registration District No. **2049**
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jimmy Leishman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

male white Single
(Write the word.)

6. DATE OF BIRTH

882
(Month) (Day) (Year)

7. AGE

40 Yrs. Mos. ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).**Painter**
Staple - Jack

9. BIRTHPLACE

(State or Country)

Glasgow Scotland
Scott. Prov.

10. NAME OF FATHER

John Leishman
Scott. Prov.

11. BIRTHPLACE OF FATHER

(State or Country)

Glasgow Scotland
Scott. Prov.

12. MAIDEN NAME OF MOTHER

Agnes Turnbull
Scott. Prov.

13. BIRTHPLACE OF MOTHER

(State or Country)

Glasgow Scotland
Scott. Prov.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

C. A. Robins
St. Maries, Ida

15.

Filed **6/21/22** 19.....**Chancellor**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 16 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from **June 7 1922** to **June 16 1922**
that I last saw him alive on **June 16 1922**
and that death occurred on the date stated above, at **3:55 P.M.**

The CAUSE OF DEATH* was as follows:

Fall from roof of mill
Accidental(Duration) Yrs. mos. **9** ds.
Contributory (Secondary) **Fracture 4th Cerv. Vertebrae**(Duration) Yrs. mos. **9** ds.
(Signed) **C. A. Robins** M. D.**6/21/1922** (Address) **St. Maries, Ida**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. **9** days. State..... yrs. mos. **12** days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Woodlawn**6/20 1922**

20. UNDERTAKER

ADDRESS

Mitchell & Merage **St. Maries, Ida**

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Benewah Registration District No. 32
 City of McCutcheon Camp Primary Registration District No. 2049
 (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jed Martin

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 38360
 Registered No. 31

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED single
 (Write the word.)

6. DATE OF BIRTH

887
 (Month) (Day) (Year)

7. AGE

35 apparently
 Yrs. Mos. ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

woodsman
sawyer

9. BIRTHPLACE

(State or Country)

Norway

10. NAME OF FATHER

not known

11. BIRTHPLACE OF FATHER

(State or Country)

not known

12. MAIDEN NAME OF MOTHER

not known

13. BIRTHPLACE OF MOTHER

(State or Country)

not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Erick Nyberg
 (Address) Plummer Id.

15.

Filed 6/30 1922 Osmerap
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 28 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 28, 1922, to June 28, 1922, that I last saw him dead on June 28, 1922, and that death occurred on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH was as follows:

Struck on head by dry tree while falling timber and killed instantly. Skull crushed.
accidental
 (Duration) Yrs. mos. ds.

Contributory
 (Secondary)

(Duration) Yrs. mos. ds.

(Signed) H. L. Aleom - Coroner

6/28, 1922 (Address) St. Maries, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Wood Camp

DATE OF BURIAL

7/1 1922

20. UNDERTAKER

Mitchell & Menager St. Maries

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bennett Registration District No. 31
City of Lensed Registration District No. 1822 (St.)
BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Onel CampbellFile No. 88362Registered No. 4

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

M. White Single (Write the word.)

6. DATE OF BIRTH

Sept 10 1896
(Month) (Day) (Year)

7. AGE

25 Yrs. 8 Mos. 19 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Farmer

9. BIRTHPLACE

(State or Country)

Mo.

10. NAME OF FATHER

Lee Campbell

11. BIRTHPLACE OF FATHER

(State or Country)

Mo.

12. MAIDEN NAME OF MOTHER

Maggie Smith

13. BIRTHPLACE OF MOTHER

(State or Country)

Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. F. Billingsley

(Address)

Lensed Id.

15.

Filed May 30 1922Y. E. Bihan
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 29 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb. 20 1922, to May 29 1922that I last saw him alive on May 8 1922,
and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

F. B. Barton

M. D.

19 (Address) Dumet Id.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Tekoa Wash

DATE OF BURIAL

5/31 1922

20. UNDERTAKER

Carl. Schulermit

ADDRESS

Tekoa Wash

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH

County of Bennett

City of Bennett

If death occurs away from usual residence, give facts called for under special information.

RECEIVED CERTIFICATE OF DEATH

JUL 1 1922

Registration District No. 11

Primary Registration District No. 11

STANDARD

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 38363

Registered No. 4

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Caroline Alexander

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F.

4. COLOR OR RACE

Indian

5. SINGLE, MARRIED, WID-OWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

May 3 1909
(Month) (Day) (Year)

7. AGE

14 Yrs. 1 Mos. 1 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Wash.

10. NAME OF FATHER

Alexander Land Louis

11. BIRTHPLACE OF FATHER

(State or Country)

Wash.

12. MAIDEN NAME OF MOTHER

Sellie

13. BIRTHPLACE OF MOTHER

(State or Country)

Wash.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Joe Vincent

(Address) Bennett, Id.

15.

Filed June 4 1922

J. L. Bilsen
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 3 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 1 1921, to May 7 1922

that I last saw her alive on May 7 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 Yrs. 1 mos. 1 ds.

Contributory
(Secondary)

(Duration) 1 yrs. 1 mos. 1 ds.

(Signed) J. Barton M. D.

19 (Address) Bennett, Id.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 1 yrs. 1 mos. 1 days. In the State 1 yrs. 1 mos. 1 days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Bennett, Id.

DATE OF BURIAL

6/5 1922

20. UNDERTAKER

J. Falcon

ADDRESS

Bennett, Id.

RECEIVED

JUL 1 1922

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bernard Registration District No. 31
 City of Desmet Primary Registration District No. _____
 (No. _____) (St. _____)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

James William Willis

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 38364Registered No. 127

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED
 (Write the word.)

6. DATE OF BIRTH

June 6 1922
 (Month) (Day) (Year)

7. AGE

Yrs. _____ Mos. 3 ds. _____

IF LESS than 1 day
 how many _____ hrs.
 or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

J. E. Willis

11. BIRTHPLACE OF FATHER

(State or Country)

Nebraska

12. MAIDEN NAME OF MOTHER

Margaret L. Atkinson

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Archie Atkinson(Address) Desmet, Idaho

15.

Filed June 10 1922

J. L. Bihan
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 9 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

6/7 1922, to 6/9 1922
 that I last saw him alive on 6/8 1922,
 and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
 (Secondary)

(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed) W. E. Clizer M. D.

19____ (Address) Idaho Wm

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Idaho Wm

DATE OF BURIAL

6/10 1922

20. UNDERTAKER

J. Falcon + C. L. Schuler

ADDRESS

Desmet, Idaho

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 31
County of Bennett Registration District No. _____
City of Bennett (State) _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Rosalie PolathinFile No. 38365
Registered No. 8

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX _____ 4. COLOR OR RACE _____ 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED _____7. Indian (Write the word.)

6. DATE OF BIRTH

not known
(Month) (Day) (Year)

7. AGE

about 90 Yrs. Mos. ds. IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Boumaniche

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Lophix Mary

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Peter Macheline

(Address)

Bennett, Id.

15.

Filed June 16 1922Y. L. Bihan
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 13 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 1 1921, to June 12 1922
that I last saw her alive on June 11 1922
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis(Duration) 10 Yrs. mos. ds.Contributory
(Secondary)

(Duration) _____ yrs. mos. ds.

(Signed) Z. Bardeau M. D.19____ (Address) Bennett Id.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. mos. days. In the State _____ yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Bennett, Id.

DATE OF BURIAL

6/16 1922

20. UNDERTAKER

J. Falcon

ADDRESS

Bennett, Id.

RECEIVED CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock Registration District No. 31
 City of Desmet Primary Registration District No. _____
 State (No. _____) (St.) _____

File No. 2 38366

Registered No. _____

If death occurs away from
usual residence, give facts
called for under special in-
formation.

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

2. FULL NAME

Nellie Lijohn

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDF.Indian

(Write the word.)

6. DATE OF BIRTH

June 23 1921
 (Month) (Day) (Year)

7. AGE

Yrs. 11 Mos. 6 ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho10. NAME OF
FATHERNicholas Lijohn11. BIRTHPLACE
OF FATHER

(State or Country)

Idaho12. MAIDEN NAME
OF MOTHERMary Prosper13. BIRTHPLACE
OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Nicholas Lijohn

(Address)

Desmet, Ida

15.

Filed June 17 1921

G. L. Bihan
Local Registrar

MEDICAL CERTIFICATE OF DEATH

91

16. DATE OF DEATH

June 16 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____ 19____, to _____ 19____
 that I last saw h. _____ alive on _____ 19____,
 and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Frank Barbeau

M. D.

19____ (Address) Desmet, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted
if not at place of death?

Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Desmet, Idaho

DATE OF BURIAL

6/18 1922

20. UNDERTAKER

J. Falcone

ADDRESS

Desmet

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 238367
Registered No. 10

1. PLACE OF DEATH

Registration District No. 31
County of Benewah Primary Registration District No. _____
City of Demoet (No. _____) (St.) _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary Blessilla Arrippa

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX _____ 4. COLOR OR RACE _____ 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED _____

7.

Indian

(Write the word.)

6. DATE OF BIRTH

(Month) June 24 (Day) 12 (Year) 1922

7. AGE

4 Yrs. 11 Mos. 26 ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work _____
(b) General nature of industry, business or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Louis Arrippa

11. BIRTHPLACE OF FATHER

(State or Country) Idaho

12. MAIDEN NAME OF MOTHER

Mary Magdalen Lott

13. BIRTHPLACE OF MOTHER

(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Louis Arrippa

(Address) Demoet Idaho

15.

Filled June 19 1922

Y. L. Bihlan
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month) June (Day) 18 (Year) 1922

17. I HEREBY CERTIFY, That I attended deceased from

_____ 19 _____ to _____ 19 _____
that I last saw h. _____ alive on _____ 19 _____
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Broken neck — automobile accident

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

_____ 19 _____ (Address) _____

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Demoet, Id

DATE OF BURIAL

6/19 1922

20. UNDERTAKER

J. Falcon

ADDRESS

Demoet

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **238368**
Registered No. **11**

1. PLACE OF DEATH

Registration District No. **31**
County of **Bernese**
Primary Registration District No. _____
City of **Desmet** (No. _____) St. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Frederick Wilson Mackelme

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

M. Indian

(Write the word.)

6. DATE OF BIRTH

Sept 15 1920
(Month) (Day) (Year)

7. AGE

1 Yrs. 9 Mos. 10 ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

John Mackelme

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Agatha Michell

13. BIRTHPLACE OF MOTHER

(State or Country)

Ido

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Agatha Michell

(Address)

Desmet, Ida

15.

Filled **June 26 1922**

Y. E. Brown

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 25 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 10 1922, to **June 12 1922**
that I last saw him alive on **June 12 1922**,
and that death occurred on the date stated above, at **3 P. M.**

The CAUSE OF DEATH* was as follows:

Tuberculosis of meningis

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. **20** ds.

(Signed) **Fred. B. Brown** M. D.

19 _____ (Address) **Desmet, Ida**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Desmet, Ida

DATE OF BURIAL

6/26 1922

20. UNDERTAKER

J. Falcon

ADDRESS

Desmet

RECEIVED CERTIFICATE OF DEATH

1. PLACE OF DEATH

Registration District No. 31
 County of Benedict BUREAU of Registration District No.
 City of Desmet STATE (No.) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Teresa Campbell

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 38369

Registered No. 1812

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

7. Indian

(Write the word.)

6. DATE OF BIRTH

Dec 31 1922
 (Month) (Day) (Year)

7. AGE

3 Yrs. 5 Mos. 26 ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Michel Campbell

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Louise Pollock

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Nick Campbell
 (Address) Desmet, Ida

15.

Filed June 28 1922

J. L. Bihans
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 37 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 25 1922 to June 27 1922
 that I last saw him alive on June 25 1922
 and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Infantile

(Duration) Yrs. mos. ds.

Contributory
 (Secondary)

(Duration) yrs. mos. 3 ds.

(Signed) Fred. Barkan M. D.

19 (Address) Desmet, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Desmet, Idaho

DATE OF BURIAL

6/29 1922

20. UNDERTAKER

J. Falcon

ADDRESS

Desmet, Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

2
#6

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bingham
City of SpringfieldRegistration District No. 116Primary Registration District No. 2193File No. 38372Registered No. 1

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ephraim Joseph Nielsen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

April 24 1888
(Month) (Day) (Year)

7. AGE

54 Yrs. 1 Mos. 8 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

Farmer

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Lars Nielsen

11. BIRTHPLACE OF FATHER

(State or Country)

Denmark

12. MAIDEN NAME OF MOTHER

Sara Marie Jersperson

13. BIRTHPLACE OF MOTHER

(State or Country)

Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. Peter Nielsen

(Address)

15.

Filed

June 1, 22 M. C. Markunian
19..... Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 1 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from May 27 1922 to June 1 1922
that I last saw h..... alive on May 31 1922
and that death occurred on the date stated above, at 4 A M.

The CAUSE OF DEATH* was as follows:

Typhoid fever(Duration) Yrs. mos. 18 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

M. C. Markunian M. D.June 1 1922 (Address) Shedden Id.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Springfield Id.

DATE OF BURIAL

June 2 1922

20. UNDERTAKER

Friends

ADDRESS

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

38371

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bingham
City of AberdeenRegistration District No. 166Primary Registration District No. 2155File No. 4Registered No. 73

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Thomas G Richards

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-OWED OR DIVORCED married

(Write the word.)

6. DATE OF BIRTH

Aug 1 1853
(Month) (Day) (Year)

7. AGE

68 Yrs. 10 Mos. 5 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)Farmer

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

James Richards

11. BIRTHPLACE OF FATHER

(State or Country)

Kentucky

12. MAIDEN NAME OF MOTHER

Millie

13. BIRTHPLACE OF MOTHER

(State or Country)

Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Alice Richards
Aberdeen Ida

15. Filed

June 6 22 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

50

16. DATE OF DEATH

June 6 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 1 1922, to June 6 1922that I last saw him alive on June 3 1922and that death occurred on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Diabetes(Duration) 3 Yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

McCuer Kinn M. D.1922(Address) Aberdeen Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Aberdeen Ida

DATE OF BURIAL

June 8 1922

20. UNDERTAKER

ADDRESS

RN Luthwaite Aberdeen Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bingham Registration District No. 221
City of Liberty Primary Registration District No. 2194
(No. 115 St.)File No. 38372
Registered No. 97

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Earl Hall

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH

Mar 23 1922
(Month) (Day) (Year)

7. AGE

Stillborn
Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)None

9. BIRTHPLACE

(State or Country)

Fort Hall Indian Reservation

10. NAME OF FATHER

Jack Hall

11. BIRTHPLACE OF FATHER

(State or Country)

Ky

12. MAIDEN NAME OF MOTHER

Betty Atkins

13. BIRTHPLACE OF MOTHER

(State or Country)

Ky.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Jack Hall
Blackfoot Idaho Post 5

15.

Filed

March 24, 1922 Mrs. Helen E. Hall
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 23 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I Investigated
death 19 to Mar 24, 19that I last saw him alive on 19and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Stillborn

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Mrs. Helen E. Hall M. D.

19

(Address)

Blackfoot Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

Marland Idaho March 24, 22
Jack Hall Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bingham
City of Shelley

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 121

Primary Registration District No. 2194

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 38373

Registered No. 92

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ethan Leonard Barrows

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-OWED OR DIVORCED

Male White Single (word.)

6. DATE OF BIRTH

September 6 1899
(Month) (Day) (Year)

7. AGE

22 Yrs. 8 Mos. 18 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Blacksmith
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE Charleston,
(State or Country) Utah

10. NAME OF FATHER Leonard E. Barrows

11. BIRTHPLACE OF FATHER Salt Lake City, Utah
(State or Country)

12. MAIDEN NAME OF MOTHER Annie Noakes

13. BIRTHPLACE OF MOTHER Utah
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. L. Barrows
(Address) Shelley, Ida

15. Filed June 14 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

169

16. DATE OF DEATH

May 22 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I investigated attended deceased from

19 to 19
that I last saw him alive on 19

and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Accidental drowning in Snake River

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) E. L. Egli, Coroner Bingham

6/14 1922 (Address) Blackfoot, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Shelley, Ida

DATE OF BURIAL 6/14 1922

20. UNDERTAKER

ADDRESS E. L. Egli, Blackfoot

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bingham
City of BlackfootRegistration District No. 121Primary Registration District No. 2114(No. 1)

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

J. EnetoneState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 38334Registered No. 93

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male Mongolian

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDSingle
(Write the word.)

6. DATE OF BIRTH

June 1882
(Month) (Day) (Year)

7. AGE

40 Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Gardener

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Japan

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

Japan

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Japan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) By: M. H. E. High - Bookkeeper(Address) Blackfoot, Idaho

15. Filled

June 11 1922 Mr. H. E. E. High

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 10 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 30, 1922, to June 10, 1922that I last saw him... alive on June 10, 1922and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Exhaustion due to Psychoses
Excited(Duration) Yrs. mos. 11 ds.

Contributory (Secondary)

acute mania(Duration) Yrs. mos. 11 ds.

(Signed)

Dr. H. E. E. High M. D.6-10-1922 (Address) Blackfoot, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. 11 days. In the State 18 yrs. mos. daysWhere was disease contracted if not at place of death? UnknownFormer or usual residence Prattville

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho Insane Asylum 6/11 1922

20. UNDERTAKER

ADDRESS

Frank E. Wilkerson Blackfoot, Ida

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **38375**
Registered No. **14**

1. PLACE OF DEATH

County of **Bingham**
City of **Blackfoot**

Registration District No. **121**Primary Registration District No. **211**(No. **1**)

St.)

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Charles A. Ellis

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

Caucasian5. SINGLE, MARRIED, WID-
OWED, OR DIVORCED**widower**
(Write the word.)

6. DATE OF BIRTH

1860
(Month) (Day) (Year)

7. AGE

62 Yrs.

Mos.

ds.

If ~~less~~ than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work**Farmer**(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country)

Illinois10. NAME OF
FATHER**Henry Ellis**11. BIRTHPLACE
OF FATHER

(State or Country)

Kentucky12. MAIDEN NAME
OF MOTHER**Miranda E. Mann**13. BIRTHPLACE
OF MOTHER

(State or Country)

✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

according to **Asylum Records**
(Informant) **Martha E. High-Bookekeeper**

(Address)

Blackfoot, Idaho

15.

Filed **June 13 1922** **Mrs. Haler E. H.**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

19

16. DATE OF DEATH

June 13 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 29 1922 to **June 13 1922**

that I last saw him alive on **June 12 1922**

and that death occurred on the date stated above, at **6 A.M.**

The CAUSE OF DEATH* was as follows:

Heart Failure(Duration) Yrs. mos. **10** ds.

Contributory **Arterio Sclerosis**
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) **C. J. Hooper** M. D.

6-13-1922 (Address) **Blackfoot, Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. **1** mos. **14** days. In the State **1** yrs. mos. days

Where was disease contracted if not at place of death? **Unknown**

Former or usual residence **Boji, Idaho**

19. PLACE OF BURIAL OR REMOVAL

E. P. High **Idaho**

20. UNDERTAKER

Boji, Idaho ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 38576
Registered No. 95-

1. PLACE OF DEATH

County of Bingham
City of Blackfoot

Registration District No. 121

Primary Registration District No. 2194

St.)

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Minnie Anderson

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Female White

(Married word.)

6. DATE OF BIRTH

June 21
(Month)

(Day)

1878
(Year)

7. AGE

43 Yrs. 17 Mos. 24 ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.

Housewife

(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

Mink Creek

(State or Country)

Idaho

10. NAME OF
FATHER

Hans Peterson

11. BIRTHPLACE
OF FATHER

Denmark

(State or Country)

12. MAIDEN NAME
OF MOTHER

Annie Marie Jenson

13. BIRTHPLACE
OF MOTHER

Denmark

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address) Blackfoot # 3

15.

Filed

June 16, 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June

15

1922

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from
June 1, 1922 to June 15, 1922
that I last saw her alive on June 15, 1922
and that death occurred on the date stated above, at 8 P. M.
The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Duration) 5 Yrs. mos. ds.

(Duration) yrs. mos. ds.

(Signed)

M. D.

(Address) Blackfoot # 3

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Grave City Cemetery

DATE OF BURIAL

6/18 1922

20. UNDERTAKER

ADDRESS

Blackfoot.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

RECEIVED

Registration District No.

County of *Bingham*

JUL 1 1922

Primary Registration District No.

City of *Blackfoot*

BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Henry M. Wilson

File No.

38377

Registered No.

96

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male Caucasian

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED
married
(Write the word.)

6. DATE OF BIRTH

March 22, 1863
(Month) (Day) (Year)

7. AGE

59 Yrs. *2* Mos. *24* ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)*Retired Stockman*

9. BIRTHPLACE

(State or Country)

Wisconsin

10. NAME OF FATHER

John C. Wilson

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Polly Andrews

13. BIRTHPLACE OF MOTHER

(State or Country)

United States

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

according to Asylum Records
(Informant) *Margaret E. High-Bookkeeper*
(Address) *Blackfoot, Idaho*

15.

Filed

June 16 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 15, 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
May 12 1922, to *June 15 1922*
that I last saw him alive on *June 15 1922*
and that death occurred on the date stated above, at *8:45 P.M.*

The CAUSE OF DEATH* was as follows:

Paresis(Duration) *2* Yrs. *6* mos. ds.Contributory
(Secondary)*Spastic*(Duration) *As far as known* ds.

(Signed)

Car J. [Signature] M. D.*June 19, 1922* (Address) *Blackfoot, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. *1* mos. *3* days. In the State *19* yrs. mos. days

Where was disease contracted if not at place of death?

Unknown

Former or usual residence

Idaho Falls, Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

*Edna [Signature]**E. J. Park*

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH
in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of BighamCity of GrovelandRegistration District No. 121Primary Registration District No. 2144

(No. _____)

St.) _____

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME Iva Lenora Mason

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 38378Registered No. 97

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDSingle (one word.)

6. DATE OF BIRTH

May 23 1904
(Month) (Day) (Year)

7. AGE

18 Yrs. 0 Mos. 23 ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.At school(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country)

PlymouthUtah10. NAME OF
FATHERJesse G. Mason11. BIRTHPLACE
OF FATHER

(State or Country)

Utah12. MAIDEN NAME
OF MOTHERLaura L. Estep13. BIRTHPLACE
OF MOTHER

(State or Country)

North Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Blackfoot Route 2

15.

Filed

June 15 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June161922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Apr 15 1922 to June 16 1922that I last saw her alive on June 1 1922and that death occurred on the date stated above, at 3:30 M.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)Mitral Stenosis and
insufficiency

(Duration)

Yrs.

mos.

ds.

(Signed)

W. W. Beck M. D.6/16 1922 (Address) Blackfoot, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place

of death

yrs.

mos.

days

In the

State

yrs.

mos.

days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Groveland Cemetery

DATE OF BURIAL

6/18 1922

20. UNDERTAKER

E. L. Egli

ADDRESS

Blackfoot

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of BinghamCity of Stirling

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 131Primary Registration District No. 2194

(No.)

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 38379Registered No. 9

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ella Tiffany Page

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female4. COLOR OR RACE white5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Widow

(Write the word.)

6. DATE OF BIRTH

Dec
(Month)23
(Day)1848
(Year)

7. AGE

73 Yrs.7 Mos.25 ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. none

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Ohio10. NAME OF FATHER Jack Tiffany

11. BIRTHPLACE OF FATHER

(State or Country) Conn.12. MAIDEN NAME OF MOTHER Cordelia Tryon

13. BIRTHPLACE OF MOTHER

(State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Eugene Page Tuckert(Address) Stirling, Idaho15. Filled June 18 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June
(Month)17
(Day)1922
(Year)17. I HEREBY CERTIFY, That I Investigated
death 19....., to 19.....

that I last saw h..... alive on 19.....

and that death occurred on the date stated above, at 2:05 P.M.The CAUSE OF DEATH* was as follows:
Cancer Liver(Duration) 2 Yrs. mos. ds.Contributory
(Secondary) Bright disease(Duration) yrs. 6 mos. ds.(Signed) Dr E. J. Tuckert

M. D.

6/18/1922 (Address) Blackfoot Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER E. J. Tuckert

ADDRESS

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

15. *Im 70 1922*
Filed *Im 70 1922*

20. UNDERTAKER	ADDRESS
E. L. Egli	Blackfoot

Local Registrar

SYMS-WORK CO., PRINTERS & BINDERS, BOISE 51088

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED

CERTIFICATE OF DEATH

PLACE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

County of

Bingham

Registration District No.

121

Primary Registration District No.

2194

City of

Basalt, Trinidad

(No.)

St.)

File No.

38282

Registered No.

1781

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Lelia Davis

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Female

White

Married

DATE OF BIRTH

June

1

1903

AGE

19

Yrs.

-

Mos.

ds.

8

IF LESS than 1 day

how many hrs.

or min.?

OCCUPATION

Trade, profession or
particular kind of work.

Housekeeper

General nature of in-
dustry, business or estab-
lishment in which employ-
(or employer)

BIRTHPLACE

(State or Country)

Sharon, Idaho

NAME OF
FATHER

Arthur W. Mills

BIRTHPLACE
OF FATHER

(State or Country)

Utah

MAIDEN NAME
OF MOTHER

Ada Heibaur

BIRTHPLACE
OF MOTHER

(State or Country)

Idaho

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Informant)

Charles Henry Davis

(Address)

Shelley Idaho

June 27 1922

M. H. H. H. H.

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June

9

19

22

17. I HEREBY CERTIFY, That I attended deceased from

was called to

and that death occurred on the date stated above, at 11 A. M.

The CAUSE OF DEATH* was as follows:

Probably Pulmonary
Edema

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)Probably acute
dilatation of heart

(Duration)

Yrs.

mos.

ds.

(Signed)

Edwin C. C. M. D.

6/10

1922

(Address)

Shelley Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place

of death

Yrs.

mos.

days.

In the

State

Yrs.

mos.

days

Where was disease contracted
if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

First E. ever

6/11

19

22

20. UNDERTAKER

ADDRESS

None Employed

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Bingham*
City of *Shelley*Registration District No. *131*Primary Registration District No. *3194*File No. *38384*Registered No. *103*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Hannah Mitchell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

*White*5. SINGLE, MARRIED, WID-
OWED OR DIVORCED*Married*
(Write the word.)

6. DATE OF BIRTH

Oct. 14 1868
(Month) (Day) (Year)

7. AGE

53 Yrs. *58* Mos. *2* ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).*House. Keeper*

9. BIRTHPLACE

(State or Country)

Hyrum Utah

10. NAME OF FATHER

N. Chris. Jensen

11. BIRTHPLACE OF FATHER

(State or Country)

Denmark

12. MAIDEN NAME OF MOTHER

Maria Paulson

13. BIRTHPLACE OF MOTHER

(State or Country)

Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

*Mitchell, L.
R. 6. Idaho Falls*

15. Filed

June 27 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 15 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

*5-1-1922 to 6-15-1922*that I last saw her alive on *6-15-1922*
and that death occurred on the date stated above, at *10³⁰* P. M.

The CAUSE OF DEATH* was as follows:

Coronary Embolism

(Duration)

Yes

mos.

ds.

Contributory
(Secondary)

(Duration)

Yes

mos.

ds.

(Signed)

Edwin Butler

M. D.

6/16/1922

(Address)

Shelley

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death.....

In the

days. State.....

yrs.....

mos.....

days

Where was disease contracted if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

Shelley Cemetery

DATE OF BURIAL

6/18-1922

20. UNDERTAKER

C. C. Danmeyer

ADDRESS

Idaho Falls

1. PLACE OF DEATH

County of Bingham
 City of Shelly

If death occurs away from
 usual residence, give facts
 called for under special in-
 formation.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No. 121
 Primary Registration District No. 2194
 (No. 1 St.)

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 38385
 Registered No. 104

If death occurred in a hos-
 pital, institution or camp,
 give its NAME instead of
 street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX F 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED Single
 (Write the word.)

6. DATE OF BIRTH

6 17 1922
 (Month) (Day) (Year)

7. AGE

IF LESS than 1 day
 how many 12 hrs.
 or 1 min.?

8. OCCUPATION

(a) Trade, profession or
 particular kind of work.
 (b) General nature of in-
 dustry, business or estab-
 lishment in which employ-
 ed (or employer).

Baker

9. BIRTHPLACE

(State or Country)

Shelly Idaho

10. NAME OF FATHER

Elmer S. Packer

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Hannah E. Crofts

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Elmer S. Packer
Idaho

(Address)

15.

Filed

June 27 1922

Mrs. Walter E. Packer
 Local Registrar

16. DATE OF DEATH

6 17 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

6-17 1922 to 6-17 1922
 that I last saw her alive on 6-17 1922

and that death occurred on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:

Premature birth

(Duration) Yrs. mos. ds.

Contributory
 (Secondary)

(Duration) yrs. mos. ds.

(Signed)

Edwin Carter M. D.

6/17/1922 (Address) Shelly Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state
 (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
 if not at place of death?

Former or
 usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho Cemetery

6-17-1922

20. UNDERTAKER

ADDRESS

none employed

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH
 in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH *Butte* Registration District No. *121*
 County of *Butte* Primary Registration District No. *2194*
 City of *Butte* (No. *100*) St. *Butte*

File No. *38386*Registered No. *100*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Baby Parker*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *7* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED *Single*
 (Write the word.)

16. DATE OF DEATH

6. DATE OF BIRTH *6/17/1922*
 (Month) (Day) (Year)

6/17 19 *22*
 (Month) (Day) (Year)

7. AGE *1/2* IF LESS than 1 day
 how many *1/2* hrs.
 or *1/2* min.?

17. I HEREBY CERTIFY, That I attended deceased from
6-17-1922 to *6-17-1922*

that I last saw her alive on *6-17-1922*
 and that death occurred on the date stated above, at *5:15* P.M.

The CAUSE OF DEATH* was as follows:

Premature birth

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

Baby

9. BIRTHPLACE *Shelley Idaho*
 (State or Country)

(Duration) Yrs. mos. ds.

Contributory (Secondary) *Unknown*

10. NAME OF FATHER *Elmer S. Parker*

(Duration) yrs. mos. ds.

11. BIRTHPLACE OF FATHER *Idaho*
 (State or Country)

(Signed) *Edmund J. Smith* M. D.

6/17 19 *22* (Address) *Shelley*

12. MAIDEN NAME OF MOTHER *Hannah E. Crofts*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

13. BIRTHPLACE OF MOTHER *Idaho*
 (State or Country)

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Elmer S. Parker*
 (Address) *Shelley Iowa Str*

19. PLACE OF BURIAL OR REMOVAL *Idaho Cemetery*

DATE OF BURIAL

15. *June 27* 19 *22* *Mrs. Hannah E. Crofts*
 Filed Local Registrar

20. UNDERTAKER *Mrs. Enplaved*

ADDRESS

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 57

County of

Primary Registration District No. 2022

City of

(No.

St.)

File No. 38388

Registered No. 25

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Eliza Arroy Brodhead

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

July, 8, 1922

R. H. Wright

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June

23

19 22

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from

June, 19, 1922 to June, 23, 1922

that I last saw her alive on June, 22, 1922

and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH was as follows:

Lacerated throat, severing trachea.

(Duration)

Yrs.

mos.

4 ds.

Contributory (Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

Robert H. Wright M. D.

6-24-22 (Address) Hailey, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

yrs.

mos.

days.

In the

State

yrs.

mos.

days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hailey, Ida

6-25-22

20. UNDERTAKER

ADDRESS

R. D. Harris

Hailey

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **38389**Registered No. **23**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH **RECEIVED**
 County of **Blaine** Registration District No. **57**
 City of **Carey** Primary Registration District No. **2075**
 State of **Idaho** (St.)
 If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Mary Jean Peterson**

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX **Female** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **married**
 (Write the word.)

6. DATE OF BIRTH

Apr 25 1897
 (Month) (Day) (Year)

7. AGE

63 Yrs. **1** Mos. **24** ds.

IF LESS than 1 day
 how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
 (b) General nature of industry, business, or establishment in which employed (or employer)...

Wife & Housekeeping

9. BIRTHPLACE

(State or Country)

Marion, Denmark

10. NAME OF FATHER

Jens Jensen

11. BIRTHPLACE OF FATHER

(State or Country)

Denmark

12. MAIDEN NAME OF MOTHER

Maryanna Kristensen

13. BIRTHPLACE OF MOTHER

(State or Country)

Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Carie Hendrickson

(Address)

Deer Lodge, Mont.

15. Filed

July 8 1922 R. H. Wright
 Local Registrar

16. DATE OF DEATH

Feb 13 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Feb 13 1922** to **Feb 13 1922**
 that I last saw him alive on **Feb 13 1922**
 and that death occurred on the date stated above, at **7:20 P.M.**

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) Yrs. mos. / ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) **Houston E. Lyden M. D.**2-13-1922 (Address) **Carey Idaho**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Feb-16 1922

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Blaine
City of HaileyRegistration District No. 57
BUREAU OF VITAL STATISTICS
Registration District No. 2022 (St.)File No. 38390
Registered No. 24

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Smitten Lee and Corley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

104

3. SEX

Male

4. COLOR OR RACE

W.C.5. SINGLE, MARRIED, WIDOWED OR DIVORCED
(Write this word.)
single

6. DATE OF BIRTH

Feb. 8 1922
(Month) (Day) (Year)

7. AGE

4 Yrs. 11 Mos. 11 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).none

9. BIRTHPLACE

(State or Country)

Hailey, Ida.

10. NAME OF FATHER

W. H. Corley

11. BIRTHPLACE OF FATHER

(State or Country)

Arkansas

12. MAIDEN NAME OF MOTHER

Julia Roper

13. BIRTHPLACE OF MOTHER

(State or Country)

Arkansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. H. Corley
(Address) Hailey, Idaho

15.

Filed July 8 1922 R. H. Wright
Local Registrar

16. DATE OF DEATH

WrightJune 19 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from 6-18 1922 to 6-19 1922
that I last saw him alive on 6-19 1922
and that death occurred on the date stated above, at 19 M.
The CAUSE OF DEATH* was as follows:
Gastro Enteritis(Duration) _____ Yrs. _____ mos. 4 ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Robert H. Wright M. D.6-20-22 (Address) Hailey, Ida

*State the Disease Causing Death; or in death from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Hailey, Ida

DATE OF BURIAL

6-21-22

20. UNDERTAKER

O. D. Harris

ADDRESS

Hailey

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B. - Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of form.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 38391

Registered No. 26

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Blaine

City of Hailey

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Gravelling, Elmer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

July 23, 1922
(Month) (Day) (Year)

7. AGE

15 Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Hailey, Idaho.

10. NAME OF FATHER

A. L. Sherrard.

11. BIRTHPLACE OF FATHER

(State or Country) Oregon.

12. MAIDEN NAME OF MOTHER

Blanche Bell.

13. BIRTHPLACE OF MOTHER

(State or Country) Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) R. H. Wright

(Address) Hailey, Idaho.

Filed July 8, 1922 R. H. Wright
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 7, 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June - 5, 1922 to June, 7, 1922 that I last saw him alive on June, 7, 1922 and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Inanition

(Duration) Yrs. mos. ds.
Contributory (Secondary) Premature birth(Signed) Robert H. Wright M. D.
6-8-1922 (Address) Hailey, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Hailey, Idaho

DATE OF BURIAL

6-8-1922

20. UNDERTAKER

R. H. Wright

ADDRESS

Hailey, Idaho

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of.....

City of.....

If death occurs away from usual residence, give facts called for under special information.

Registration District No.....

Primary Registration District No.....

(No.....

St.)

2. FULL NAME

John H. Monks.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.....

38392

Registered No.....

27

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Divorced
(Write the word.)

6. DATE OF BIRTH

July 8 1847
(Month) (Day) (Year)

7. AGE

74 Yrs 11 Mos 16 ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Retired Farmer

9. BIRTHPLACE

(State or Country)

Pennsylvania

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

Pennsylvania

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

William Monks

(Address)

May Idaho

15.

Filed

July-8 1922

R. H. Wright

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June-22 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 22 1922, to June 22 1922, that I last saw him alive on June 22 1922, and that death occurred on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage, Apoplexy

(Duration) Yrs. mos. 1 ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

J. H. Williams

M. D.

6-19-22 (Address) May Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Ketchum, Ida

DATE OF BURIAL

6-26-22

20. UNDERTAKER

R. D. Harris

ADDRESS

Bailey

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 57
County of Blaine Primary Registration District No. 2022
City of Belleme (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ira WulschlegerFile No. 38393
Registered No. 18

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH

May 4 1885
(Month) (Day) (Year)

7. AGE

66 Yrs. 11 Mos. 3 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Housewife

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

Smith

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

A. B. Hager
Belleme, Ida.

15.

Filed

5-1 1922 R. H. Wright

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Wright
April 7 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

3-30 1922 to 4-7 1922
that I last saw her alive on 4-5 1922
and that death occurred on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:

Diabetes mellitus(Duration) 2 Yrs. mos. ds.
Contributory (Secondary) Influenza

(Duration) yrs. mos. ds.

(Signed)

Robert H. Wright M. D.
4/8 1922 (Address) Hailey, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Belleme, Ida 4-9 1922

20. UNDERTAKER

ADDRESS

R. D. Harris Hailey

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

(No.)

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many.....hrs.

or.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw h..... alive on.....

and that death occurred on the date stated above, at.....M.

The CAUSE OF DEATH* was as follows:

(Duration) Yrs.....mos.....ds.

Contributory (Secondary)

(Duration) yrs.....mos.....ds.

(Signed) M. D.

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

1. PLACE OF DEATH

 RECEIVED
 JUN 28 1922
 Registration District No. 57
 County of Blaine Primary Registration District No. 2022
 City of Hailey (No. _____) St. _____

 File No. 38395
 Registered No. 20

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Virginia A. Beaton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

married
(Write the word.)

6. DATE OF BIRTH

April 14 1955
 (Month) (Day) (Year)

7. AGE

67 Yrs. 1 Mos. 1 ds.

 IF LESS than 1 day
 how many _____ hrs.
 or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Id.

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Dan Beaton
Hailey, Idaho

15.

 Filed 5-1 1922 R. H. Wright

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Plummer
April 15 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 1 1920 to April 15 1922
 that I last saw him alive on April 15 1922
 and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Cancer(Duration) 3 Yrs. - mos. - ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. Plummer M. D.19. (Address) Hailey

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hailey, Ida 4-17-22

20. UNDERTAKER

ADDRESS

R. D. Harris Hailey

RECEIVED CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 38396

Registered No. 21

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Blaine

City of Ketchum

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Frank C. Miller

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

69

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Indiana

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

5-1

19.22

R. H. Wright

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April

20

1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 25, 1922, to Mar 25, 1922,

that I last saw him alive on Mar 25, 1922, and that death occurred on the date stated above, at 1 A.M.

The CAUSE OF DEATH* was as follows:

Ischemic

(Duration) Yrs. 6 mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Ketchum, Ida

DATE OF BURIAL

4-22-22

20. UNDERTAKER

R. D. Harris

ADDRESS

Hailey

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. *Blaine* Registration District No. *57*
County of *Blaine* Primary Registration District No. *2095*
City of *Carey* (No. *2095* St.)

File No. *38397*
Registered No. *22*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lorene Wilde

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *Female* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. *Single*
(Write the word.)

6. DATE OF BIRTH.

April 26 1922
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many *1* hrs. or
30 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

Baby

9. BIRTHPLACE

(State or Country)

Blaine Co Idaho

10. NAME OF FATHER

James H Wilde

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Ida J Clarke

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Ben G. Wilde
Carey, Ida

(Address)

15.

Filed

5-1

1922

R. H. Wright
Local Registrar

16. DATE OF DEATH

April 27 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *April 26 1922* to *April 27 1922*, that I last saw her alive on *April 27 1922* and that death occurred on the date stated above, at *12:48 M.*

The CAUSE OF DEATH* was as follows:

Premature birth

(Duration) Yrs. mos. *1* ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *Karsten E. Snyder* M. D.

4-27-1922 (Address) *Carey Idaho*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Carey Idaho.

4-27 1922

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD. N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

38398

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of Bonner

Primary Registration District No.

City of Coolin, Ida.

(No. Coolin, Ida.

St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Walter W. Slee

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

July 4 1872
(Month) (Day) (Year)

7. AGE

49 yrs 11 mos 1 ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Prop Priest Lake Navigation Co
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Kenyon, Minn

10. NAME OF FATHER

Joseph B. Slee

11. BIRTHPLACE OF FATHER

(State or Country)

Utica, N Y.

12. MAIDEN NAME OF MOTHER

Harriett Watford

13. BIRTHPLACE OF MOTHER

(State or Country)

Ripon, Wisc

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Fred Slee

(Address) 1513 W Boone Ave. Spokane Wash

15.

Filed

1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 5 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1910 to 1920
that I last saw him alive on Feb 12 1920

and that death occurred on the date stated above, at 5 A. M.

The CAUSE OF DEATH* was as follows:

Effusion Pleurisy -
(Duration) yrs. mos. 2 ds.
Contributory Infantile Paralysis
(Secondary)
(Duration) 32 yrs. mos. - ds.
(Signed) E. S. Kirk M. D.
June 19 1922 (Address) Spokane

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. 14 days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence 1513 W Boone Ave. Spokane, Wn

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Incineration-Spokane

June 6 1922

20. UNDERTAKER

ADDRESS

Smith & Company

Spokane, Wash

CERTIFICATE OF DEATH

38399

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH **RECEIVED**
 Registration District No. **81**
 County of **Bonner**
 City of **Morton**
 Primary Registration District No. **2158**
 (St.)

File No. **9**
 Registered No. **43**

If death occurs away from
 usual residence, give facts
 called for under special in-
 formation.

2. FULL NAME **Nancy Milliken**

If death occurred in a hos-
 pital, institution or camp,
 give its NAME instead of
 street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **F.** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED **Married**
 (Write the word.)

6. DATE OF BIRTH
Dec 30 1951
 (Month) (Day) (Year)

7. AGE
70 Yrs. **5** Mos. **23** ds.
 IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION
 (a) Trade, profession or
 particular kind of work. **Housewife**
 (b) General nature of in-
 dustry, business or estab-
 lishment in which employ-
 ed (or employer).

9. BIRTHPLACE
 (State or Country) **Ore.**

10. NAME OF
 FATHER **Saunders.**

11. BIRTHPLACE
 OF FATHER
 (State or Country) **-----**

12. MAIDEN NAME
 OF MOTHER **not known**

13. BIRTHPLACE
 OF MOTHER **not known**
 (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) **W. J. Milliken**
 (Address) **Morton Idaho**

15. Filed **6/30** 19**22** **JWD**
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
June 23 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
June 17 1922 to **June 23 1922**
 that I last saw h. er alive on **June 17 1922**
 and that death occurred on the date stated above, at **2A. M.**
 The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) **1** Yrs. **—** mos. **—** ds.
 Contributory
 (Secondary)

(Duration) **—** yrs. **—** mos. **—** ds.
 (Signed) **[Signature]** M. D.

June 23 1922 address **Priest River, Idaho.**

*State the Disease Causing Death; or in deaths from Violent Causes, state
 (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
 Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted
 if not at place of death?

Former or
 usual residence

19. PLACE OF BURIAL OR REMOVAL **Spangle, Wash.** DATE OF BURIAL **June 24, 1922**

20. UNDERTAKER **L. L. Moon** ADDRESS **Saunders, Idaho**

CERTIFICATE OF DEATH

38400

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of **Bonner**City of **Priest River**

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
JUN 8 1922
BUREAU OF VITAL STATISTICSRegistration District No. **85**Registration District No. **2185**

St.)

File No. **2**Registered No. **62**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME **Gustav R. Lythman**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married

(Write the word.)

6. DATE OF BIRTH

June 2 1883
(Month) (Day) (Year)

7. AGE

39 Yrs. 11 Mos. 21 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Boat operator on lake

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Minn.

10. NAME OF FATHER

Carl Lythman

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME OF MOTHER

Not known

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Mrs. Edith Lythman**(Address) **Priest River, Ida.**

15.

Filed **June 1 1922**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 27 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 19 21 to May 27 1922
that I last saw him alive on **May 14 1922**and that death occurred on the date stated above, at **8:30 PM**

The CAUSE OF DEATH* was as follows:

Valvular Heart disease(Duration) **1 Yrs. -- mos. -- ds.**Contributory **Tuberculosis of Lungs.**
(Secondary)(Duration) **16 yrs. -- mos. -- ds.**(Signed) **C. F. Getchell** M. D.**May 30 1922** (Address) **Priest River, Ida.**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Priest River

DATE OF BURIAL

May 30 1922

20. UNDERTAKER

Wm Davis

ADDRESS

Newport.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of **Bonner**City of **Priest River,**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ellen BakerRegistration District No. **85**Primary Registration District No. **2185**

401

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **2**Registered No. **61**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F.

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widowed

(Write the word.)

6. DATE OF BIRTH

Dec.

(Month)

(Day)

1839

(Year)

7. AGE

83

Yrs.

--

Mos.

--

ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Housewife

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Canada.

10. NAME OF FATHER

Thomas McDonald

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Maggie

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Chas. Barr**(Address) **Priest River, Ida.**

15.

Filed **June 1** 19**22**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May

(Month)

23

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from
May 23 19**22**, to **May 23** 19**22**that I last saw her alive on **May 23** 19**22**,and that death occurred on the date stated above, at **11 P.M.**

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) **C. P. Gettloff**

M. D.

May 24 19**22** (Address) **Priest River**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL
Spokane Wn.DATE OF BURIAL
..... 19.....

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

38404

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock
City of Idaho FallsRegistration District No. 73Primary Registration District No. 2140

File No. _____

Registered No. 72

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Laurence Blaine Vance

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Aug 13
(Month) (Day) (Year)1920

7. AGE

1 Yrs. 10 Mos. 9 ds.

IF LESS than 1 day

how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

Ida none

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Geo. L. Vance

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Phyllis Ostler

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

R. D. 1 - City

15.

Filed

6/301922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 24 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19____, to 19____

that I last saw him alive on 19____

and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

B. E. Woodward
6/30 1922 (Address) Idaho Falls, Id.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lincoln, Ida6/25 1922

20. UNDERTAKER

ADDRESS

B. E. Woodward
Idaho Falls

1. PLACE OF DEATH

County of Booneville
City of Ida Falls

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Bayle

CERTIFICATE OF DEATH

Registration District No. 73Primary Registration District No. 21-0

BUREAU

STATISTICS

38405

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No. 71

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

m

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Infant
(Write the word.)

6. DATE OF BIRTH

May 21 1922
(Month) (Day) (Year)

7. AGE

0 Yrs. 0 Mos. 24 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

C S Bayle

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Laverne Grumble

13. BIRTHPLACE OF MOTHER

(State or Country)

Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

C S Bayle

(Address)

Idaho Falls

15.

Filed 6/31922W. J. ...
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 15 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

.....19....., to19.....

that I last saw h..... alive on19.....

and that death occurred on the date stated above, atM.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration)Yrs.....mos.....ds.

Contributory
(Secondary)

(Duration)yrs.....mos.....ds.

(Signed)

A. R. Soderquist M. D.

19.....

(Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Idaho Falls

DATE OF BURIAL

6/16 1922

20. UNDERTAKER

B. E. Woodward

ADDRESS

Idaho FallsDr. Soderquist

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 38406

Registered No. 70

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Bonneville Registration District No. 73
Primary Registration District No. 215-0
City of Bigby #2 BUREAU (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Sarah Wilson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female White

(Write the word.)

6. DATE OF BIRTH

6 (Month) 16 (Day) 1837 (Year)

7. AGE

IF LESS than 1 day
how many..... hrs.
or..... min.?84 Yrs. 10 Mos. 4 ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

Housewife

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

Thos Pashley

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Elizabeth Beale

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Sarah Wilson

(Address)

Bigby, Rd # 2

15.

Filed 6/22 1922 W. J. Wilson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

4 (Month) 22 (Day) 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

.....19....., to19.....

that I last saw him..... alive on.....19.....

and that death occurred on the date stated above, at.....M.

The CAUSE OF DEATH* was as follows:

Unknown
No death in attendance
(Duration).....Yrs.....mos.....ds.
Contributory (Secondary).....
(Duration).....Yrs.....mos.....ds.
(Signed) J. C. Call M. D.
No death in attendance
.....19..... (Address) Bigby Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....Yrs.....mos.....days. In the State.....Yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Milo Ida. 4-24-1922

20. UNDERTAKER

ADDRESS

Ed. Kellner Bigby

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

Sp.

38407

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Infant

(Write the word.)

6. DATE OF BIRTH

Moh

29

1922

(Month)

(Day)

(Year)

7. AGE

0 Yrs. 1 Mos. 8 ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

J. W. Lanning

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Eva Ainsworth

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

G. B. Auger, phone

(Address)

Lava, Ida

15.

Filed

June 14 - 1922

W. C. Lanning

Local Registrar

16. DATE OF DEATH

May

7

1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 6, 1922, to May 7, 1922

that I last saw him alive on May 6, 1922

and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Unknown

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed)

John O. Mellas, M. D.

518 1926 (Address) Lava, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Lava, Ida

DATE OF BURIAL

8/9 1922

20. UNDERTAKER

G. B. Lanning

ADDRESS

Ida Falls

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 38408

Registered No. 68

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Blaineville Registration District No. 73
City of Sona Primary Registration District No. 215-0
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Cliff Barlow

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Child
(Write the word.)

6. DATE OF BIRTH

January 7 1916
(Month) (Day) (Year)

7. AGE

6 Yrs. 4 Mos. 20 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. at home
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

T. C. Barlow

11. BIRTHPLACE OF FATHER

(State or Country) Utah

12. MAIDEN NAME OF MOTHER

Nellie Raupston

13. BIRTHPLACE OF MOTHER

(State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) T. C. Barlow(Address) Sona, Ida

15.

Filed June 14 1922 Wm. J. M. M.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 27 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 24, 1922 to May 27, 1922that I last saw him alive on May 26, 1922and that death occurred on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:

Diphtheria(Duration) Yrs. mos. 14 ds.Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) John O. Mellor M. D.19 (Address) Idaho Falls, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Idaho Falls, Ida 5/27/22

20. UNDERTAKER

Edenwood Idaho Falls

mellor

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 73
 County of Bonneville Primary Registration District No. 2100
 City of Coltman (No. _____ St.)

File No. 38409
 Registered No. 61

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Victor M. Stucki

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED child

(Write the word.)

6. DATE OF BIRTH

Dec 20 1916
 (Month) (Day) (Year)

7. AGE

5 Yrs. 4 Mos. 28 da.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work _____
 (b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer) _____

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Jacob Stucki

11. BIRTHPLACE OF FATHER

(State or Country)

Switz

12. MAIDEN NAME OF MOTHER

Anna Marya Butelko

13. BIRTHPLACE OF MOTHER

(State or Country)

Uctah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Fred Stucki
R D 5 - City

15.

Filed

June 15 - 1922 Cover
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 18 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
May 18 1922 to May 18 1922
 that I last saw him alive on May 18 1922
 and that death occurred on the date stated above, at 10:30 M.
 The CAUSE OF DEATH* was as follows:

Diphtheria

(Duration) _____ Yrs. _____ mos. 9 ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

H. V. Ray / Hatch M. D.

June 19 (Address) Idaho Falls, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state
 (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Coltman 5720 1922

20. UNDERTAKER

ADDRESS

Coltman Idaho Falls

1. PLACE OF DEATH

County of *Bonneville*City of *Caltuan, Idaho*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED

CERTIFICATE OF DEATH

Registration District No. *73*Primary Registration District No. *2107*(No. *73*)

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *38410*Registered No. *66*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Child
(Write the word.)

6. DATE OF BIRTH

*May**30**1914*

(Month)

(Day)

(Year)

7. AGE

8

Yrs.

1

Mos.

18

ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

None

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Jacob Sturki

11. BIRTHPLACE OF FATHER

(State or Country)

Switz.

12. MAIDEN NAME OF MOTHER

Mary A. Buetz

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Fred Sturki

(Address)

Rt 5 Cely

15.

Filed

*June 15**1922**W. H. H. H. H.*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

*May**18**22*

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 13 19*22* to *May 13* 19*22*that I last saw him alive on *May 13* 19*22*and that death occurred on the date stated above, at *2:30 P.* M.

The CAUSE OF DEATH* was as follows:

Diphtheria(Duration) Yrs. mos. *9* ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

H. R. Hatch

M. D.

19 (Address) *Idaho Falls, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Caltuan, Idaho

DATE OF BURIAL

6/20 19*22*

20. BURIALER

Edmund H. H.

ADDRESS

Idaho Falls

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Laramieville Registration District No. 73
 City of Idaho Falls (No. _____ St.)
 If death occurs away from usual residence, give facts called for under special information.

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 38411
 Registered No. 611

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Thomas Higgs

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
 (Write the word.)

6. DATE OF BIRTH Sept 17 1884
 (Month) (Day) (Year)

7. AGE 77 Yrs. 8 Mos. 19 ds. IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Retired Farmer
 (b) General nature of industry, business or establishment in which employed (or employer) _____

9. BIRTHPLACE England
 (State or Country)

10. NAME OF FATHER Nathaniel Higgs

11. BIRTHPLACE OF FATHER England
 (State or Country)

12. MAIDEN NAME OF MOTHER Martha Woodley

13. BIRTHPLACE OF MOTHER England
 (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Jessie Scarsby
 (Address) Iona Ida

15. Filed June 14 19 22 Wm. H. Woodley
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 1 19 22
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 19 _____, to _____ 19 _____
 that I last saw him _____ alive on _____ 19 _____
 and that death occurred on the date stated above, at 10 a.m.
 The CAUSE OF DEATH* was as follows: Pneumonia - in
medical attendance

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
 (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Wm. H. Woodley M. D.

6/14 19 22 (Address) Idaho Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Iona, Ida DATE OF BURIAL 6/14 19 22

20. UNDERTAKER Wm. H. Woodley ADDRESS Idaho Falls

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

38412

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bonneville
City of Idaho FallsRegistration District No. 73Primary Registration District No. 2100

(No. _____ St.)

File No. 64Registered No. 64

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Wm Howard

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

Colored

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

(Month) _____ (Day) _____ (Year) _____

7. AGE

about 35 yrsIF LESS than 1 day
how many _____ hrs.
or _____ min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Porter at Hotel

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) ?

10. NAME OF FATHER

?

11. BIRTHPLACE OF FATHER

(State or Country) ?

12. MAIDEN NAME OF MOTHER

?

13. BIRTHPLACE OF MOTHER

(State or Country) ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) B B Humwood(Address) Idaho Falls

15.

Filed June 10 - 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 27 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19____, to 19____
that I last saw h. _____ alive on _____ 19____
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

"Hemorrhage from rupture of on ulcerative syphilitic Endocarditis"Autopsy by Dr. J. A. NearContributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) B B Humwood5-31-1922 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Idaho Falls

DATE OF BURIAL

6/1/1922

20. UNDERTAKER

B B Humwood

ADDRESS

Idaho Falls

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock
City of Idaho FallsRegistration District No. 73Primary Registration District No. 210-0(No.)St.)File No. 38415Registered No. 1-1

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Nielsen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Child
(Write the word.)

6. DATE OF BIRTH

ger age

(Month)

(Day)

1 (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

none

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Wm Nielsen

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Mary Williams

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ben W Nielsen

(Address)

1573 City

15.

Filed

Apr 11 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 6 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar 4 - 1922 to Mar 4 - 1922that I last saw her alive on Mar 5 - 1922and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia following
Influenza

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) J C Hallister M. D.3/7/22 (Address) Idaho Falls, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Union Ida

DATE OF BURIAL

3/7/22

20. UNDERTAKER

B. H. Woodley

ADDRESS

Idaho Falls

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

Registration District No.

Primary Registration District No.

(No. of)

St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

Aug 25 1846
(Month) (Day) (Year)

7. AGE

75 Yrs. 9 Mos. 6 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Retired

(b) General nature of industry, business or establishment in which employed (or employer).

Merchant

9. BIRTHPLACE

(State or Country)

New York

10. NAME OF FATHER

Adam Lockstadu

11. BIRTHPLACE OF FATHER

(State or Country)

New York

12. MAIDEN NAME OF MOTHER

Sarah Haimme

13. BIRTHPLACE OF MOTHER

(State or Country)

New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Mrs E W Hailig
Idaho Falls, Id

15. Filled

June 2 1922

Upmanned
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 1 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 29 1922 to 6/1 1922
that I last saw him alive on 6/27 1922
and that death occurred on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

Sarcoma of Rectum

(Duration) Yrs. Mos. ds.

Contributory
(Secondary)

(Duration) Yrs. Mos. ds.

(Signed)

M. D.

6/2 1922 (Address) Idaho Falls, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lenox, Iowa

6-2 1922

20. UNDERTAKER

ADDRESS

C. C. Woodward

Idaho Falls

RECEIVED
JUN 22 1922
CERTIFICATE OF DEATH
73
Registration District No. 214-0
BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 38417
Registered No. 60

1. PLACE OF DEATH

County of Bonneville
City of Idaho Falls

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

James D. Thorne

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

May 11 1878
(Month) (Day) (Year)

7. AGE

44 Yrs. 0 Mos. 7 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Farming

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Frederick Thorne

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Margaret Armstrong

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. D. Thorne

(Address)

R.D.H. - Carey

15. Filed

May 13 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 11 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 9 1922 to May 11 1922 that I last saw him alive on May 11 1922 and that death occurred on the date stated above, at 6:10 P. M. The CAUSE OF DEATH* was as follows:

General peritonitis
following perforation of
duodenal ulcer
(Duration) Yrs. mos. 2 ds.

Contributory (Secondary)

Chronic duodenal ulcer

(Duration) yrs. 9 mos. 9 ds.

(Signed) H. Ray Hatch M. D.

May 11, 1922 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Goodville, Ida 5-14-22

20. UNDERTAKER

ADDRESS

Edgewood Idaho Falls

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 38418

Registered No. 1-9

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from
Oct 1 1921, to May 10 1922
that I last saw him alive on May 10 1922
and that death occurred on the date stated above, at 10:30 A.M.
The CAUSE OF DEATH* was as follows:
Infectious disease

(Duration) 9 Yrs. 3 mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. H. Smith M. D.

(Address) 1119 1/2 E. 1st St. Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

RECEIVED CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 38419

Registered No. 1-7

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Bonneville
City of Idaho FallsRegistration District No. 73
Primary Registration District No. 21 v - 0
No. 1-1 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Roy A. Smith

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH 116

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Child
(Write the word.)6. DATE OF BIRTH March 1917
(Month) (Day) (Year)7. AGE 5 yrs. 2 mos. 2 ds. IF LESS than 1 day how many..... hrs. or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).at home

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

G.R. Smith

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Violet Allen

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

G. R. Smith
Driggs, Idaho

15.

Filed May 12 1922 W. R. Smith
Local Registrar

16. DATE OF DEATH

May 8 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from May 6 1922, to May 8 1922, that I last saw him alive on May 8 1922, and that death occurred on the date stated above, at 4:15 P. M.

The CAUSE OF DEATH* was as follows:

Injury to Spleen, due to
injury.

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Chas. Martin M. D.May 8 1922 (Address) Driggs, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

Ship

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Driggs, Ida 5/8 1922

20. UNDERTAKER

ADDRESS

B. B. Woodward Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH

County of Bannock
 City of Ida Falls

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED CERTIFICATE OF DEATH

Registration District No. 73
 Registration District No. 21 V-0
 (No. 1 St.)

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 38429
 Registered No. 92

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female White

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
 (Write the word.)

6. DATE OF BIRTH

June 19 1907
 (Month) (Day) (Year)

7. AGE

14 Yrs. 10 Mos. 16 ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

at Home

9. BIRTHPLACE

(State or Country)

Larugo, Ida

10. NAME OF FATHER

Jno W Holland

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Amie Staker

13. BIRTHPLACE OF MOTHER

(State or Country)

Switz.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Jno W Holland
Larugo, Ida

(Address)

15.

Filed May 12 1922 W. H. H. H.
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 5 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 27, 1922 to May 5, 1922
 that I last saw him alive on May 5, 1922

and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Encephalitis and
mitral insuff.

(Duration) Yrs. mos. ds.

Contributory
 (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. H. H. H. M. D.

5-6-22 (Address) Ida Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

Ship

19. PLACE OF BURIAL OR REMOVAL

Larugo, Ida

DATE OF BURIAL

5/6 1922

20. UNDERTAKER

E. E. H. H.

ADDRESS

Ida Falls

1. PLACE OF DEATH

County of Bonneville
City of Idaho Falls

If death occurs away from usual residence, give facts called for under special information.

CERTIFICATE OF DEATH

Registration District No. 73Primary Registration District No. 2150

(No. St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 38421Registered No. 176

If death occurred in a hospital, institution, or camp, give its NAME instead of street and number.

2. FULL NAME

James A. Heurie

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widower
(Write the word.)

6. DATE OF BIRTH

April 15 1887
(Month) (Day) (Year)

7. AGE

65 Yrs. 75 Mos. ds.
IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

Farming

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

Joseph Heurie
Mo

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Lucie Luncheon
Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

James A. Heurie
Tetonia, Ida

15.

Filed May 12 1922 W. H. Heurie
Local Registrar

16. DATE OF DEATH

May 10 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

..... 19....., to 19.....

that I last saw him alive on 19.....

and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Apparent Absence
(Duration) Yrs. mos. 28 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. H. Heurie M. D.
5711 1922 (Address) Ida Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Tetonia, Ida 5/12 1922

20. UNDERTAKER

ADDRESS

B. H. Woodley Ida Falls

1. PLACE OF DEATH

County of Bonneville
City of Heon

If death occurs away from usual residence, give facts called for under special information.

RECEIVED

JUN 22 1922

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 73Primary Registration District No. 2140

(No. 125)

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 38422Registered No. 8-4

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Mohachi Uyeno

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

Japanese

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

February 4 1887
(Month) (Day) (Year)

7. AGE

35 Yrs. 2 Mos. 22 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Japan

10. NAME OF FATHER

Keishiro

11. BIRTHPLACE OF FATHER

(State or Country)

Japan

12. MAIDEN NAME OF MOTHER

None

13. BIRTHPLACE OF MOTHER

(State or Country)

Japan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

The Idols Japanese Ass'n

(Address)

Idaho Falls Idaho

15.

Filed May 2 19 22W. R. Kinnard
Local Registrar

MEDICAL CERTIFICATE OF DEATH

29

16. DATE OF DEATH

April 28 19 22
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from March 30 19 22 to April 28 19 22that I last saw him alive on April 27 19 22and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Acute Mikary Tuberculosis
Respiratory Failure(Duration) Yrs. mos. 42 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Larry L. Willson

M. D.

4-29-22 (Address) Idaho Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Idaho Falls, Ida.

DATE OF BURIAL

4-30-22

20. UNDERTAKER

B. E. Linwood

ADDRESS

Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH

County of Boundary Registration District No. 79
 City of Bonner Ferry Primary Registration District No. 3156
 (State or Country) Idaho (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ellen Wells

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 38423

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
 (Write the word.)

6. DATE OF BIRTH

June 5 1856
 (Month) (Day) (Year)

7. AGE

65 yrs. 11 mos. 20 ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Ill.

10. NAME OF FATHER

Phillip Lewis

11. BIRTHPLACE OF FATHER

(State or Country)

Kentucky

12. MAIDEN NAME OF MOTHER

Anna Anderson

13. BIRTHPLACE OF MOTHER

(State or Country)

Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Frances Bailey

(Address)

Lenix Idaho

15.

Filed June 12 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 29 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 28 1922 to May 29 1922
 that I last saw h. 11 alive on May 28 1922
 and that death occurred on the date stated above, at 30 M.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage.

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

6/3 1922 (Address) Bonner Ferry, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bonner Ferry Ida

June 13 1922

20. UNDERTAKER

ADDRESS

Onstorky

Bonner Ferry

1. PLACE OF DEATH

County of Bonanza
City of Bonanza

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Henry Charles Baumgartner

CERTIFICATE OF DEATH

Registration District No. 79Registration District No. 2156

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 38424

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH

Dec. 31 1890
(Month) (Day) (Year)

7. AGE

32 Yrs. 5 Mos. 4 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Lumberman

9. BIRTHPLACE

(State or Country)

Kansas

10. NAME OF FATHER

Mike Baumgartner

11. BIRTHPLACE OF FATHER

(State or Country)

Kansas

12. MAIDEN NAME OF MOTHER

Clara Dickson

13. BIRTHPLACE OF MOTHER

(State or Country)

Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mike Baumgartner

(Address)

15.

Filed June 26 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 4 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19..... to 19.....

that I last saw h..... alive on 19.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

(Duration) Yrs..... mos..... ds.

Contributory
(Secondary)

(Duration) Yrs..... mos..... ds.

(Signed)

6/26/22 (Address) Bonanza, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Bonanza Ferry, Ida

DATE OF BURIAL

6/26 1922

20. UNDERTAKER

Opportunity

ADDRESS

Bonanza FerryWRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Boundary Registration District No. 79
 City of Bonners Ferry Primary Registration District No. 215-6
 (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Grace Loraine Warner

State of Idaho
BOARD OF HEALTH

Bureau of Vital Statistics
File No. 38425

Registered No.
 If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single

6. DATE OF BIRTH.

January 8 1919
 (Month) (Day) (Year)

7. AGE

3 Yrs. 4 Mos. 21 ds.
 IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business, or establishment in which employed (or employer)

Infant

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Burton Warner
 (Address) Bonners Ferry

15.

Filed June 1 1922

ES Jr.
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 29 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 1922 to May 1922

that I last saw her alive on May 28 1922
 and that death occurred on the date stated above, at 6:30 P.M.

The CAUSE OF DEATH* was as follows:

Microcephalic Idiocy

(Duration) 3 Yrs. 4 mos. 21 ds.

Contributory
 (Secondary)

(Duration) 3 Yrs. 4 mos. 21 ds.

(Signed) R. B. Sowell M. D.

June 17 1922 (Address) Bonners Ferry Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
 of death yrs. mos. days, State yrs. mos. days

Where was disease contracted
 if not at place of death?

Former or
 usual residence

19. PLACE OF BURIAL OR REMOVAL Bonners Ferry Idaho DATE OF BURIAL May 29 1922

20. UNDERTAKER Burton Warner ADDRESS Bonners Ferry

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 79
County of Boundary Primary Registration District No. 2156
City of Bonners Ferry (St.)File No. 38426
Registered No. 38426

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Henry Sawyer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Widower
(Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed June 12 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 12 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan. 1 1922, to June 12 1922
that I last saw him alive on June 11 1922
and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Myocarditis(Duration) 1 Yrs. mos. ds.Contributory
(Secondary)(Duration) yrs. mos. ds.

(Signed)

Paul Bowell M. D.June 12 1922 (Address) Bonners Ferry Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. 15 mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cover & Mine Idaho June 13 1922

20. UNDERTAKER

ADDRESS

Off Stocking Bonners Ferry Id

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Boundary Registration District No. 79
City of Bonners Ferry Primary Registration District No. 2156
(No.) St.)File No. 38428

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Anna Harrington Berger

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH

June 28 1873
(Month) (Day) (Year)

7. AGE

48 Yrs. 10 Mos. 17 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Housewife

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

John Harrington

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Margaret Driscoll

13. BIRTHPLACE OF MOTHER

(State or Country)

East Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

F. T. Berger

(Address)

15.

Filed

May 16 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 15 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 7 1922 to May 15 1922
that I last saw h. alive on May 14 1922
and that death occurred on the date stated above, at 8 A.M.
The CAUSE OF DEATH* was as follows:Tubercular Peritonitis(Duration) 5 Yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

5/16/22(Address) Bonners Ferry, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Bonners Ferry Ida

DATE OF BURIAL

May 17 1922

20. UNDERTAKER

Dr. Stork

ADDRESS

Bonners Ferry

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B. - Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED CERTIFICATE OF DEATH

JUN 22 1922

1. PLACE OF DEATH

County of Boundary

City of Bonner Ferry

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

George R. Isman

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 38429

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

unknown
(Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

75

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Lumberman
retired

9. BIRTHPLACE

(State or Country)

Mich.

10. NAME OF FATHER

unknown

11. BIRTHPLACE OF FATHER

(State or Country)

unknown

12. MAIDEN NAME OF MOTHER

unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

M. P. De Wolf

(Address)

15.

Filed May 27 - 1922

58
Local Registrar

MEDICAL CERTIFICATE OF DEATH

68

16. DATE OF DEATH

May 26 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1920 to May 26 1922

that I last saw him alive on May 25 1922

and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Senile Dementia

(Duration) 2 Yrs. mos. ds.

Contributory
(Secondary)

Myocarditis

(Duration) yrs. mos. ds.

(Signed)

5/27/1922

(Address) Bonner Ferry, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. 56 days. In the State 8 yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Bonner Ferry, Ida.

DATE OF BURIAL

May 28, 1922

20. UNDERTAKER

Dr. Stokely

ADDRESS

Bonner Ferry

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 58-
County of Camas Primary Registration District No. 2138
City of Fairfield (No. _____ St.)File No. 38430
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Okle O. Tronsted

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDmale white Single
(Write the word.)

6. DATE OF BIRTH

1870
(Month) (Day) (Year)

7. AGE

52 Yrs. Mos. ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Farmer

9. BIRTHPLACE

(State or Country)

Norway

10. NAME OF FATHER

Okle Olson

11. BIRTHPLACE OF FATHER

(State or Country)

Norway

12. MAIDEN NAME OF MOTHER

Annie K. Mathansen

13. BIRTHPLACE OF MOTHER

(State or Country)

Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ingho Nielsen (per LW)

(Address)

Lyrum, Utah

15.

Filed

June 27^d 1922LW Deencheek
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 22^d 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 19^d 1922, to June 22^d 1922
that I last saw him alive on June 21st 1922
and that death occurred on the date stated above, at 6³⁰A.M.

The CAUSE OF DEATH* was as follows:

Rocky Mountain Spotted Fever(Duration) _____ Yrs. _____ mos. 10 ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

LW Deencheek

M. D.

June 27^d 1922 (Address) Fairfield, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Soldier, Idaho

DATE OF BURIAL

6-26-19-22

20. UNDERTAKER

Mc Han Hardware Co

ADDRESS

Fairfield, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **38431**
Registered No. **15**

1. PLACE OF DEATH.

County of Buttman

City of Parram, Ida

Registration District No. 3

Primary Registration District No. 2007

(St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Louis Ellis Fireman

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widower
(Write the word.)

6. DATE OF BIRTH

4 15 1885
(Month) (Day) (Year)

7. AGE

67 yrs. 2 mos. 5 ds.

IF LESS than 1 day
how many.....hrs. or
.....min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work

Rancher

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Oregon

10. NAME OF FATHER

Leonard Fireman

11. BIRTHPLACE OF FATHER

(State or Country)

Iowa

12. MAIDEN NAME OF MOTHER

Do not know

13. BIRTHPLACE OF MOTHER

(State or Country)

" " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

George Fireman

(Address)

Parram, Ida

15.

Filed

7/1

1922 July Waldorf
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 20 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 1921, to June 1922

that I last saw him alive on June 18 1922,

and that death occurred on the date stated above, at 2:55 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) yrs. mos. 10 ds.

Contributory (Secondary)

Myocarditis

(Duration) 2 yrs. mos. ds.

(Signed) Chas. B. Allen M. D.

6/1 1922 (Address) Parram, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted,

If not at place of death?.....

Former or

usual residence.....

19. PLACE OF ~~DEATH~~ REMOVAL, 4 DATE OF BURIAL

Barker Crig ore

191

20. UNDERTAKER

ADDRESS

Fireman Lm Co Parram

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 3County of CanyonPrimary Registration District No. 2007City of Parma

(Non-Vital St.)

File No. 58432Registered No. 14

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Annie Francis Henderson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

F

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married

(Write the word.)

6. DATE OF BIRTH.

March 16

(Month)

(Day)

(Year)

7. AGE

43 Yrs. 2 Mos. 24 ds.IF LESS than 1 day
how many.....hrs. or
.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....Housewife

9. BIRTHPLACE

(State or Country)

Mo

10. NAME OF FATHER

G. W. Kelly

11. BIRTHPLACE OF FATHER

(State or Country)

Ky

12. MAIDEN NAME OF MOTHER

Annie Francis

13. BIRTHPLACE OF MOTHER

(State or Country)

Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

C. T. Francis

(Address)

Parma

15.

Filed

July 11922Hubert H. H. H.

Local Registrar

16. DATE OF DEATH

June

(Month)

10

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 26 1922, to Apr 5 1922.that I last saw her alive on Apr 5 1922.and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of rectum, uterus, and vagina.

(Duration)

about 4

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

May W. PattenDa

19..... (Address)

Parma Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death.....yrs.....mos.....days

In the

State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Parma IdahoJuly 11 1922

20. UNDERTAKER

Peckham Fur Co

ADDRESS

ParmaJune 10 5 P. M.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED
JUL 5 1922

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

County of Canyon Registration District No. 1007
City of Parma (No. _____) St. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Charles S. FooteState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 38433Registered No. 13

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married

(Write the word.)

6. DATE OF BIRTH.

July
(Month)21
(Day)1854
(Year)

7. AGE

67 Yrs. 10 Mos. 17 ds.IF LESS than 1 day
how many _____ hrs. or
_____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....Poultry raiser

9. BIRTHPLACE

(State or Country)

Wisconsin

10. NAME OF FATHER

John Foote

11. BIRTHPLACE OF FATHER

(State or Country)

Do not know

12. MAIDEN NAME OF MOTHER

Mary Smith

13. BIRTHPLACE OF MOTHER

(State or Country)

Do not know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. C. F. Foote

(Address)

Parma

15.

Filed

July 11922John M. Madsen
Local Registrar

16. DATE OF DEATH

June
(Month)8
(Day)1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Found dead in bed 191.....that I last saw him alive on about 191.....and that death occurred on the date stated above, at 5 a.m.

The CAUSE OF DEATH* was as follows:

Natural Causes

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory Heart Disease
(Secondary) mitral regurgitation

(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed) W. E. Walcott M. D.19..... (Address) Parma, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Parma Idaho

DATE OF BURIAL

June 10, 1922

20. UNDERTAKER

Parma Funeral Co

ADDRESS

Parma

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of CanyonCity of Wilder

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED
JUL 8 1922
BUREAU OF VITAL STATISTICS

Registration District No. 3Primary Registration District No. 2009

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 38434
Registered No. 75

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

June 28 1922
(Month) (Day) (Year)

7. AGE

Yrs. 3 Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

H. Ward Hume

11. BIRTHPLACE OF FATHER

(State or Country)

Missouri

12. MAIDEN NAME OF MOTHER

Pansy Vanscoy

13. BIRTHPLACE OF MOTHER

(State or Country)

Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

H. Ward Hume
Wilder, Idaho

15.

Filed

July 1 1922 John D. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 1 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 30 1922, to July 1 1922
that I last saw him alive on July 1 1922
and that death occurred on the date stated above, at 9:30 P.M.

The CAUSE OF DEATH* was as follows:

Intussusception

(Duration) Yrs. mos. ds.

Contributory (Secondary) Obstruction of common duct

(Duration) yrs. mos. ds.

(Signed) W. B. Bouch M. D.

July 19 22 (Address) Wilder, Idaho

State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wilder, Idaho 7-2 1922

20. UNDERTAKER

ADDRESS

C. V. Beckham Caldwell

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **38435**
Registered No. **76**

1. PLACE OF DEATH

County of **Canyon**
City of **Caldwell**

Registration District No. **3**
Primary Registration District No. **1005**
(No. **10** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Joseph Jane Rowberry

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX **Female** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **widow**

6. DATE OF BIRTH

Feb 19 1885
(Month) (Day) (Year)

7. AGE

71 Yrs. **4** Mos. **12** ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

House keeping

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Thos. Lee

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Harriet Wolcott

13. BIRTHPLACE OF MOTHER

(State or Country)

Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Mrs. E. L. Ekmann**
(Address) **Idaho**

15. FILED

July 3 - 1922 **John H. Meyers**
Local Registrar

16. DATE OF DEATH

July 1 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 25 1922 to **July 1 1922**
that I last saw her alive on **July 1st 1922**
and that death occurred on the date stated above, at **5 A.M.**

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) Yrs. mos. **15** ds.

Contributory (Secondary) **Atherosclerosis**

(Duration) **10** yrs. **about** mos. ds.

(Signed) **W. Montgomery M. D.**

July 3 1922 (Address) **Caldwell Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Toole Utah **19**

20. UNDERTAKER

ADDRESS

C. V. Peckham **Caldwell Ida.**

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon Registration District No. 3
City of Calderwell Primary Registration District No. 2005
(No. of VITALS) St.)File No. 38436
Registered No. 74

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Mary A. Alexander Runciman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH

Jan 16 1859
(Month) (Day) (Year)

7. AGE

63 Yrs. 5 Mos. 9 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Wisconsin

10. NAME OF FATHER

Wm Alexander

11. BIRTHPLACE OF FATHER

(State or Country) Scotland

12. MAIDEN NAME OF MOTHER

Mary A. Goodfellow

13. BIRTHPLACE OF MOTHER

(State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo. Runciman(Address) Calderwell Ida15. Filed June 25 1922 John V. Hayes
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 25 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 19 1922 to June 25 1922
that I last saw him alive on June 19 1922
and that death occurred on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:

Diphtheria
Scarlet & Liver(Duration) Yrs. 6+ mos. ds.
Contributory (Secondary) Age?

(Duration) yrs. mos. ds.

(Signed) S. B. Dingley M. D.19. (Address) Calderwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Canyon Hill

DATE OF BURIAL

6-28 1922

20. UNDERTAKER

Paul L. Case

ADDRESS

Calderwell

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Canyon Registration District No. 3
 City of Caldwell Primary Registration District No. 2005
 (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mrs. Lura Ann Fretwell

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 38437
 Registered No. 73

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widow

6. DATE OF BIRTH

_____. _____ 1
 (Month) (Day) (Year)

7. AGE

77 Yrs. _____ Mos. _____ ds.

IF LESS than 1 day
 how many _____ hrs.
 or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

House Keeping

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

Alva Wells

11. BIRTHPLACE OF FATHER

(State or Country)

Kentucky

12. MAIDEN NAME OF MOTHER

Winnie Adams

13. BIRTHPLACE OF MOTHER

(State or Country)

Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. T. Wilson

(Address)

Middletown, Ida.

15.

Filed

June 26, 1922

John H. Meyer

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 24 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 14, 1922 to June 24, 1922
 that I last saw her alive on June 24, 1922
 and that death occurred on the date stated above, at 4:30 A.M.

The CAUSE OF DEATH* was as follows:

Nephritis

(Duration) Yrs. 4 mos. 5 ds.

Contributory
 (Secondary)

(Duration) Yrs. _____ mos. _____ ds.

(Signed)

6-26-22 M. J. M. J.
 (Address) Caldwell, Ida.

*State the Disease Causing Death or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Middletown

DATE OF BURIAL

6-27, 1922

20. UNDERTAKER

E. V. Chapman

ADDRESS

Caldwell

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon
City of CaldwellRegistration District No. 3
Primary Registration District No. 1005
(No. 3 St.)File No. 38439Registered No. 71

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Chas. Richard Nelson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED married

6. DATE OF BIRTH

Oct 19 1891
(Month) (Day) (Year)

7. AGE

30 Yrs. 8 Mos. 2 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Richter coach

9. BIRTHPLACE

(State or Country)

Oregon

10. NAME OF FATHER

L. D. Nelson

11. BIRTHPLACE OF FATHER

(State or Country)

Oregon

12. MAIDEN NAME OF MOTHER

Eva. Levens

13. BIRTHPLACE OF MOTHER

(State or Country)

Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Eli. Smith Nelson
Caldwell, Ida.

15.

Filed

June 23 - 1922 John H. Innes
Local Registrar

16. DATE OF DEATH

June 21 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 21 1922 to June 21 1922
that I last saw h. in alive on June 21 1922
and that death occurred on the day stated above, at 5:17 P.

The CAUSE OF DEATH* was as follows:

Broken neck. The 6th & 5. vertebrae(Duration) Yrs. mos. 3 mos. 7 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

6/21 1922 (Address) Caldwell, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho State Cemetery 6-24-192220. UNDERTAKER W. J. Beckham ADDRESS Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Canyon
City of BarberRegistration District No. 3Primary Registration District No. 1005State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 38440Registered No. 70

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary E. Field

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widowed
(Write the word.)

6. DATE OF BIRTH

4 29 1841
(Month) (Day) (Year)

7. AGE

81 Yrs. 1 Mos. 20 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

House Wife

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Ind.

10. NAME OF FATHER

Alvinth Russell

11. BIRTHPLACE OF FATHER

(State or Country) Ky

12. MAIDEN NAME OF MOTHER

E. Elizabeth

13. BIRTHPLACE OF MOTHER

(State or Country) Ky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

R. E. Field
Calwell

15.

Filed June 19 1922John D. Meyers
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

6 18 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

General 19 6/18 1922
that I last saw her alive on 6/18 1922
and that death occurred on the date stated above, at 10 A.
The CAUSE OF DEATH* was as follows:old age and pneumonia
anemia

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

6/19 1922 (Address) Calwell

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Canyon

DATE OF BURIAL

June 19 1922

20. UNDERTAKER

Paul G. Gare

ADDRESS

Calwell

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 3
County of Canyon Primary Registration District No. 1005
City of Caldwell BUREAU STA St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Dora Van WasmereFile No. 38441
Registered No. 67

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married

6. DATE OF BIRTH

Aug 19 1894
(Month) (Day) (Year)

7. AGE

87 Yrs. 9 Mos. 19 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)House wife

9. BIRTHPLACE

(State or Country)

Denmark

10. NAME OF FATHER

Christian Kuhl

11. BIRTHPLACE OF FATHER

(State or Country)

Denmark

12. MAIDEN NAME OF MOTHER

Chuke

13. BIRTHPLACE OF MOTHER

(State or Country)

Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

N.S. van Wasmere

(Address)

Caldwell, Idaho

15.

Filed

June 12- 1922John H. Meyer

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 8 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 8 1922 to June 8 1922
that I last saw h. & r. alive on June 8 1922and that death occurred on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia -
Bad - Fast for me.

(Duration) Yrs. mos. ds.

Contributory
(Secondary)(Duration) 10 Yrs. mos. ds.

(Signed)

T. D. Turner M. D.6/10 1922 (Address) Caldwell, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Canyon Hill

DATE OF BURIAL

6-13 1922

20. UNDERTAKER

W. Beckham

ADDRESS

Caldwell

RECORDED
CERTIFICATE OF DEATH.State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics1. PLACE OF DEATH
County of Carson Registration District No. 1
City of Pampa, Ida. (No. 1 St.)File No. 38442Registered No. 38442
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Joe Tureman

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. W

6. DATE OF BIRTH.

May 23 1896
(Month) (Day) (Year)

7. AGE

26 Yrs. 11 Mos. 8 ds.IF LESS than 1 day
how many hrs. or
min.

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).Homemaker

9. BIRTHPLACE

(State or Country)

Ore

10. NAME OF FATHER

L. D. King

11. BIRTHPLACE OF FATHER

(State or Country)

Ore

12. MAIDEN NAME OF MOTHER

Hattie Gildenwater

13. BIRTHPLACE OF MOTHER

(State or Country)

Ore

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

George E. Tureman
(Address) Pampa, Ida.

15.

Filed

6-11922Lulu Waldorf

Local Registrar

16. DATE OF DEATH

May 1 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Apr. 29, 1922 to May 1, 1922and that I last saw her alive on Apr. 29, 1922and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Apoplexy(Duration) Yrs. 1 mos. 1 ds.

Contributory (Secondary)

(Signed) W. M. Mitchell M. D.5/1/1922 (Address) Pampa, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Baker City, Ore1922

20. UNDERTAKER

ADDRESS

Seckman & Co. Pampa

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

Registration District No. 7

County of Canyon Primary Registration District No. 1806

City ofampa (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Walter LeRoy Lammers

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 38444

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed June 5 1922

Local Registrar

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

The CAUSE OF DEATH* was as follows:

acute gastro-Enteritis

(Duration) Yrs. mos. 7 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Leo W Chilton M. D.

6/3 1922 (Address)ampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Kohlutawn Cem

5-16 1922

20. UNDERTAKER

ADDRESS

Frank Robinson

ampa

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

RECEIVED

Registration District No.

County of Canyon

Primary Registration District No.

City of Nampa(No. 2586)

File No.

38445

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William C Anderson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

40

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male whiteMarried
(write the word.)

6. DATE OF BIRTH

Feb 23 1876
(Month) (Day) (Year)

7. AGE

46 Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Farmer

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Mo.

10. NAME OF FATHER

Gustav Anderson

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME OF MOTHER

Naomi Clayton

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mr. Brassey
Buhl Id.

(Address)

15.

Filed June 2 1922George L. Lids
Local Registrar

16. DATE OF DEATH

6 2 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

January 1922 to 6-2 1922
that I last saw him alive on 6-2 1922and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma Abdominal, involving the Abdominal Aorta causing aneurism of Abdominal Aorta(Duration) Yrs. 2 mos. ds.Contributory Cystitis
(Secondary)(Duration) yrs. 8 mos. ds.(Signed) H.C. Robinson M. D.6-5-1922 (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Nampa6-8-1922

20. UNDERTAKER

ADDRESS

F.A. RobinsonNampa

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada Registration District No. 7
City of Idaho Falls Primary Registration District No. 2886
State (No. 1) St. Idaho

File No. 38446

Registered No. 38446

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Hugh O'Hara

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male White Married

6. DATE OF BIRTH

Feb 10 1862
(Month) (Day) (Year)

7. AGE

60 Yrs. 1 Mos. 27 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Ireland

10. NAME OF FATHER

Samuel

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Blocksley

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Wm. B. O'Hara
Meridian, Ida

15.

Filed June 15 1922

Local Registrar

16. DATE OF DEATH

Apr 7 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1922 to Apr 6 1922

that I last saw him alive on Apr 6 1922

and that death occurred on the date stated above, at 3 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart

(Duration) 2 Yrs. 2 mos. 2 ds.

Contributory (Secondary)

(Duration) 2 yrs. 2 mos. 2 ds.

(Signed)

H. O. Ross M. D.
Apr 7 1922 (Address) Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Peter's Cemetery 4 9 1922

20. UNDERTAKER

ADDRESS

Fred R. P. Pinner Nampa

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Canyon Registration District No. 7
 City of Nampa Primary Registration District No. 15
 State (No. Idaho) Mercy Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Josephine May Miller

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 38447

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

20

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female white Married
 (Write the word.)

6. DATE OF BIRTH

Sept 18 1882
 (Month) (Day) (Year)

7. AGE

38 Yrs. 4 Mos. 1 ds.

IF LESS than 1 day
 how many _____ hrs.
 or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

C. C. Miller

(Address)

Nampa Ida

15.

Filed June 18 1922

George Miller
 Local Registrar

16. DATE OF DEATH

May 19 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5-17-1922 to 5-19-1922

that I last saw him alive on 5-18-1922

and that death occurred on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:

General Septicemia

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory

(Secondary)

PR. D. W. SUSIE A. STANDARD

(Duration) _____ yrs. _____ mos. _____ ds.

201-2-3 Wadell Bldg. Nampa Idaho

(Signed)

J. C. Zwick M. D.

19. (Address) _____

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Nampa Idaho

DATE OF BURIAL

5/21/1922

20. UNDERTAKER

Frank H. Robinson

ADDRESS

Nampa

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **38448**
Registered No. _____
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. **PLACE OF DEATH.** **JUN** Registration District No. **7**
County of **Campan** Primary Registration District No. **1002**
City of **Nampa** (No. _____ St.)
If death occurs away from usual residence, give facts called for under special information. 2. **FULL NAME** **Calvin Luther Rand**

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX** **Male** 4. **COLOR OR RACE** **white** 5. **SINGLE, MARRIED, WIDOWED OR DIVORCED.** **married**
(Write the word.)

6. **DATE OF BIRTH** **Jan 30 1849**
(Month) (Day) (Year)

7. **AGE** **73 yrs. 3 mos. 14 ds.**
IF LESS than 1 day how many hrs. or mins.?

8. **OCCUPATION** **Farmer**
(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. **BIRTHPLACE** **West Virginia**
(State or Country)

10. **NAME OF FATHER** **John Rand**

11. **BIRTHPLACE OF FATHER** **W. Va.**
(State or Country)

12. **MAIDEN NAME OF MOTHER** **Mary Rand**

13. **BIRTHPLACE OF MOTHER** **W. Va.**
(State or Country)

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) **Calvin L. Rand**
(Address) _____

15. **Filed** **Feb 22 1922** **John Rand**
Local Registrar

MEDICAL CERTIFICATE OF DEATH. **79**

16. **DATE OF DEATH** **May 13 1922**
(Month) (Day) (Year)

17. **I HEREBY CERTIFY**, That I attended deceased from **Jan 1 1920** to **May 13 1922**
that I last saw him alive on **May 13 1922**
and that death occurred on the date stated above, at **7 P. M.**

The CAUSE OF DEATH* was as follows:
Chronic Valvular Heart

Several yrs. mos. ds.
(Duration)
Contributory **Arteriosclerosis**
(Secondary) **Chronic Nephritis**
Several yrs. mos. ds.
(Duration)
(Signed) **H. P. Ross** M. D.
May 13 1922 (Address) **Nampa, Ida**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. **LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)**
At place of death yrs. mos. days. In the State yrs. mos. days.
Where was disease contracted if not at place of death? _____
Former or usual residence. _____

19. **PLACE OF BURIAL OR REMOVAL** **W. Va.** **DATE OF BURIAL** **May 17 1922**

20. **UNDERTAKER** **W. Va.** **ADDRESS** **W. Va.**

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 38449
Registered No.

1. PLACE OF DEATH JUN 22 1922
Registration District No. 7
County of Camanche
City of Nauvoo
(No. 1006) St. Mary Hospital
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME Mary E. Collins

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widow
(Write the word.)
6. DATE OF BIRTH Dec 30 1853
(Month) (Day) (Year)
7. AGE 69 Yrs. 4 Mos. 26 ds.
IF LESS than 1 day how many.....hrs. or.....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE
(State or Country) Calif

10. NAME OF FATHER Wm C. Lewis

11. BIRTHPLACE OF FATHER Kentucky
(State or Country)

12. MAIDEN NAME OF MOTHER Anna J. Vlach

13. BIRTHPLACE OF MOTHER Ohio
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. E. Collins
(Address) Nauvoo, Idaho

15. Filed June 11 1922
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 26 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1 1922 to May 26 1922 that I last saw her alive on May 26 1922 and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:
Carcinoma of Lungs (metastatic)

(Duration) 1 yrs. 10 mos. 26 ds.
Contributory (Secondary) Bronchitis & Pulmonary Effusion
(Duration) 1 yrs. 10 mos. 26 ds.
(Signed) M. S. Link M. D.
May 27 1922 (Address) Nauvoo, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL.
Richmond Utah 19

20. UNDERTAKER ADDRESS
Fred K. Robinson Nauvoo, Idaho

RECEIVED
JUN 22 1922

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon Registration District No. 7
City of Nampa Primary Registration District No. 6586
(No. Mersey Hospital St.)File No. 38450

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Clara M. Covington

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female White Married

6. DATE OF BIRTH

May 1 1885
(Month) (Day) (Year)

7. AGE

37 Yrs. - 21 Mos. ds.
IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)Housewife

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

D. F. Lott

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Susan J. Farnsworth

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

G. J. Covington

(Address)

Nampa, Idaho

15.

Filed June 15 1922 Charles D. Smith
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 22 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 18 1922, to May 22 1922
that I last saw her alive on May 22 1922
and that death occurred on the date stated above, at 11 P. M.
The CAUSE OF DEATH* was as follows:Peritonitis(Duration) 12 Yrs. 12 mos. 12 ds.
Contributors (Secondary) Peritonitis(Duration) 12 yrs. 12 mos. 12 ds.(Signed) Marion J. Long M. P.June 9, 1922 (Address) Nampa, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 12 yrs. 12 mos. 12 days. In the State 12 yrs. 12 mos. 12 days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Idaho Idaho 19

20. UNDERTAKER ADDRESS

W. K. Robinson Nampa, Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **38451**
Registered No.

1. PLACE OF DEATH

County of **Buylon**
City of **Nampa**

Registration District No. **7**
Primary Registration District No. **1006**
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

David D. Doll

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

married
(Write the word.)

6. DATE OF BIRTH

Nov 23 1898
(Month) (Day) (Year)

7. AGE

73 Yrs. **5** Mos. **29** ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Farmer

9. BIRTHPLACE

(State or Country)

Penn.

10. NAME OF FATHER

Wm. Doll

11. BIRTHPLACE OF FATHER

(State or Country)

Penn.

12. MAIDEN NAME OF MOTHER

Mary Schupar

13. BIRTHPLACE OF MOTHER

(State or Country)

Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Mrs. D. B. Doll
1621, 6th St. Nampa

15.

Filed **June 15** 19**22**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 22 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Apr 24 1922** to **May 22 1922** that I last saw him alive on **May 22 1922** and that death occurred on the date stated above, at **9:30 P.M.** The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(Duration) **5** Yrs. **-** mos. **-** ds.

Contributory **Chronic Nephritis**
(Secondary)

(Duration) **10** yrs. **-** mos. **-** ds.

(Signed) **Leo W. Chilton** M. D.

6/3 1922 (Address) **Nampa, Ida.**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Kohlstaun

DATE OF BURIAL

3/24 1922

20. UNDERTAKER

J. Robinson

ADDRESS

Nampa

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 7
County of Caribou Primary Registration District No. 1886
City of Nampa No. 117-17th Ave South St.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Austin Lee NettletonFile No. 38452
Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male White Married

6. DATE OF BIRTH

Aug 31 1841
(Month) (Day) (Year)

7. AGE

80 Yrs. 8 Mos. 13 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

Farmer
(Retired)

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

Lewis B. Nettleton

11. BIRTHPLACE OF FATHER

(State or Country)

Conn.

12. MAIDEN NAME OF MOTHER

Julia Baldwin

13. BIRTHPLACE OF MOTHER

(State or Country)

Conn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. L. E. Perkins

(Address)

Nampa, Ida.

15.

Filed June 3 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 13 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 1 1920 to May 13 1922
that I last saw him alive on May 13 1922
and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease(Duration) 5 Yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) H. P. Ross M. D.5/15 1922 (Address) Nampa, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Kohlerman Ave

DATE OF BURIAL

5-15 1922

20. UNDERTAKER

Frank Robinson

ADDRESS

Nampa
Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **38453**
Registered No. _____

1. PLACE OF DEATH

County of Ada

Registration District No. _____

Primary Registration District No. 1806

City of _____

(No. _____)

(St. _____)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

 Evelyn Stewart

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female white

(Write the word.)

6. DATE OF BIRTH

Apr61919

(Month)

(Day)

(Year)

7. AGE

3

Yrs.

1

Mos.

23

ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

H. V. Stewart

11. BIRTHPLACE OF FATHER

(State or Country)

Kentucky

12. MAIDEN NAME OF MOTHER

Emma Beaublossom

13. BIRTHPLACE OF MOTHER

(State or Country)

Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

H. V. Stewart

(Address)

Meridian, Ida.

15.

Filed June 101922Pearle Dadds

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

October 5311922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

5-30-1922

to

5-311922that I last saw h.c. alive on 5-30-1922and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

Thos. P. Mangum, M. D.5-31-1922

(Address)

Memph. Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

yrs.

mos.

days.

In the

State

yrs.

mos.

days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Funer. Home Cem6-1 1922

20. UNDERTAKER

ADDRESS

None

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED CERTIFICATE OF DEATH

Reg. District No.

Primary Registration District No.

St. (No.)

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 38454
Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed June 18 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from 6-6-1922 to 6-7-1922

that I last saw him alive on 6-7-1922 and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows: *

Bronchopneumonia

(Duration) Yrs. mos. ds.

Contributory (Secondary)

Drs. D. E. & SUSIE STANLEY

201-2-3 Waddell Bldg. Nampa Idaho (Signed) M. D.

19. (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

✓ State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 38455
Registered No.

1. PLACE OF DEATH

Registration District No. _____
County of Canyon
City of Nampa, Idaho
Primary Registration District No. 1124
St. _____

If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME Helen Marie Keim

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED single
(Write the word.)

6. DATE OF BIRTH April 18 1922
(Month) (Day) (Year)

7. AGE no yrs. no mos. 9 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work ✓
(b) General nature of industry, business or establishment in which employed (or employer) ✓

9. BIRTHPLACE

(State or Country) Nampa, Idaho, Canyon Co.

10. NAME OF FATHER C. Ray Keim

11. BIRTHPLACE OF FATHER

(State or Country) Louisville, Ohio Stark County

12. MAIDEN NAME OF MOTHER Annie Keim

13. BIRTHPLACE OF MOTHER

(State or Country) Ladoga, Indiana Montgomery Co.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. Ray Keim
(Address) Nampa, Idaho

15. Filed May 22 1922
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Apr - 27 - 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 18 - 1922 to Apr 27 - 1922 that I last saw her alive on Apr 27 - 1922 and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Convulsions probably due to Gastric Intestinal Intoxication

(Duration) _____ Yrs. _____ mos. _____ ds.
Contributory (Secondary) Premature birth (1 1/2 mo)

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) J. H. E. Mangum M. D.

5-10-1922 (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death x yrs. x mos. 9 days. In the State yrs. mos. days

Where was disease contracted if not at place of death? x

Former or usual residence x

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Fakelawn, Nampa Apr 28 1922

20. UNDERTAKER Private Burial ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon Registration District No. 4
City of Nampa Primary Registration District No. 1506
(No. Mercy Hospital St.)File No. 38456

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Infant Daughter of Mrs. F. Miller

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Fem. 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED
(Write the word.)

6. DATE OF BIRTH

May 13 1922
(Month) (Day) (Year)

7. AGE

13
Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Lloyd Miller

11. BIRTHPLACE OF FATHER

(State or Country) Iowa

12. MAIDEN NAME OF MOTHER

Bernice Spencer

13. BIRTHPLACE OF MOTHER

(State or Country) _____

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. May Bach(Address) Nampa Ida

15.

Filed June 15 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 25 22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 17 1922 to May 25 1922that I last saw her alive on May 24 1922and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

undeveloped lungs & Colic (Congenital)

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) H. P. Ross M. D.May 19 22 (Address) Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Turn Falls Ida 19

20. UNDERTAKER

ADDRESS

Fred T. Robinson Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon Registration District No. 3
City of Caldwell Registration District No. 2005
(No. 22 St.)

File No. 38457
Registered No. 68

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary Angelina Apperson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED married

6. DATE OF BIRTH

Feb 20 1886
(Month) (Day) (Year)

7. AGE

66 Yrs. 3 Mos. 12 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

Bailey

11. BIRTHPLACE OF FATHER

(State or Country)

Dartmouth

12. MAIDEN NAME OF MOTHER

Murphy

13. BIRTHPLACE OF MOTHER

(State or Country)

Dartmouth

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. C. Apperson 912 Albany
(Address) Caldwell, Idaho

15.

Filed June 4 - 1922 John H. Mayes
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 2 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 29 1922 to June 2 1922
that I last saw h. lx alive on June 2 1922
and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Streptococcus Infection
Fractal, Noval, Inus

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

T. D. Jones M. D.
6/3 1922 (Address) Caldwell Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Canyon Hill 6-4 1922

20. UNDERTAKER

ADDRESS

V. Beekham Caldwell

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon Registration District No. 2005
City of Middleton (No. 1754 St.)File No. 38458
Registered No. 66

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Glen Moberly

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Nov. 21 1917
(Month) (Day) (Year)

7. AGE

4 Yrs. 6 Mos. 7 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Oscar C. Moberly

11. BIRTHPLACE OF FATHER

(State or Country)

Missouri

12. MAIDEN NAME OF MOTHER

Muriel Hadsall

13. BIRTHPLACE OF MOTHER

(State or Country)

Colorado

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

John H. Meyer
Middleton - Idaho

15.

Filed June 14 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 28 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19that I last saw him alive on 19and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Struck by Boise Valley Ry
car, Accident

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Paul L. Case M.D.5-29-22 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Middleton

DATE OF BURIAL

6-1 1922

20. UNDERTAKER

Paul L. Case

ADDRESS

Caldwell

1. PLACE OF DEATH

County of Canyon Registration District No. 3
 City of Baldwell Primary Registration District No. 2005
 St. STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mrs Muriel Moberly

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 38459
 Registered No. 65

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
 (Write the word.)

6. DATE OF BIRTH March 23 1889
 (Month) (Day) (Year)

7. AGE 33 Yrs. 2 Mos. 5 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

Housewife

9. BIRTHPLACE

(State or Country)

Colorado

10. NAME OF FATHER

P. D. Hadsall

11. BIRTHPLACE OF FATHER

(State or Country)

Ills

12. MAIDEN NAME OF MOTHER

Muriel M. Fox

13. BIRTHPLACE OF MOTHER

(State or Country)

Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15. Filed June 1st 1922

John H. Meyers
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 28 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 19 to 19

that I last saw him alive on 19 and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Struck by Boise Valley Ry. car, accident

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Carl L. Case M. D.

57-29-22 (Address) Baldwell Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Middleton

DATE OF BURIAL

6-1 1922

20. UNDERTAKER

Carl L. Case

ADDRESS

Baldwell Idaho

1. PLACE OF DEATH

County of Canyon
City of Caldwell

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
JUN 22 1922

CERTIFICATE OF DEATH

Registration District No. 3Primary Registration District No. 2005

BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 38460Registered No. 64

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Dennis R. Johnston

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word)

6. DATE OF BIRTH

March 22 1933
(Month) (Day) (Year)

7. AGE

89 Yrs. 2 Mos. 7 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Kentucky

10. NAME OF FATHER

Thomas Johnston

11. BIRTHPLACE OF FATHER

(State or Country)

Kentucky

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. F. Johnston
Notus, Idaho

15.

Filed May 31 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

154

16. DATE OF DEATH

May 29 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Dec 19 21 to May 29 22that I last saw him alive on May 29 19 22and that death occurred on the date stated above, at 2:30 P M.

The CAUSE OF DEATH* was as follows:

General Senility(Duration) 3 Yrs. 5 mos. 29 ds.

Contributory (Secondary)

Prostatectomy(Duration) 5 yrs. 5 mos. 29 ds.

(Signed)

529 19 22

(Address)

Notus, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Canyon Hill

DATE OF BURIAL

May 31 19 22

20. UNDERTAKER

Paul H. Case

ADDRESS

Caldwell, Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH **RECEIVED**
 County of Canyon Registration District No. 1005
 City of Cal No. 9th St.)

File No. 38461
 Registered No. 43

If death occurs away from
 usual residence, give facts
 called for under special in-
 formation.

If death occurred in a hos-
 pital, institution or camp,
 give its NAME instead of
 street and number.

2. FULL NAME

Ira Goldsmith

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED
 (Write the word.)

6. DATE OF BIRTH

Apr 10 1846
 (Month) (Day) (Year)

7. AGE

76 Yrs. 1 Mos. 19 ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or
 particular kind of work
 (b) General nature of in-
 dustry, business or estab-
 lishment in which employ-
 ed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Indiana

10. NAME OF FATHER

James Goldsmith

11. BIRTHPLACE OF FATHER

(State or Country)

Indiana

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Ind

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mr. J. H. Goldsmith

(Address)

714 No. 9. Caldwell

15.

Filed May 31- 1922

John H. Meyer
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 29 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
19 to 19

that I last saw h..... alive on 19
 and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Suicide - Took
strychnine

(Duration) Yrs. mos. ds.

Contributory
 (Secondary)

(Duration) yrs. mos. ds.

(Signed) Paul L. Base M. D.

Cornet - Caldwell Ida
 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state
 (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
 if not at place of death?

Former or
 usual residence

19. PLACE OF BURIAL OR REMOVAL

Canyon Hill

DATE OF BURIAL

May 31, 1922

20. UNDERTAKER

Paul L. Base

ADDRESS

Caldwell

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH
 in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 38462
Registered No. 62

1. PLACE OF DEATH

County of Canyon Registration District No. 9
City of Wilder Primary Registration District No. 2005
St. Idaho

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Marmette Myrtle Coverhill
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

female white married

6. DATE OF BIRTH

Jan 10 1892
(Month) (Day) (Year)

7. AGE

30 Yrs. 4 Mos. 4 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

House Wife

9. BIRTHPLACE

(State or Country) Oregon

10. NAME OF FATHER

William Johnson

11. BIRTHPLACE OF FATHER

(State or Country) Oregon

12. MAIDEN NAME OF MOTHER

Illinois

13. BIRTHPLACE OF MOTHER

(State or Country) Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Carl Coverhill

(Address) Wilder Idaho

Filed May 15 1922 John H. Hayes
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 14 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY That I attended deceased from

June 1920 to May 14 1922
that I last saw her alive on May 14 1922
and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

disaster - mulligan

(Duration) 2 Yrs. mos. ds.

Contributory (Secondary) acute follicular tonsillitis

(Duration) yrs. mos. ds. 3

(Signed) Dr. J. B. Smith M. D.

May 1922 (Address) Wilder Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Baswell Cem.

DATE OF BURIAL

5-15-1922

20. UNDERTAKER

E. V. Beckham Caldwell

ADDRESS

Baswell

RECEIVED
JUN 22 1922

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

Canyon

Registration District No.

Mary Registration District No.

City of

Houston

STATISTICAL

St.)

File No.

38463

Registered No.

67

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary Lucile Kiger

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

female white

(Write the word.)

6. DATE OF BIRTH

April 20 1922

(Month)

(Day)

(Year)

7. AGE

Yrs. 1 Mos. 12 ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

John A. Kiger

11. BIRTHPLACE OF FATHER

(State or Country)

Nebraska

12. MAIDEN NAME OF MOTHER

Nellie McIntire

13. BIRTHPLACE OF MOTHER

(State or Country)

Colorado

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John A. Kiger

(Address)

Houston #1

15.

Filed

June 3 - 1922

John V. Meyers
Local Registrar

MEDICAL CERTIFICATE OF DEATH

151-2

16. DATE OF DEATH

June 2 1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

birth 1922 to June 2 1922
that I last saw him alive on June 1 1922
and that death occurred on the date stated above, at 12:45 A.M.

The CAUSE OF DEATH* was as follows:

premature & unusual

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. V. Meyers M. D.

19 (Address) 6/2 22

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Canyon Hill

6-3 1922

20. UNDERTAKER

ADDRESS

J. V. Beckham

Caldwell

1. PLACE OF DEATH

County of *Conibury*City of *Soda Springs*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED

CERTIFICATE OF DEATH

Registration District No. *82*Primary Registration District No. *2159*(No. *1*)

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *38464*Registered No. *6*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

*Nov.**20th**1889*

(Month)

(Day)

(Year)

7. AGE

32 Yrs.*7* Mos.*18* ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

Rancher

9. BIRTHPLACE

(State or Country)

Butler Springs Kansas

10. NAME OF FATHER

W. G. Perry

11. BIRTHPLACE OF FATHER

(State or Country)

Terrahaute Indiana

12. MAIDEN NAME OF MOTHER

Terrie Herbold

13. BIRTHPLACE OF MOTHER

(State or Country)

Moncie Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. G. Perry

(Address)

Cokeville Wyoming

15.

Filed *June 30* 19*22**Earl K. Kelley*

Local Registrar

16. DATE OF DEATH

June 7

(Month)

(Day)

1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 1 19*22*, to *June 7* 19*22*that I last saw him alive on *June 7* 19*22*and that death occurred on the date stated above, at *8 A.* M.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)*Failure of Heart*

(Duration)

Yrs.

mos.

ds.

(Signed)

Edis K. Kelley

M. D.

(Address)

Soda Springs Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death..... yrs..... mos..... days.

In the

State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cokeville Wyoming June 10 19*22*

20. UNDERTAKER

ADDRESS

Schumacher & Hall

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH

Bureau of Vital Statistics

File No.

Registered No. 590.
If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

1. PLACE OF DEATH

County of *Carson*City of *Burley*If death occurs away from
usual residence, give facts
called for under special
information.Registration District No. *117*Primary Registration District No. *2196*

(No.)

38466

2. FULL NAME

Thomas Collett

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

*White*5. SINGLE, MARRIED, WID-
OWED OR DIVORCED*Married*

6. DATE OF BIRTH

May 8th 1866
(Month) (Day) (Year)

7. AGE

57 Yrs. Mos. 10 ds.IF LESS than 1 day
how many hrs. or
.... min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of in-
dustry, business, or estab-
lishment in which em-
ployed (or employer)*Farmer*

9. BIRTHPLACE

(State or Country)

*Smithfield, Utah*10. NAME OF
FATHER*Daniel Collett*11. BIRTHPLACE
OF FATHER

(State or Country)

*England*12. MAIDEN NAME
OF MOTHER*Elizabeth Ward*13. BIRTHPLACE
OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Daniel W. Collett

15.

Filed

*May 19 1922**Dr. J. C. Patterson*
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 18th 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
May 12 1912 to *May 18 1917*that I last saw h..... alive on 191.....
and that death occurred on the date stated above, at *2 a* M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris(Duration) *Acute* mos. ds.Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

Joseph Tremstad

(Address)

*State the Disease Causing Death; or in deaths from Violent
Causes, state (1) Means of Injury; and (2) whether Accidental,
Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)At place In the
of death yrs. mos. days, State yrs. mos. daysWhere was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Soda Springs, Ida

DATE OF BURIAL

191....

20. UNDERTAKER

L. B. Galloway

ADDRESS

Burley

80

1922

1917

191

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MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS
should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement
of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Cassia Registration District No. 117
 City of Jackson Subcity Registration District No. 2196 St.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED
 JUN 22 1922
 BUREAU OF VITAL STATISTICS

Alfred Muenner

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 38467

Registered No. 597

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

M. White Widower
 (Write the word.)

6. DATE OF BIRTH

July 1 1841
 (Month) (Day) (Year)

7. AGE

80 Yrs. 10 Mos. 4 ds.

IF LESS than 1 day
 how many..... hrs.
 or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

N. Y.

10. NAME OF FATHER

Leonard Muenner

11. BIRTHPLACE OF FATHER

(State or Country)

N. Y.
Not known

12. MAIDEN NAME OF MOTHER

Lydia Jordan

13. BIRTHPLACE OF MOTHER

(State or Country)

New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ray Bowen

(Address)

Jackson Idaho

15.

Filed May 19 1922 Dr. J. C. Patterson
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

5 4 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Patient dead on arrival of Physician
 that I last saw him alive on 19
 and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) Yrs. mos. ds.

Contributory
 (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. B. Kennedy M. D.

5/6 1922 (Address) Rapart

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rapart

5/7 1922

20. UNDERTAKER

ADDRESS

Alvin Haller

Rapart

CERTIFICATE OF DEATH

38468

State of Idaho
BOARD OF HEALTH

Bureau of Vital Statistics

File No.

Registered No. 588

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

1. PLACE OF DEATH

County of Cassia

Registration District No. 117

City of Burley

Registration District No. 2196

If death occurs away from
usual residence, give facts
called for under special
information.

2. FULL NAME Frances Maid Barnes

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

Married

6. DATE OF BIRTH.

Oct. 10 1878
(Month) (Day) (Year)

7. AGE

43 Yrs. 6 Mos. 24 ds.

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of in-
dustry, business, or estab-
lishment in which em-
ployed (or employer)

Housewife

9. BIRTHPLACE

(State or Country) London England.

10. NAME OF
FATHER

Geo. Cook.

11. BIRTHPLACE
OF FATHER

(State or Country) London England.

12. MAIDEN NAME
OF MOTHER

Sarah Port.

13. BIRTHPLACE
OF MOTHER

(State or Country) London England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) O. L. Barnes

(Address) Burley, Ida.

15. Filed May 19 1922

Dr. J. W. Patterson
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 4 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 4 1922 to May 4 1922

that I last saw him alive on May 4 1922

and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Hemorrhage, Placenta
Praevia Centralis

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) J. C. Patterson M. D.

5-5 1922 (Address) Burley, Ida.

*State the Disease Causing Death; or in deaths from Violent
Causes, state (1) Means of Injury; and (2) whether Accidental,
Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days, State ... yrs. ... mos. ... days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Burley Ida.

DATE OF BURIAL

May 7 1922

20. UNDERTAKER

L. B. Gossely

ADDRESS

Burley Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS
should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement
of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH *Idaho* Registration District No. *117*
 County of *Cassia* Registration District No. *2196*
 City of *Burley* St.
 If death occurs away from usual residence, give facts called for under special information.

38469

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. *592*
 Registered No. *592*
 If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Voltaire Savage Braden

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M.* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. *Single*

6. DATE OF BIRTH. *May 13th 1914*
 (Month) (Day) (Year)

7. AGE *7* Yrs. *11* Mos. *28* ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
 (a) Trade, profession or particular kind of work *None*
 (b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE *Elba Idaho*
 (State or Country)

10. NAME OF FATHER *John R. Braden*

11. BIRTHPLACE OF FATHER *Council Bluffs Iowa*
 (State or Country)

12. MAIDEN NAME OF MOTHER *Mary P. Savage*

13. BIRTHPLACE OF MOTHER *Elba Idaho*
 (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) *John S. Braden*
 (Address) *Burley, No. 221 S. W.*

15. Filed *May 19th 1922* *W. J. C. Patterson*
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *May 11th 1922*
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *May 6 - 1922* to *May 11 - 1922*
 that I last saw him alive on *May 11 - 1922*
 and that death occurred on the date stated above, at *3 P.M.*

The CAUSE OF DEATH* was as follows *Cerebral Thrombosis*
 (Duration) *2* Yrs. *—* mos. *—* ds.

Contributory (Secondary)
 (Duration) *1* Yr. *—* mos. *—* ds.
 (Signed) *W. J. Cooper* M. D.
 19 *Burley, Idaho* (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
 of death *—* yrs. *—* mos. *—* days, State *—* yrs. *—* mos. *—* days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Elba Idaho* DATE OF BURIAL *May 13th 1922*

20. UNDERTAKER ADDRESS

PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. If death occurs away from usual residence, give facts called for under special information. of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M, 6-15-17.

1. PLACE OF DEATH

County of Cassia
City of Burley
If death occurs away from usual residence, give facts called for under special information.

CERTIFICATE OF DEATH

Registration District No. 117
Primary Registration District No. 2196
(No. 103 St.)

38470

State of Idaho
BOARD OF HEALTH

Bureau of Vital Statistics

File No. 593
Registered No. 593
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Florance Warner

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED single

6. DATE OF BIRTH May 26th 1921
(Month) (Day) (Year)

7. AGE 11 Yrs. 10 Mos. 20 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) None

9. BIRTHPLACE

(State or Country) Keyburn

10. NAME OF FATHER

Melvin C Warner

11. BIRTHPLACE OF FATHER

(State or Country) Coyote Utah

12. MAIDEN NAME OF MOTHER

D. C. Prescott

13. BIRTHPLACE OF MOTHER

(State or Country) Bear Lake Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wallace D. Warner
(Address) Keyburn R. 7. D. =

15. Filed 5-17-22 191... D. J. Patterson
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

91

16. DATE OF DEATH May 16 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 9 1922 to May 16 1922 that I last saw her alive on May 16 1922 and that death occurred on the date stated above, at Keyburn M.
The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(Duration) 8 Yrs. 5 mos. 5 ds.

Contributory (Secondary) Pleuronitis

(Duration) 5 Yrs. 5 mos. 5 ds.

(Signed) Dorothy Rich M. D.

19 (Address) Burley, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 8 yrs. 8 mos. 8 days, State 8 yrs. 8 mos. 8 days

Where was disease contracted if not at place of death? Keyburn

Former or usual residence Keyburn, Idaho

19. PLACE OF BURIAL OR REMOVAL

Keyburn

DATE OF BURIAL

May 17 1922

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

1. PLACE OF DEATH

County of Cassia
City of Burley

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Bernice Evelyn Stout

CERTIFICATE OF DEATH.

Registration District No. 117Primary Registration District No. 2196

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 38471Registered No. 594

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

F

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH.

Sept
(Month)

10

(Day)

1920
(Year)

7. AGE

1 Yrs. 8 Mos. 7 ds.

IF LESS than 1 day
how many hrs. or
..... min. 2

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

G. Stout

11. BIRTHPLACE OF FATHER

(State or Country)

Oregon

12. MAIDEN NAME OF MOTHER

Evelyn Royle

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

J. G. Stout

(Address)

Burley - Ida

15.

Filed

May 151922

D. J. Patterson
Local Registrar

16. DATE OF DEATH

May
(Month)

17

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from
May 1, 1922, to May 17, 1922.

that I last saw him alive on May 17, 1922
and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia(Duration) Yrs. mos. 17 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. C. Patterson M. D.19. (Address) Burley, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Reasays View Cemetery

May 18, 1922

20. UNDERTAKER

ADDRESS

R. J. Matt

Burley, Ida

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **38474**
Registered No. _____

1. PLACE OF DEATH _____
Registration District No. **125**
County of **Clark** _____
Primary Registration District No. **2203**
City of **Subois** (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Edith Albertsen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Married**
(Write the word.)

6. DATE OF BIRTH

July 3 1893
(Month) (Day) (Year)

7. AGE

28 Yrs. **9** Mos. **28** ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Thos. B. Wilson

11. BIRTHPLACE OF FATHER

(State or Country)

Peru

12. MAIDEN NAME OF MOTHER

Sarah Jane Woolley

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Thos B Wilson
Spencer Idaho

15.

Filled

May 2 1922

W E Jones M D

Local Registrar

16. DATE OF DEATH

May 2 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **April 27 1922** to **May 2 1922**
that I last saw him alive on **May 2 1922**
and that death occurred on the date stated above, at **6:45 PM**.

The CAUSE OF DEATH* was as follows:

Influenza
Pneumonia
Pernicious Anemia

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

W E Jones M D
5/2 1922 (Address) **Subois Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Subois Idaho **May 5 1922**

20. UNDERTAKER

ADDRESS

W E Jones M D **Idaho Falls**

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Clearwater Registration District No. 90
City of Profino Primary Registration District No. 2168
(No. 31) (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mrs. Anna May ShoemakerFile No. 38475
Registered No. 28

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widowed
(Write the word.)

6. DATE OF BIRTH

July 15 1865
(Month) (Day) (Year)

7. AGE

57 Yrs. 11 Mos. 7 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Troy, Ohio.

10. NAME OF FATHER

H.C. Sage

11. BIRTHPLACE OF FATHER

(State or Country) Ohio

12. MAIDEN NAME OF MOTHER

Miss Summers

13. BIRTHPLACE OF MOTHER

(State or Country) unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Miss Ora Shoemaker(Address) Profino, Ida.

15.

Filed June 23 1922 Profino
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 22 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 1 1922 to June 22 1922
that I last saw him alive on June 22 1922
and that death occurred on the date stated above, at 2 A.M.

The CAUSE OF DEATH* was as follows:

apoplexy

(Duration) Yrs. mos. ds.

Contributory (Secondary) Cerebrospinal arterial sclerosis.

(Duration) Yrs. mos. ds.

(Signed) E. W. Howard M. D.June 23 (Address) Profino, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Profino
C. C. Bobo

DATE OF BURIAL

June 24, 22

ADDRESS

Profino

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **38476**
Registered No. **26**

1. PLACE OF DEATH

County of **Leguwater**
City of **Profrina**Registration District No. **90**Primary Registration District No. **2168**(No. **1** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John O. Carr

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

married
(Write the word.)

6. DATE OF BIRTH

Dec. 30 18**69**
(Month) (Day) (Year)

7. AGE

53 Yrs. **5** Mos. **3** ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Farmer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

Jim Carr

11. BIRTHPLACE OF FATHER

(State or Country)

Missouri

12. MAIDEN NAME OF MOTHER

—

13. BIRTHPLACE OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. O. Carr

(Address)

Lincoln Idaho

15.

Filed

June 29, 1922**J. M. Bailey**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

92

16. DATE OF DEATH

June 28 19**22**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 23, 1922 to June 28, 1922
that I last saw him alive on **June 28, 1922**and that death occurred on the date stated above, at **3:30 P.M.**

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) Yrs. mos. ds.

Contributory
(Secondary)**Insanity**

(Duration) yrs. mos. ds.

(Signed)

John W. Sinsness M. D.**6/29/1922** (Address) **Profrina, Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. **5** days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Lincoln Idaho

DATE OF BURIAL

19

20. UNDERTAKER

L. B. Bolo

ADDRESS

Profrina, Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Clearwater Registration District No. 90
 City of Prosser Primary Registration District No. 2168
 (Nov. 1922) (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Francis M. Snider

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 38477
 Registered No. 27

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
 (Write the word.)

6. DATE OF BIRTH

May 23 1833
 (Month) (Day) (Year)

7. AGE

90 Yrs. 25 Mos. ds.

IF LESS than 1 day
 how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

Carpenter.

9. BIRTHPLACE

(State or Country)

West Virginia

10. NAME OF FATHER

unknown

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. R. Snider
 (Address) Prosser, Idaho.

Filed June 19 1922 J. M. Gairly
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

154

16. DATE OF DEATH

June 19 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 19 1922 to June 19 1922

that I last saw him alive on June 19 1922

and that death occurred on the date stated above, at 8:55 AM

The CAUSE OF DEATH* was as follows:

Old age

(Duration) Yrs. mos. ds.

Contributory (Secondary) Arteriosclerosis

(Duration) yrs. mos. ds.

(Signed) J. M. Gairly M. D.

6/19 1922 (Address) Prosser, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Prosser June 20 1922

20. UNDERTAKER

Bobo Prosser.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED

JUN 22 1922

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH. Registration District No. 90
County of Clearwater Primary Registration District No. 715
City of Profino, Idaho (No. North State Insane Asylum St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Joseph King

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 38478

Registered No. 21

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH About 1842
(Month) (Day) (Year)

7. AGE About 80 yrs. mos. ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Laborer
(b) General nature of industry business or establishment in which employed (or employer). General Miscellaneous Laborer, Farm Work Etc

9. BIRTHPLACE (State or Country) Canada

10. NAME OF FATHER King

11. BIRTHPLACE OF FATHER (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. W. Galt
(Address) Profino, Idaho

15. June 1 1922
Filed J. M. Galt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 9th 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 15, 1905 to May 9th 1922
that I last saw him alive on May 8th 1922
and that death occurred on the date stated above, at 4 A. M.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

Unknown
(Duration) yrs. mos. ds.

Contributory (Secondary) Insanity

(Duration) yrs. mos. ds.
(Signed) J. W. Galt M. D.
5/11 1922 (Address) Profino, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) over

At place of death 16 yrs. 9 mos. 25 ds. In the State 23 yrs. mos. ds.
Where was disease contracted, If not at place of death?
Former or usual residence. Shoshone County, Idaho

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Grave 13 Row 5 New Add. 5/11 1922
The Northern Idaho Sanitarium

20. UNDERTAKER Profino, Idaho ADDRESS

J. W. Galt Profino, Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH *Profino* Registration District No. *90*
County of *Blaine* Registration District No. *2168*
City of *Profino* (No. *10. Idaho Insane Asylum St.*)

File No. *38479*
Registered No. *22*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Richard Bray

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. *Single*
(Write the word.)

6. DATE OF BIRTH

About 1863
(Month) (Day) (Year)

7. AGE

About 59 yrs. mos. ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Mine
Working in Mines

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

Bray

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

W. J. McHenry
Profino, Idaho

15.

Filed *June 1* 1922

W. J. McHenry
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

96

16. DATE OF DEATH

May 17th 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *July 10th* 1905, to *May 17th* 1922, that I last saw him alive on *May 17th* 1922, and that death occurred on the date stated above, at *5:15 P.* M.

The CAUSE OF DEATH* was as follows:

Cordeic Asthma

(Duration) *Unknown* yrs. mos. ds.

Contributory (Secondary)

Insanity

(Duration) *Unknown* yrs. mos. ds.

(Signed)

5/19 1922 (Address) *Profino, Idaho*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death *16* yrs. *10* mos. *8* ds. In the *over 23 years* State *Idaho* yrs. mos. ds.

Where was disease contracted,

If not at place of death,

Former or

usual residence

Quater County, Idaho

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

N. O. Sanitarium cemetery *5/19* 1922

20. UNDERTAKER

ADDRESS

Wayne Johnson *Profino, Idaho*

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11 JUN 22 1922

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 38480
Registered No. 23

1. PLACE OF DEATH, Registration District No. 90
County of Clearwater Primary Registration District No. 2168
City of Progreso (No. North Idaho Indian Agency St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Gertrude Dregger

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)
6. DATE OF BIRTH about 1895
(Month) (Day) (Year)

7. AGE 27 yrs. 3 mos. 3 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. None
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Wisconsin
(State or Country)

10. NAME OF FATHER Gustaff Dregger

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER ?

13. BIRTHPLACE OF MOTHER ?
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. W. Atterberry
(Address) Progreso Idaho

15. Filed June 1, 1922 J. M. Fain Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH May 22 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 14 1911, to May 22 1922
that I last saw her alive on May 22 1922
and that death occurred on the date stated above, at 11 A.M.
The CAUSE OF DEATH* was as follows:
Insanity

(Duration) 3 yrs. 3 mos. 3 ds.
Contributory (Secondary) Insanity
(Duration) 3 yrs. 3 mos. 3 ds.
(Signed) John W. Givens M. D.
3722 1922 (Address) Progreso Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 11 yrs. 4 mos. 8 ds. In the State 3 yrs. 3 mos. 3 ds.
Where was disease contracted, If not at place of death? St. Mary's Ida
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL St. Mary's Ida DATE OF BURIAL 191...

20. UNDERTAKER U. A. Shaw ADDRESS Crefin Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

RECEIVED
JUN 22 1922
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 38481
Registered No. 24

1. PLACE OF DEATH. Clearwater
County of Clearwater Registration District No. 2168
City of Idaho (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Susan B. Harlach

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH Nov 1857
(Month) (Day) (Year)

7. AGE 65 yrs. 6 mos. 6 ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Illinois

10. NAME OF FATHER P. C. Carson

11. BIRTHPLACE OF FATHER
(State or Country) Penn.

12. MAIDEN NAME OF MOTHER Catherine Carson

13. BIRTHPLACE OF MOTHER
(State or Country) Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Dr. F. E. Harlach
(Address) Idaho R.F.D.

15. Filed May 31 1922 John Fairley
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 24 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1922 to May 29 1922
that I last saw him alive on May 12 1922
and that death occurred on the date stated above, at 4 1/2 M.

The CAUSE OF DEATH* was as follows:
Cancer of bowel
(Duration) 2 yrs. 0 mos. 0 ds.

Contributory (Secondary)
(Duration) 0 yrs. 0 mos. 0 ds.
(Signed) Edith M. Morris M. D.
5/24 1922 (Address) Orford Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Tribun Idaho DATE OF BURIAL 5/30 1922

20. UNDERTAKER McGee ADDRESS Orford Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 38482

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of CusterCity of MacKay

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 76Primary Registration District No. 2153

(No. _____)

St.)

2. FULL NAME

James R. Cullen

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

79

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

male whiteMarried
(Write the word.)

6. DATE OF BIRTH

Apr.
(Month)19
(Day)1843
(Year)

7. AGE

78 Yrs. 11 Mos. 25 ds.IF LESS than 1 day
how many.....hrs.
or.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

Freighter

9. BIRTHPLACE

(State or Country)

Christian County Kentucky

10. NAME OF FATHER

Malcom McLellan

11. BIRTHPLACE OF FATHER

(State or Country)

Don't Know

12. MAIDEN NAME OF MOTHER

Miss Harris

13. BIRTHPLACE OF MOTHER

(State or Country)

Don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Sarah McLellan

(Address)

MacKay - Idaho

15.

Filed

6/261922Rose Nowacki

Local Registrar

16. DATE OF DEATH

March
(Month)24
(Day)1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 24 1922 to March 24 1922that I last saw him alive on March 24 1922and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Chr. Myocarditis

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)Senility

(Duration)

yrs.

mos.

ds.

(Signed)

Canell A. B. Jensen M. D.3/26 1922(Address) MacKay, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 38484

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of

City of

Registration District No. 76

Primary Registration District No. 2153

(No. of VITAL STATISTICS)

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jon Batilda Herrick

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

7em

white

single

(Write the word.)

6. DATE OF BIRTH.

Nov. 21

(Month)

1915

(Day)

(Year)

7. AGE

6

Yrs.

4

Mos.

4

ds.

IF LESS than 1 day
how many.....hrs. or
.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

none

9. BIRTHPLACE

(State or Country)

Salt Lake City, ut.

10. NAME OF FATHER

Chas. W. Herrick

11. BIRTHPLACE OF FATHER

(State or Country)

Denver Colo.

12. MAIDEN NAME OF MOTHER

Mary Nielson

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Charles W. Herrick

(Address)

Philly Idaho

15.

Filed

6/26

1922

R. Nowack

Local Registrar

MEDICAL CERTIFICATE OF DEATH

176

16. DATE OF DEATH

March 25

(Month)

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191

to

191

that I last saw h..... alive on..... 191

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Accidental discharge of gun by her little brother causing instant death - no attending physician

(Duration)

Yrs. physician

Contributory (Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

M. D.

19..... (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

191

UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 35County of ElmorePrimary Registration District No. 3021City of Hill City

(No. _____ St.)

File No. 38486

Registered No. _____

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Edward Lee Stokes

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDmalewhitesingle
(Write the word.)

6. DATE OF BIRTH

May
(Month)13^d
(Day)1922
(Year)

7. AGE

Yrs. _____ Mos. 29 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer).

None

9. BIRTHPLACE

(State or Country)

Elmore County, Idaho10. NAME OF
FATHERLra David Stokes11. BIRTHPLACE
OF FATHER

(State or Country)

Iowa12. MAIDEN NAME
OF MOTHERMattie Anna Lester13. BIRTHPLACE
OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Lra David Stokes (per L.W.)

(Address)

Hill City, Idaho

15.

Filed

June 30 1922J. W. Davis
Local Registrar

16. DATE OF DEATH

June
(Month)9^d
(Day)1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 13^d 1922, to June 9^d 1922
that I last saw him alive on June 9^d 1922
and that death occurred on the date stated above, at 9:20 P.M.

The CAUSE OF DEATH* was as follows:

Premature Birth (3 months gestation)

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

L. W. L. W. L. W.

M. D.

6-10-1922 (Address) Fairfield, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Hill City, Idaho

DATE OF BURIAL

6-11 1922

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **38487**

1. PLACE OF DEATH. Registration District No. **35**
County of **Elmore** Primary Registration District No. **2031**
City of **Glenn's Ferry** (State) **Idaho** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

J. D. Clark

Registered No. _____
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Married**
(Write the word.)

6. DATE OF BIRTH

Aug 8 1865
(Month) (Day) (Year)

7. AGE

56 yrs. 8 mos. 6 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work **Boat binder**
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) **Iand Rapids Mich**

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Rea. A. W. James**
(Address) **Glenn's Ferry**

15.

Filed **April 16 1922** **J. W. Davis**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 14 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Fauna** 191 to **him dead** 191 that I last saw him alive on 191, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Valvular heart disease

(Duration) yrs. mos. ds.

Contributory (Secondary)

Own exertion

(Duration) yrs. mos. ds.

(Signed) **J. C. Pond** M. D.
4-14 1922 (Address) **Glenn's Ferry**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was Disease contracted,
If not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Glenn's Ferry **4-24 1922**

20. UNDERTAKER

ADDRESS

C. W. Rickson **Glenn's Ferry**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **38488**

1. PLACE OF DEATH. Registration District No. **35**
County of **Elmore** Primary Registration District No. **2021**
City of **Glenn's Ferry** (No. **2021**, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ledbetter

Registered No. _____

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male **White** **Single**
(Write the word.)

6. DATE OF BIRTH

April **10** **1922**
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day
how many _____ hrs. or
_____ yrs. _____ mos. _____ ds. _____ min.

8. OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

C. T. Ledbetter

11. BIRTHPLACE OF FATHER

(State or Country)

Ark.

12. MAIDEN NAME OF MOTHER

Jewel Rose

13. BIRTHPLACE OF MOTHER

(State or Country)

Ark.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

C. T. Ledbetter

(Address)

Glenn's Ferry

15.

Filed

April 13 1922**J. W. Davis**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April **10** **1922**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar 10 1922 to **Mar 10 1922**
that I last saw him alive on **Mar 10 1922**

and that death occurred on the date stated above, at **4 P.M.**

The CAUSE OF DEATH* was as follows:

Birth - Asphyxia - Premature
Seven months

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

J. E. Evans M. D.
Mar 13 1922 (Address) **Mar 13 1922**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was Disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Glenn's Ferry**4-10 1922**

20. UNDERTAKER

ADDRESS

F. W. Ruckham**Glenn's Ferry**

MARGIN RESERVED FOR BINDING
WHITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 38489

Registered No.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH RECEIVED
Registration District No. 365
County of Elmore JUL 14
City of Glenn's Ferry, Idaho Primary Registration District No. 2021
If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Lee Gordon Danner

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single (Write the word.)

6. DATE OF BIRTH June 2 1921 (Month) (Day) (Year)

7. AGE 9 yrs. 17 mos. 17 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Lee Danner

11. BIRTHPLACE OF FATHER Tenn

12. MAIDEN NAME OF MOTHER Thelma Liddle

13. BIRTHPLACE OF MOTHER Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lee Danner
(Address) Glenn's Ferry

15.

Filed March 22 1922 J. W. Davis Local Registrar

MEDICAL CERTIFICATE OF DEATH 49

16. DATE OF DEATH March 19 1922 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 11 1922, to Mar 19 1922 that I last saw him alive on Mar 14 1922 and that death occurred on the date stated above, at 2 30 P.M.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

(Duration) yrs. mos. ds. Contributory (Secondary) Asthenia

(Duration) yrs. mos. ds. (Signed) J. W. Davis M. D. 19 (Address) Glenn's Ferry

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL,

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the of death yrs. mos. ds. State yrs. mos. ds. Where was Disease contracted, If not at place of death? Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Glenn's Ferry Mar 21 1922

20. UNDERTAKER ADDRESS J. W. Richards Glenn's Ferry

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Elmore
City of Glenns Ferry

Registration District No. 36

Primary Registration District No. 2021

File No. 38490

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Alice Mary Ingersoll

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widow
(Write the word.)

6. DATE OF BIRTH

Nov 14 1844
(Month) (Day) (Year)

7. AGE

77 yrs. 6 mos. - ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

At Home

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

W. C. Cumber

11. BIRTHPLACE OF FATHER

(State or Country)

Penn

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. F. A. Laing

(Address)

Glenns Ferry

15.

Filed March 15 1922

J. W. Doorn
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 13 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 20 1922 to Mar 13 1922

that I last saw her alive on Mar 12 1922

and that death occurred on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral thrombosis

(Duration) 0 yrs. 8 mos. 10 ds.

Contributory
(Secondary)

Senility

(Duration) 2 yrs. - mos. - ds.

(Signed) J. W. Doorn M. D.

Mar 14 1922 (Address) Glenns Ferry

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place yrs. mos. ds. In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was Disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho Falls

Mar 16 1922

20. UNDERTAKER

ADDRESS

J. W. Ruckham

Glenns Ferry

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 36

County of Elmore

Primary Registration District No. 2021

City of Glenris Ferry (No. _____ St.)

File No. 38491

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Charles Skipper

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male

White

Widower
(Write the word.)

6. DATE OF BIRTH

July
(Month)

14
(Day)

1852
(Year)

7. AGE

69 yrs. 8 mos. ds.

IF LESS than 1 day
how many hrs. or
..... min.

8. OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Stationary Engineer

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

Clewille M. J.

11. BIRTHPLACE OF FATHER

(State or Country)

Holland

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Holland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Blanche Skipper

(Address)

Glenris Ferry

15.

Filed March 16 1922

J. R. Doris
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar
(Month)

14
(Day)

1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 20 1922, to Mar 13 1922

that I last saw him alive on Mar 12 1922,

and that death occurred on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:

Acute dilatation of stomach

(Duration) _____ yrs. _____ mos. 15 ds.

Contributory
(Secondary)

Spinal sclerosis

(Duration) X yrs. 11 mos. X ds.

(Signed)

J. J. Pond

M. D.

Mar 15 1922 (Address) Glenris Ferry

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was Disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Glenris Ferry

Mar 17 1922

20. UNDERTAKER

ADDRESS

C. W. Rubsam

Glenris Ferry

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Franklin
City of Fairview

RECEIVED

Registration District No. 2119Primary Registration District No. 27City of Fairview (State of Idaho)

STATES

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Margannite Elizabeth HeadFile No. 38493Registered No. 42

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

31

3. SEX

F

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married

6. DATE OF BIRTH

Oct. 19 1898
(Month) (Day) (Year)

7. AGE

24 Yrs. 8 Mos. 11 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Housewife

9. BIRTHPLACE

(State or Country)

Fairview Idaho

10. NAME OF FATHER

W.E. Steers

11. BIRTHPLACE OF FATHER

(State or Country)

Franklin Idaho

12. MAIDEN NAME OF MOTHER

Julia Hall

13. BIRTHPLACE OF MOTHER

(State or Country)

Fairview Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Eugene Head

(Address)

Fairview Idaho

15.

Filed

July 3 19 22 Mrs. Ida Lippert

Local Registrar

16. DATE OF DEATH

July 30 19 22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb. 28 19 22 to June 30 19 22that I last saw him alive on June 1 19 22

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Tubercular Peritonitis(Duration) Yrs. 3 mos. ds.Contributory Tubercular of Pleural Membr.
(Secondary)(Duration) 5 yrs. mos. ds.(Signed) A.R. Cullley M. D.7-3 19 22 (Address) Preston, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Preston Idaho July 3 19 22

20. UNDERTAKER

ADDRESS

W.A. Skednoore Preston

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

JUL 5 Registration District No. 2119
County of Franklin Primary Registration District No. 27
City of Preston State No. St.)

File No. 38494

Registered No. 41

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Glen Martin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

M.

W.

Male
(Write the word.)

6. DATE OF BIRTH

Dec 4 1921
(Month) (Day) (Year)

7. AGE

Yrs. 6 Mos. 22 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Winder Idaho

10. NAME OF FATHER

Edward Moran Martin

11. BIRTHPLACE OF FATHER

(State or Country)

Berer River Co. Ut.

12. MAIDEN NAME OF MOTHER

Emma Stephens

13. BIRTHPLACE OF MOTHER

(State or Country)

Preston Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

E. M. Martin

15.

Filed

July 24 1922 Mrs. Ida Lippert
Local Registrar

MEDICAL CERTIFICATE OF DEATH

91

16. DATE OF DEATH

June 26 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 26 1922 to June 26 1922

that I last saw him alive on June 26 1922

and that death occurred on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(Duration) 4 Yrs. 1 mos. 2 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. H. Stetson M. D.

(Address) Preston, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Preston

June 27 1922

20. UNDERTAKER

ADDRESS

W. A. Skidmore

Preston, Idaho

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No.

Primary Registration District No.

(No.)

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 38495
Registered No. 38

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many 20 hrs.
or 2 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1922

Local Registrar

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from JUNE 11 1922 to JUNE 12 1922 that I last saw h.E.R. alive on JUNE 12 1922 and that death occurred on the date stated above, at 7 P M.

The CAUSE OF DEATH* was as follows:

Premature birth - 6 1/2 hrs

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

G. B. Bland M. D.

(Address) Preston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

20. UNDERTAKER

ADDRESS

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Franklin
City of Preston

If death occurs away from usual residence, give facts called for under special information.

RECEIVED

CERTIFICATE OF DEATH

JUL 5 1922

BUREAU

Registration District No. 3119Primary Registration District No. 37

STATE

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 38496Registered No. 39

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

John Henry Carling

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married

6. DATE OF BIRTH

Sept 13 1860
(Month) (Day) (Year)

7. AGE

62 Yrs. 9 Mos. 6 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Farmer

9. BIRTHPLACE

(State or Country)

Fillmore Idaho

10. NAME OF FATHER

Isaac Vanwagner

11. BIRTHPLACE OF FATHER

(State or Country)

New York Ill.

12. MAIDEN NAME OF MOTHER

Miriam Hobson

13. BIRTHPLACE OF MOTHER

(State or Country)

Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Henry Carling

(Address)

Preston Idaho

15.

Filed

July 3 1922 Mrs. H. Lippel
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 18 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 18 1922 to June 19 1922that I last saw him alive on June 18 1922and that death occurred on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:

Group A

(Duration) Yrs. mos. ds.

Contributory (Secondary) Anterior

(Duration) yrs. mos. ds.

(Signed) R. B. Cutler M. D.621/19 22 (address) Preston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Preston Ida June 21 1922

20. UNDERTAKER

ADDRESS

W. A. Heidmore Preston Ida

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Franklin
City of Preston

If death occurs away from usual residence, give facts called for under special information.

RECEIVED

JUL 5 1922

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 2119Primary Registration District No. 27State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 38498Registered No. 36

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Arson Sheddill

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widower
(Write the word.)

6. DATE OF BIRTH

May 7 1842
(Month) (Day) (Year)

7. AGE

80 Yrs. 1 Mos. 6 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

Miner

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sarah Thomas(Address) 1637 Grant ave

15.

Filed July 5 1922Wm. S. Ogden
Mrs. S. S. Lippert
Local Registrar

MEDICAL CERTIFICATE OF DEATH

1W

16. DATE OF DEATH

6 12 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

4-15-1922 to 6-12-1922that I last saw him alive on 6-8-1922and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Bright's disease(Duration) Yrs. 6 mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) C. R. Cutler M. D.6-14-1922 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Preston

DATE OF BURIAL

June 14 1922

20. UNDERTAKER

W. A. Skidmore

ADDRESS

Preston

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Franklin Registration District No. 2119
 City of Preston Primary Registration District No. 29
 (No. St.)

File No. 38498
 Registered No. 37

If death occurs away from
usual residence, give facts
called for under special in-
formation.

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

2. FULL NAME x Harnnah Corbridge

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE White 5. ~~SINGLE~~ MARRIED
~~WIDOWED OR DIVORCED~~
married
 (Write the word.)

6. DATE OF BIRTH

June 10 - 1922
 (Month) (Day) (Year)

7. AGE

77 Yrs. 5 Mos. 10 ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work House wife
 (b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country)

Sheffield England

10. NAME OF FATHER

George Lee

11. BIRTHPLACE OF FATHER

(State or Country)

Sheffield England

12. MAIDEN NAME OF MOTHER

Sarah Peter Lee

13. BIRTHPLACE OF MOTHER

(State or Country)

Sheffield England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

John Corbridge
Preston Idaho

15. Filed

July 3 1922

Local Registrar

16. DATE OF DEATH

June 10th 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Apr 1 1922 to June 10 1922
 that I last saw her alive on June 9 1922
 and that death occurred on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage(Duration) Yrs. 2 mos. 10 ds.

Contributory (Secondary)

ages

(Duration) yrs. mos. ds.

(Signed)

Dr. A. C. C. C.

M. D.

June 2 1922 (Address) Preston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state
 (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death x yrs. mos. days. In the State x yrs. mos. days

Where was disease contracted
 if not at place of death? x

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Franklin Idaho
 20. UNDERTAKER ✓

ADDRESS

RECEIVED
JUL 5 1922

CERTIFICATE OF DEATH.

1. PLACE OF DEATH. Registration District No. 2119
 County of Franklin Primary Registration District No. 27
 City of Merion (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Martha Ellen Rose

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 38499
 Registered No. 28

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. widow
 (Write the word.)

6. DATE OF BIRTH. Aug 29 1852
 (Month) (Day) (Year)

7. AGE 69 Yrs. 8 Mos. 14 ds. IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. House keeper
 (b) General nature of industry, business, or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country) Utah

10. NAME OF FATHER

Elijah Shane

11. BIRTHPLACE OF FATHER

(State or Country) U.S.A.

12. MAIDEN NAME OF MOTHER

Anner

13. BIRTHPLACE OF MOTHER

(State or Country) Tenn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thos E Rose
 (Address) Merion, Ida.

15. Filed July 3 19122 Mrs H. L. Rose
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 9 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1920, to June 4 1922, that I last saw her alive on June 4 1922 and that death occurred on the date stated above, at 4:45 P. M.

The CAUSE OF DEATH* was as follows:

Hebilla's Melitis(Duration) _____ Yrs. 6 mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Thos E Rose M. D.19. (Address) Merion, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Merion Ida. 6-11 19122

UNDERTAKER W. A. Edmore ADDRESS Merion

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 38500

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Fremont

City of St. Anthony

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Phebe Stroup

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female

White

Widow

(Write the word.)

6. DATE OF BIRTH

May 12th, 1844

(Month)

(Day)

(Year)

7. AGE

78 Yrs. --- Mos. 3 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Kentucky

10. NAME OF FATHER

Jones

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Martha Peyton

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

June 10

1922

W. M. Keenan

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 15th 1922

(Month)

(Day)

19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 12 1922 to May 15 1922
that I last saw her alive on May 15 1922
and that death occurred on the date stated above, at 12 pm

The CAUSE OF DEATH* was as follows:

Mental degeneration

(Duration) 9 days mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

M. D.

19 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Mound City, Mo

DATE OF BURIAL

May 21st 1922

20. UNDERTAKER

ADDRESS

W. M. Keenan

St. Anthony Idaho

1. PLACE OF DEATH

County of FremontCity of Newdale

If death occurs away from usual residence, give facts called for under special information.

BUREAU OF VITAL STATISTICS

2. FULL NAME

Elda May Cox

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

(Write the word.)

6. DATE OF BIRTH

June

(Month)

29th

(Day)

1921

(Year)

7. AGE

-- Yrs. 10 Mos. 14 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Child

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Newdale, Ida.

10. NAME OF FATHER

Frank W. Cox

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Rosina Ward

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed 6 101922

Local Registrar

E OF DE

BUREAU OF VITAL STATISTICS

File No.

38501

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May

(Month)

12

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 17 1922 to May 13 1922that I last saw him alive on May 13 1922and that death occurred on the date stated above, at 30 A.M.

The CAUSE OF DEATH* was as follows:

Bronchitis
adventitia

(Duration)

Yrs.

mos.

ds.

Contributory

(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

J. Frank Starkewicz M.D.

(Address)

St. Anthony's

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

REXBURG, IDA.

DATE OF BURIAL

5/14 1922

20. UNDERTAKER

DAVID R. YOUNG

ADDRESS

REXBURG

1. PLACE OF DEATH

 County of **Fremont** Registration District No. _____
 City of **St. Anthony** Primary Registration District No. _____
 (No. _____) (St. _____)

 If death occurs away from
 usual residence, give facts
 called for under special in-
 formation.

2. FULL NAME

Charles William Ryan
 If death occurred in a hos-
 pital, institution or camp,
 give its NAME instead of
 street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

2 1/2 **March** **17** **1859**
 (Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

 IF LESS than 1 day
 how many hrs.
 or min. ?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.**Labrer**(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer).

9. BIRTHPLACE

(State or Country)

Lockport New York10. NAME OF
FATHER**Thomas Ryan**11. BIRTHPLACE
OF FATHER

(State or Country)

Ireland12. MAIDEN NAME
OF MOTHER**Mary Ann Lavelle**13. BIRTHPLACE
OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs C. W. Ryan

(Address)

15.

Filed

6 10**19 22****W. M. Hansen**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 7 **19 22**
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 1 **19 22** to **May 7** **19 22**
 that I last saw him alive on **May 6** **19 22**
 and that death occurred on the date stated above, at **10 A.M.**

The CAUSE OF DEATH was as follows:

Chronic Paucity of Nephritis

(Duration) Yrs. mos. ds.

Contributory
(Secondary)**Chronic Bronchitis**

(Duration) yrs. mos. ds.

(Signed)

J. E. Melton

M. D.

5-9 **19 22** (Address)
 *State the Disease Causing Death; or in deaths from Violent Causes, state
 (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.
18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

 Where was disease contracted
 if not at place of death?

 Former or
 usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Anthony (Riverview)**May 9th 19 22**

20. UNDERTAKER

ADDRESS

W. M. Hansen**St. Anthony Ida**

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED CERTIFICATE OF DEATH

1. PLACE OF DEATH
County of Idaho Registration District No. 1
City of Idaho Falls Primary Registration District No. 1
City of Idaho Falls (No. 1) St. Idaho

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Albert Lorenzo Walters

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 38503
Registered No. 126

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-OWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH July - 26 - 1867
(Month) (Day) (Year)

7. AGE 54 Yrs. 9 Mos. 2 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Common Laborer
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE Toronto, Canada
(State or Country)

10. NAME OF FATHER William Walters

11. BIRTHPLACE OF FATHER Eastern Canada
(State or Country)

12. MAIDEN NAME OF MOTHER Lizzie Grant

13. BIRTHPLACE OF MOTHER London Canada
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm Walters
(Address) Dummer, Col

15. Filed May 10 1922 W Walters
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr 28 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 18 1922 to Apr 28 1922
that I last saw him alive on Apr 27 1922
and that death occurred on the date stated above, at 6²⁹ A.M.
The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum and Prostate

(Duration) 1 Yrs. 6 mos. ds.
Contributory (Secondary)

(Duration) yrs. mos. ds.
(Signed) J E Motton M. D.

4-28-1922 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Reveries Cemetery DATE OF BURIAL Apr 30 1922

20. UNDERTAKER Wm Hansen ADDRESS Idaho Falls

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Fremont

City of St. Anthony

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Maria Flويد Staley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH

August 26th, 1851
(Month) (Day) (Year)

7. AGE

70 Yrs. 7 Mos. 26 ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Boston, Main

10. NAME OF FATHER

Joseph Peasley

11. BIRTHPLACE OF FATHER

(State or Country) Boston Main

12. MAIDEN NAME OF MOTHER

Mobray

13. BIRTHPLACE OF MOTHER

(State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. D. Staley

(Address) St. Anthony, Idaho

15.

Filed May 14 1922

Local Registrar

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 38504

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 17th, 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

4/17/1922 to 4/17/1922
that I last saw him alive on 4/17/1922
and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH, was as follows:

acute dilatation heart

(Duration) Yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) yrs. 3 mos. _____ ds.

(Signed)

4/17/1922 (Address) St. Anthony, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Parker, Idaho

DATE OF BURIAL

Apr. 22, 1922

20. UNDERTAKER

W. M. Hansen

ADDRESS

St. Anthony, Idaho

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of FremontCity of ParkerRegistration District No. 91Registration District No. 2117

(No.)

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Helen Maria MillerFile No. 38505

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married

(Write the word.)

6. DATE OF BIRTH

December 14th, 1861

(Month)

(Day)

(Year)

7. AGE

60 Yrs. 4 Mos. 2 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Housewife

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Farmington, Utah

10. NAME OF FATHER

Jesse W. Smith

11. BIRTHPLACE OF FATHER

(State or Country) New York

12. MAIDEN NAME OF MOTHER

Kathrine Danvelzer

13. BIRTHPLACE OF MOTHER

(State or Country) Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

H. G. Miller
Parker Idaho

15.

Filed

May 101922W. S. Miller

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 16th,

(Month)

(Day)

1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 5, 1922 to April 15, 1922
that I last saw her alive on April 15, 1922
and that death occurred on the date stated above, at 4:00 P. M.

The CAUSE OF DEATH was as follows:

Nephritis Chronic Interstitialunknown
(Duration) Yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

M. D.

April 15, 1922 (Address)J. Frank Statkema

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Parker Cemetery

DATE OF BURIAL

Apr. 18, 1922

20. UNDERTAKER

W. H. Hansen

ADDRESS

St. Anthony Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of FremontCity of New Dale

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 99Primary Registration District No. 2177

(No. _____)

St.)

File No. 38506

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Margaret Petty Davenport

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Widowed

(Write the word.)

6. DATE OF BIRTH

September 13th 1847
(Month) (Day) (Year)

7. AGE

74 Yrs. 6 Mos. 13 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

None

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Tennessee

10. NAME OF FATHER

Robert Petty

11. BIRTHPLACE OF FATHER

(State or Country)

Indiana

12. MAIDEN NAME OF MOTHER

Margaret Wells

13. BIRTHPLACE OF MOTHER

(State or Country)

Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Martha Heath(Address) Rexburg Ida.15. 4/10Filed 19221922W. D. W. D.

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 26th 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from 3-25 1922 to 3-26 1922that I last saw him alive on 3-25 1922
and that death occurred on the date stated above, at 2:45 M.

The CAUSE OF DEATH* was as follows:

Intest. Obstruction(Duration) _____ Yrs. _____ mos. 24 hrs. ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) H. T. Packard, M.D.19 (Address) Rexburg, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL
Richmond, UtahDATE OF BURIAL
3/30 1922

20. UNDERTAKER

David R. YoungADDRESS
Rexburg, Ida.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of FremontCity of St. AnthonyIf death occurs away from
usual residence, give facts
called for under special in-
formation.2. FULL NAME Elizabeth Orr SevereRegistration District No. 19Primary Registration District No. 177

(No.)

(St.)

File No. 38507

Registered No. _____

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Female White

Widow

(Write the word.)

6. DATE OF BIRTH

August 28th, 1840

(Month)

(Day)

(Year)

7. AGE

81 Yrs. 7 Mos. 19 ds.

IF LESS than 1 day

how many _____ hrs.

or _____ min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.

None

(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country) Glasgow, Scotland10. NAME OF
FATHERRobert Orr11. BIRTHPLACE
OF FATHER(State or Country) Glasgow, Scotland12. MAIDEN NAME
OF MOTHERElizabeth McQueen13. BIRTHPLACE
OF MOTHER(State or Country) Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. H. Hunter(Address) St. Anthony, Idaho

15.

Filed Apr 101922W. B. Hunter
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 16th, 1922

(Month)

(Day)

19
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 2 1922 to Mar 12 1922that I last saw her alive on Mar 12 1922

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Pneumonia (Bronchitis)(Duration) _____ Yrs. _____ mos. 9 ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W. B. Hunter

M. D.

19 _____ (Address) St. Anthony, Idaho*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted
if not at place of death?Former or
usual residence Grantsville, Utah.

19. PLACE OF BURIAL OR REMOVAL

Burmester, Utah.

DATE OF BURIAL

March 19, 1922

20. UNDERTAKER

David R. Young

ADDRESS

Cepburg, Idaho

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Princeton Registration District No. 49
 City of St. Anthony Registration District No. 2177 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Emerson Stewart

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 38508

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH

Jan 29 1922
 (Month) (Day) (Year)

7. AGE

IF LESS than 1 day
 how many 9 hrs.
 or min. min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work none
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Ida

10. NAME OF FATHER

Aug & Stewart

11. BIRTHPLACE OF FATHER

(State or Country) Ida

12. MAIDEN NAME OF MOTHER

Greenhalgh

13. BIRTHPLACE OF MOTHER

(State or Country) Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(Address) _____

15.

Filed May 10 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 29 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

124 1922 to 129 1922
 that I last saw him alive on 129 1922
 and that death occurred on the date stated above, at 30 M.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
 (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W Stewart

M. D.

19. (Address) _____

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Wiford Ida

DATE OF BURIAL

2 1922

20. UNDERTAKER

none

ADDRESS

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH **JUL 6 1922**
 Registration District No. **102**
 County of **Fremont** BUREAU OF VITAL STATISTICS
 Primary Registration District No. **6**
 City of **Ashton** (No. St.)

File No. **38509**
 Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME **Peter Fransen**

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **(Married word.)**

16. DATE OF DEATH

6. DATE OF BIRTH

June 3 rd / 1922
 (Month) (Day) (Year)

7. AGE

59 Yrs. **4** Mos. **4** ds.

IF LESS than 1 day
 how many hrs.
 or min.?

17. I HEREBY CERTIFY, That I attended deceased from **May 25 1922** to **June 3 1922**
 that I last saw h. **alive on June 3 1922**
 and that death occurred on the date stated above, at **11 PM**.

The CAUSE OF DEATH* was as follows:

Myocardial infarction
 (Duration) Yrs. **2** mos. ds.

Contributory
 (Secondary)

(Duration) Yrs. mos. ds.

(Signed) **E. R. Higgins** M. D.

June 4 1922 (Address) **Ashton Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **Ashton Idaho** DATE OF BURIAL **6/5/22 19**

20. UNDERTAKER **Lewis Kiser** ADDRESS **Ashton Idaho**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Mrs Peter Fransen**

(Address) **Ashton Idaho**

15. Filed **June 4 1922** **E. R. Higgins**
 Local Registrar

RECEIVED
JUL 5 1922
BUREAU OF VITAL
STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **38510**
Registered No.

1. PLACE OF DEATH
County of **FREMONT**
City of **ASHTON**
Registration District No. **102**
Primary Registration District No. **6**
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **LOWELL, DON, MCGAVIN**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **MALE** 4. COLOR OR RACE **WHITE** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **SINGLE**
(Write the word.)

6. DATE OF BIRTH **AUGUST 13th 1921**
(Month) (Day) (Year)

7. AGE **9 Mos. 25 ds.**
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION **AT HOME**
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE **IDAHO**
(State or Country)

10. NAME OF FATHER **JAMES E. MCGAVIN**

11. BIRTHPLACE OF FATHER **OXFORD IDAHO**
(State or Country)

12. MAIDEN NAME OF MOTHER **BERTHA WHEELER**

13. BIRTHPLACE OF MOTHER **LEWISTON UTAH?**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **BERTHA WHEELER MCGAVIN**
(Address) **MARYSVILLE IDAHO.**

15. **6-9-1922**
Filed **6-9-1922**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **JUNE 8th 1922**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **no medical attention**
that I last saw him alive on **19**
and that death occurred on the date stated above, at **M.**
The CAUSE OF DEATH* was as follows:
Heart Failure

(Duration) **Heart Failure** mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) **Wm. C. McLaughlin** M. D.
6/9/22 (Address) **Ashton, Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **ASHTON IDAHO** DATE OF BURIAL **6/9/22**

20. UNDERTAKER **LEWIS KISER** ADDRESS **ASHTON IDAHO.**

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **38511**
Registered No.

1. PLACE OF DEATH

County of **REMONT**City of **ASHTON**Registration District No. **103**Primary Registration District No. **6**

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CLIFFORD JAMES WATTS

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED
SINGLE
(Write the word.)

6. DATE OF BIRTH

NOVEMBER 30th 1920
(Month) (Day) (Year)

7. AGE

1- 6 Mos. 18 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Athlete

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Frank Idaho

10. NAME OF FATHER

Everett Watts

11. BIRTHPLACE OF FATHER

(State or Country)

Dakota

12. MAIDEN NAME OF MOTHER

Ida. S. Potter

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Everett Watts**(Address) **Ashton Idaho**

15.

Filed **June 19/ 1922**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 18th/ 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

6-14-1922 to 6-17-1922
that I last saw him alive on **6-17-1922**
and that death occurred on the date stated above, at **1 A.M.**

The CAUSE OF DEATH* was as follows:

Enteric-Enteritis(Duration) Yrs. mos. **5** ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) **Clifford James Watts** M. D.6/19/1922 (Address) **Ashton, Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Ashton Idaho

DATE OF BURIAL

6/19/22

20. UNDERTAKER

Lewis Kiser

ADDRESS

Ashton Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 38512

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of FREMONT

City of SQUIRREL IDAHO

Registration District No. 102

Registration District No. 6

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME MARY EMRY ROSS

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

FEMALE

4. COLOR OR RACE

WHITE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

MARRIED

(Write the word.)

6. DATE OF BIRTH

APRIL.

(Month)

5th

(Day)

1858

(Year)

7. AGE

64

Yrs.

2

Mos.

20

ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

HOUSE WIFE

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

OHIO

10. NAME OF FATHER

LOUIS MEINGUS

11. BIRTHPLACE OF FATHER

(State or Country)

DONT KNOW

12. MAIDEN NAME OF MOTHER

TEETERS

13. BIRTHPLACE OF MOTHER

(State or Country)

DONT KNOW

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) GEORGE . G. ROSS

(Address) SQUIRREL IDAHO

15.

Filed June 28th 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

JUNE

(Month)

25th

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 25 1922, to June 25 1922

that I last saw him alive on June 25 1922

and that death occurred on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH* was as follows:

Cancer of brain

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. P. Higgins M.D.

June 26 1922 (Address) Ashton Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

SQUIRREL

IDAHO

DATE OF BURIAL

6/28/22

20. UNDERTAKER

LEWIS KISER

ADDRESS

ASHTON IDAHO

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Gem*City of *Emmett*

Registration District No.

Primary Registration District No.

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Amy A. Miller*File No. *38513*
Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female white

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

married

(Write the word.)

6. DATE OF BIRTH

June 22 18*66*
(Month) (Day) (Year)

7. AGE

56 Yrs. — Mos. *10* ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Housewife

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

J. J. McCreedy

11. BIRTHPLACE OF FATHER

(State or Country)

Kentucky

12. MAIDEN NAME OF MOTHER

Hester Hicks

13. BIRTHPLACE OF MOTHER

(State or Country)

Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Vernon Miller*(Address) *Emmett 2da*

15.

Filed *7/3* 19*22* *J. H. Reynolds*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 2 19*22*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 1 19*22* to *July 2* 19*22*that I last saw her alive on *July 2* 19*22*and that death occurred on the date stated above, at *8:45 AM*

The CAUSE OF DEATH* was as follows:

Empyema(Duration) Yrs. *3* mos. ds.Contributory (Secondary) *Influenza*(Duration) yrs. mos. *14* ds.(Signed) *Austin G. Boyd* M. D.*July 3* 19*22* (Address) *Emmett Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Clearmont, Mo*19*22*

20. UNDERTAKER

ADDRESS

*C. D. Buckner**Emmett Idaho*

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Gooding
City of HagermanDistrict No. 27
Primary Registration District No. 22
(No. 22 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Walter D BrownleeFile No. 38514
Registered No. 39

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-OWED OR DIVORCED
(Write the word.)

6. DATE OF BIRTH

July 11th 1884
Month Day Year

7. AGE

IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)Farmer

9. BIRTHPLACE

(State or Country)

West Virginia

10. NAME OF FATHER

Walter Brownlee

11. BIRTHPLACE OF FATHER

(State or Country)

West Virginia

12. MAIDEN NAME OF MOTHER

Anna Eliza Poles

13. BIRTHPLACE OF MOTHER

(State or Country)

Maryland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Walter Brownlee
(Address) _____15. Filed Aug 31 1922R. T. Greene
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 30 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from 2 or 3 times during
Saw him to leave on
that I last saw him 19

and that death occurred on the date stated above, at _____

The CAUSE OF DEATH* was as follows:

Cancer of tongue

(Duration) yrs. mos. ds.

Contributory
(Secondary)3 months

(Duration) yrs. mos. ds.

(Signed)

R. T. Greene

M. D.

Hagerman (Address) Hagerman

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hagerman1922

20. UNDERTAKER

ADDRESS

None

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics1. PLACE OF DEATH
County of Gooding Registration District No. 21
City of Hagerman Primary Registration District No. 1322
(STATISTICS) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Marion ConyersFile No. 38515
Registered No. 38515

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female White Married

6. DATE OF BIRTH

Oct 15 1861
(Month) (Day) (Year)

7. AGE

61 Yrs. 2 Mos. 23 ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

Jas M Duffee

11. BIRTHPLACE OF FATHER

(State or Country)

Vermont

12. MAIDEN NAME OF MOTHER

Malinda Butts

13. BIRTHPLACE OF MOTHER

(State or Country)

New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Gw Conyers
Hagerman

15.

Filed

Jan 10 1922

R N Greene
Local Registrar

MEDICAL CERTIFICATE OF DEATH

115

16. DATE OF DEATH

Jan 7 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY That I attended deceased from

now occasionally 1921 to Jan 7 1922
that I last saw her alive on Jan 7 1922
and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Liver & gall bladder
with complications

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

R N Greene M. D.

Jan 10 1922 (Address) Hagerman

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hagerman Jan 11 1922

20. UNDERTAKER

ADDRESS

None

CERTIFICATE OF DEATH

✓ State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH, *Gooding* Registration District No. *21*
County of *Gooding* Primary Registration District No. *102*
City of *Hagerman* St. *Idaho*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Sarah Elizabeth Hill

File No. *38516*

Registered No. *97*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Widowed*

6. DATE OF BIRTH

Aug 28 1847
(Month) (Day) (Year)

7. AGE

77 Mos. *7* ds. IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Aged widow

9. BIRTHPLACE

(State or Country)

Sparta Ill

10. NAME OF FATHER

Thomas Heir

11. BIRTHPLACE OF FATHER

(State or Country)

Ill

12. MAIDEN NAME OF MOTHER

Mary Ann Taylor

13. BIRTHPLACE OF MOTHER

(State or Country)

Tenn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Lee Shells

(Address)

Hagerman, R.D.

15.

Filed *Mar 29 1922*

R N Greene
Local Registrar

16. DATE OF DEATH

March 28 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Mar 1922* to *Mar 27 1922*

that I last saw her alive on *March 27 1922* and that death occurred on the date stated above, at *12* M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) Yrs. mos. ds.

Contributory (Secondary)

Influenza & age

(Duration) Yrs. mos. ds.

(Signed)

R N Greene M. D.

Mar 29 1922 (Address) *Hagerman*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Hagerman

DATE OF BURIAL

Mar 30 1922

20. UNDERTAKER

Thompson

ADDRESS

Gooding

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **38517**

Registered No. _____

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

1. PLACE OF DEATH.

Registration District No. **24**County of **Gooding**

Primary Registration District No. _____

City of **Gooding**

(No. _____ St.)

If death occurs away from
usual residence, give facts
called for under special
information.2. FULL NAME **Charles O. Gridley**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.**Married**

(Write the word.)

6. DATE OF BIRTH.

June 29 1884

(Month)

(Day)

(Year)

7. AGE

38 (approximate)

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs. or
min.

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
(b) General nature of in-
dustry, business, or estab-
lishment in which employ-
ed (or employer).**Sheep Farmer**

9. BIRTHPLACE

(State or Country)

California10. NAME OF
FATHER**Charles E. Gridley**11. BIRTHPLACE
OF FATHER

(State or Country)

Illinois12. MAIDEN NAME
OF MOTHER**Mary E. Tayler**13. BIRTHPLACE
OF MOTHER

(State or Country)

California

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Frank Gridley

(Address)

Hagerman Ida

15.

Filed

6-29-1912

1912

J. J. Lay, M.D.

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 29 1912
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
June 22 1912 to **June 29 1912**that I last saw him alive on **June 22 1912**and that death occurred on the date stated above, at **3 A.M.**

The CAUSE OF DEATH* was as follows:

**Typhoid fever
with hemorrhage and perforation**(Duration) Yrs. mos. **7** ds.Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

H. E. Ferrie M. D.
Gooding Ida*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Hagerman

DATE OF BURIAL

7-1-1912

20. UNDERTAKER

A. E. Thompson

ADDRESS

Gooding Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully applied. AGE should be stated EXACTLY, PHYSICIANS
should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement
of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Gooding
City of GoodingRegistration District No. 24

Primary Registration District No. _____

(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Cardelia A. HoppleState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 38518

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widowed

6. DATE OF BIRTH

August 17 1922
(Month) (Day) (Year)

7. AGE

69 Yrs. 10 Mos. 4 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).House work

9. BIRTHPLACE

(State or Country) Indiana

10. NAME OF FATHER

William Squires

11. BIRTHPLACE OF FATHER

(State or Country) New York State

12. MAIDEN NAME OF MOTHER

Mary Bailey

13. BIRTHPLACE OF MOTHER

(State or Country) New York State

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harry G. Hobald
(Address) Gooding, Idaho15. 6-22 1922 J. J. Caynes
Filed _____ 19____ Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 21 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 17 1922 to June 20 1922
that I last saw her alive on June 20 1922
and that death occurred on the date stated above, at A.M.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease
Bright's Disease
(Duration) Yrs. 4 mos. 21 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) T. A. Johnson, D.C., M.D.6-22-1922 (Address) Gooding, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. 5 days. In the State 1 yrs. _____ mos. 1 days

Where was disease contracted if not at place of death?

Former or usual residence Thomas Oklahoma

19. PLACE OF BURIAL OR REMOVAL

Thomas Oklahoma

DATE OF BURIAL

6-24 1922

20. UNDERTAKER

W. J. Johnson

ADDRESS

Gooding, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **38519**

1. PLACE OF DEATH **Gooding** Registration District No. **24**
County of **Gooding** Primary Registration District No. **24**
City of **Gooding** (No. **24** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

A. L. Furbee

Registered No.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Married**
(Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)
about 70 yrs. IF LESS than 1 day how many hrs. or min.
yrs. mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Farming

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

5-30

191

W. H. Boyd

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May - 29 - 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May - 24 - 1922 to May 29 - 1922
that I last saw him alive on **May 29 - 1922**

and that death occurred on the date stated above, at **10 A. M.**

The CAUSE OF DEATH* was as follows:

Rocky Mountain Spotted Fever

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Gooding

5-29-1922

20. UNDERTAKER

ADDRESS

A. L. Shuman

Gooding

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

PLACE OF DEATH

Registration District No. 124

Gooding

Registration District No.

Gooding

(No.)

St.)

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Nora Maybel Van Amberg

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

1. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

White

Married

(Write the word.)

6. DATE OF BIRTH.

October

6

1922

(Month)

(Day)

(Year)

AGE

39

Yrs.

6

Mos.

27

ds.

IF LESS than 1 day
how many.....hrs. or
.....min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Kansas

10. NAME OF FATHER

Charles E. Jenks

11. BIRTHPLACE OF FATHER

(State or Country)

Pennsylvania

12. MAIDEN NAME OF MOTHER

Elma E. Howe

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Fred Van Amberg

(Address)

Gooding, Ida

16. DATE OF DEATH

May

3, 1922

191

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from April 11, 1922, to May 3 1922

that I last saw her alive on May 3 1922

and that death occurred on the date stated above, at 9:30 M.

The CAUSE OF DEATH* was as follows:

Asthenia

Acidosis

(Duration)

Yrs.

mos

5

ds.

Contributory (Secondary)

Neurasthenia, Rheumatism
Mitral Insufficiency
Exophthalmic goitre

(Duration)

Yrs.

mos

ds.

(Signed)

5/6/22

(Address)

Gooding, Idaho

M. D.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death.....yrs.....mos.....days

In the

State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

MARGIN RESERVED FOR

WRITE PLAINLY, WITH UNFADING INK—THIS Every item of information should be carefully supplied. It would state CAUSE OF DEATH in plain terms, so that it might be of OCCUPATION is very important. See instructions.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD.
N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Gooding

City of Gooding

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Barker

Registration District No. 24

Primary Registration District No.

(No. 108)

St.)

File No. 38521

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

single

(Write the word.)

6. DATE OF BIRTH.

March

(Month)

16

(Day)

1922

(Year)

7. AGE

Yrs. 2 Mos. ds.

IF LESS than 1 day how many hrs. or min. 2

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...

infant

9. BIRTHPLACE

(State or Country)

Gooding, Idaho

10. NAME OF FATHER

Hugh Barker

11. BIRTHPLACE OF FATHER

(State or Country)

Kansas

12. MAIDEN NAME OF MOTHER

Marion Brown

13. BIRTHPLACE OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15.

Filed 5-31-1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March

(Month)

18, 1922

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar. 16

1922

to Mar. 18

1922

that I last saw him alive on Mar. 18

1922

and that death occurred on the date stated above, at 6: P. M.

The CAUSE OF DEATH* was as follows:

Melena Neonatorum.

(Duration)

Yrs. 2 mos. ds.

Contributory (Secondary)

(Duration)

Yrs. mos. ds.

(Signed)

M. D.

4/18/22 (Address) Gooding, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

Yrs. mos. days

In the

State

Yrs. mos. days

Where was disease contracted if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

1922

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Boonville Registration District No. 100
County of Boonville Primary Registration District No. 100
City of Hagerman (No. 100 St.)

File No. 38522
Registered No. 151a

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Dunn

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single

6. DATE OF BIRTH May 15 1922
(Month) (Day) (Year)

7. AGE 30 yrs. 0 mos. 0 ds. IF LESS than 1 day how many hrs. or min. 30

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

None

9. BIRTHPLACE
(State or Country)

Hagerman

10. NAME OF FATHER

James T Dunn

11. BIRTHPLACE OF FATHER
(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Agnes Gredley

13. BIRTHPLACE OF MOTHER
(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J H Cromwell
Boonville Ida

15.

Filed 6-9-1922 J H Craymond

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 15 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

5/13 1922 to 5/13 1922

that I last saw her alive on 5/13 1922

and that death occurred on the date stated above, at 6:30 P.M.

The CAUSE OF DEATH* was as follows:

Premature birth
gestation period 6 mo.
(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J H Cromwell M. D.

(Address) Boonville Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. ds. State. yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

1922

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

1. PLACE OF DEATH.

County of GoodingCity of Gooding

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Drazick

CERTIFICATE OF DEATH.

Registration District No. 24

Primary Registration District No.

(No. 1000)

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 38523

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.
singlefemalewhite

(Write the word.)

6. DATE OF BIRTH.

Jan.25, 1922

(Month)

(Day)

(Year)

7. AGE

Yrs. 3 Mos. no ds.

IF LESS than 1 day
how many hrs. or
min. >|

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Infant

9. BIRTHPLACE

(State or Country)

Wendell, Idaho

10. NAME OF FATHER

Sam Drazick

11. BIRTHPLACE OF FATHER

(State or Country)

Austria

12. MAIDEN NAME OF MOTHER

Anna Vasofsky

13. BIRTHPLACE OF MOTHER

(State or Country)

Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15.

Filed

5-31-19122J. H. Raymond

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 25, 1922

(Month)

(Day)

191

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191

to

191

that I last saw h. alive on

191

and that death occurred on the date stated above, 4:30 A.M.

The CAUSE OF DEATH* was as follows:

Baby had been dead abouttwo hours when Doctor arrived.Cause unknown.

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) H. C. Lamb M. D.5/4, 1922 (Address) Gooding, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

191

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Idaho
 City of Brangerville

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 103Primary Registration District No. 1001City of Idaho St.)

2. FULL NAME

Berna Ellen Potter

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 38524Registered No. 1518

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

June 1 1922
 (Month) (Day) (Year)

7. AGE

Yrs. 6 Mos. 6 ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Brangerville

10. NAME OF FATHER

Silver Potter

11. BIRTHPLACE OF FATHER

(State or Country)

Montana

12. MAIDEN NAME OF MOTHER

Gladys Grace Eckerburg

13. BIRTHPLACE OF MOTHER

(State or Country)

Brangerville

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Silver W. Potter
Brangerville Idaho

15.

Filed

July 1 1922 G. S. Stockton
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 6 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 1 1922, to June 6 1922
 that I last saw her alive on June 6 1922
 and that death occurred on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Transition(Duration) Yrs. 6 1/2 mos. months ds.

Contributory (Secondary)

(Duration) yrs. 6 1/2 mos. months ds.

(Signed)

G. S. Stockton

M. D.

6/8 1922 (Address) Brangerville

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. 6 1/2 mos. months days. In the State yrs. 6 1/2 mos. months days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Brangerville

DATE OF BURIAL

6/7 1922

20. UNDERTAKER

E. Hancock

ADDRESS

Brangerville

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Idaho
 City of Idaho

Registration District No. 103Primary Registration District No. 1001(No. 1001 St.)

If death occurs away from
 usual residence, give facts
 called for under special in-
 formation.

2. FULL NAME

Elijah John Buscoe

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 38526Registered No. 14

If death occurred in a hos-
 pital, institution or camp,
 give its NAME instead of
 street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED Married
 (Write the word.)

6. DATE OF BIRTH

June 13 1860
 (Month) (Day) (Year)

7. AGE

61 Yrs. 11 Mos. 17 ds.

IF LESS than 1 day
 how many..... hrs.
 or..... min.?

8. OCCUPATION

(a) Trade, profession or
 particular kind of work.
 (b) General nature of in-
 dustry, business or estab-
 lishment in which employ-
 ed (or employer).

Merchant.

9. BIRTHPLACE

(State or Country)

Arkansas

10. NAME OF FATHER

John E Buscoe

11. BIRTHPLACE OF FATHER

(State or Country)

Arkansas

12. MAIDEN NAME OF MOTHER

Margaret Burgen

13. BIRTHPLACE OF MOTHER

(State or Country)

North Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Mrs E. J. Buscoe
Idaho

15.

Filed

July 1 1922 G. S. Stockton
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 30 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
May 30 1922 to May 30 1922
 that I last saw him alive on May 30 1922

and that death occurred on the date stated above, at 6 P. M.
 The CAUSE OF DEATH* was as follows:

Found dead - Probably
myocarditis following the
 (Duration) Yrs. mos. ds.

Contributory
 (Secondary)

(Duration) yrs. mos. ds.

(Signed)

G. S. Stockton M. D.
5/31 1922 (Address) Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state
 (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted
 if not at place of death?

Former or
 usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Prairie View June 2, 1922

20. UNDERTAKER

ADDRESS

A. J. Maugy Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.

County of *Jefferson*

Primary Registration District No.

City of *Boise*

(No.)

St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Eldora R. V. Hansen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

*Female White**Single*
(Write the word.)

6. DATE OF BIRTH

1 (Month) *23* (Day) *1901* (Year)

7. AGE

21 Yrs. *2* Mos. *5* ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country)

Blackfoot Ida

10. NAME OF FATHER

Alfred E. Hansen

11. BIRTHPLACE OF FATHER

(State or Country)

Denmark

12. MAIDEN NAME OF MOTHER

Dene Lilly Holst

13. BIRTHPLACE OF MOTHER

(State or Country)

Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Alfred E. Hansen

(Address)

Boise Idaho

15.

Filed

April 10 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

11 (Month) *1* (Day) *1922* (Year)17. I HEREBY CERTIFY, That I *do not* deceased from*July 1902* to *Mar 21* 19*22*that I last saw h. *or* alive on *Mar 21* 19*22*and that death occurred on the date stated above, at *9* M.

The CAUSE OF DEATH* was as follows:

*Marasmus, malnutrition
due to the mendedness*(Duration) Yrs. *5 1/2* mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *J. A. Anderson* M. D.*Apr 1* 19*22* (Address) *Boise Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Memor**4/2 1922*

20. UNDERTAKER

ADDRESS

*E. W. Lillie**Boise*

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 38528
Registered No. 40

1. PLACE OF DEATH
County of Jefferson Registration District No. 98
City of Rigby Primary Registration District No. 2176
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lola Lessey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH Aug 20 1918
(Month) (Day) (Year)

7. AGE 3 Yrs. 9 Mos. 9 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Rigby, Idaho

10. NAME OF FATHER

Chester R. Lessey

11. BIRTHPLACE OF FATHER

(State or Country) Elba, Idaho

12. MAIDEN NAME OF MOTHER

Mattie Udy

13. BIRTHPLACE OF MOTHER

(State or Country) Farmington Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Therman Lessey

(Address) Rigby, Idaho

15. Filled 6-30-22 Ray H. Fisher
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

5/20/22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5/14 1922 to 5/20 1922
that I last saw him alive on 5/19 1922
and that death occurred on the date stated above, at 99 M.
The CAUSE OF DEATH* was as follows:

Diphtheria

(Duration) Yrs. mos. 6 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

5/22 1922

(Address)

Rigby, Ida

*State the Disease Causing Death; or in deaths from violent causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

Ed Green

Rigby, Ida

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 38530
Registered No. 37

1. PLACE OF DEATH

County of *Jefferson*
City of *Bigby*

Registration District No. *98*Primary Registration District No. *2176*(No. *108*)

St.)

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Infant

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

6. DATE OF BIRTH

6 *15* *1922*
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day

how many hrs.
of *few* min.?

Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or
particular kind of work.(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer).*Bale.*

9. BIRTHPLACE

(State or Country)

*Bigby - RD #3*10. NAME OF
FATHER*C. F. Burgess*11. BIRTHPLACE
OF FATHER

(State or Country)

*Oklahoma*12. MAIDEN NAME
OF MOTHER*Rachel S. Mullen*13. BIRTHPLACE
OF MOTHER

(State or Country)

Jefferson Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

C. F. Burgess

(Address)

Bigby, RD #3

15.

Filed

*July 1st 1922**Ray Fisher*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

6 *15* *22*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 *Physician* *19*
that I last saw him alive on *19*

and that death occurred on the date stated above, at *M.*

The CAUSE OF DEATH* was as follows:

Probably Congenital Rosh
or Atelestasis No Physician

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *Ray Fisher* M. D.*4/16* *19.22* (Address) *Bigby, Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bigby *6-16* *19.22*

20. UNDERTAKER

ADDRESS

E. D. Linton *Bigby*

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 38531
Registered No. 38531

1. PLACE OF DEATH

County of JeffersonCity of BlaineRegistration District No. 98Primary Registration District No. 2176St. Blaine

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary O Wilbur

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

7

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

12 30 1866
(Month) (Day) (Year)

7. AGE

53 Yrs. 5 Mos. 9 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Nurse

9. BIRTHPLACE

(State or Country)

Gdon City Utah

10. NAME OF FATHER

Daniel S Wright

11. BIRTHPLACE OF FATHER

(State or Country)

Greencastle Indiana

12. MAIDEN NAME OF MOTHER

Butler

13. BIRTHPLACE OF MOTHER

(State or Country)

Era Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

S Wright
Sugar City Idaho

15.

Filed

6-30-22Ray Fisher

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 9th 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 1st 1922, to June 9th 1922
that I last saw him alive on June 5th 1922

and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver(Duration) Yrs. 6 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. A. Anderson M. D.19. (Address) Regby Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Amnis, Idaho 6/12/1922

20. UNDERTAKER

ADDRESS

Ed Gilman Regby Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of

Primary Registration District No.

City of

(No.) St.)

File No. **38532**

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Edna M. Nielsen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

March 15 1905
(Month) (Day) (Year)

7. AGE

16 yrs. 5 mos. 14 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

home

9. BIRTHPLACE

(State or Country)

Bozeman, Mont. R. D. 3.

10. NAME OF FATHER

Soren P. Nielsen

11. BIRTHPLACE OF FATHER

(State or Country)

Denmark

12. MAIDEN NAME OF MOTHER

Annie C. Peterson

13. BIRTHPLACE OF MOTHER

(State or Country)

Logan, Wyo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Father

(Address)

Bozeman, Mont.

15.

Filed

July 10th 1922 Gray, J. Fisher.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

169

16. DATE OF DEATH

June 29 1912
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 29 1912 to *June 29 1912*

that I last saw *her* alive on *June 29 1912*

and that death occurred on the date stated above, at *4:30 P.M.*

The CAUSE OF DEATH* was as follows:

Unknown

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. Call M. D.

19 (Address) *Bozeman, Mont.*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Shelton, Ida.

DATE OF BURIAL

July 1 - 1912

20. UNDERTAKER

Friends.

ADDRESS

Bozeman, Mont. R. D. 3.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH

County of *Jefferson*
City of *Rich*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Golden Aaron McCulloch

RECEIVED CERTIFICATE OF DEATH

Registration District No. *98*

Primary Registration District No. *2176*

(No. *1003*)

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. *38533*

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

10 (Month) *11* (Day) *1921* (Year)

7. AGE

6 Yrs. *5* Mos. *5* ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Chief

9. BIRTHPLACE

(State or Country) *Annis*

10. NAME OF FATHER

Wm H McCulloch

11. BIRTHPLACE OF FATHER

(State or Country) *Weston Ida*

12. MAIDEN NAME OF MOTHER

Ester Jensen

13. BIRTHPLACE OF MOTHER

(State or Country) *Kearns, Utah*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ester McCulloch

(Address)

Corning Bldg, Ida.

15.

Filed

May 10 19*22* *Ray H. Fish*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Apr. (Month) *9* (Day) *1922* (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 19*22* to *Apr. 9* 19*22*

that I last saw him alive on *Apr. 2* 19*22*

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) Yrs. *1* mos. ds.

Contributory (Secondary)

Pneumonia

(Duration) yrs. mos. ds.

(Signed) *A. M. Palmer* M. D.

19..... (Address) *Rich, Idaho.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Reynolds

DATE OF BURIAL

4-12 19*22*

20. UNDERTAKER

Ed Gellner

ADDRESS

Rich

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **38534**Registered No. _____
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

Registration District No. **23**County of **Jerome** Primary Registration District No. **1017**
City of **Jerome** **2017** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Alexander Lind

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

923. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Single**

6. DATE OF BIRTH

Nov 4 1900
(Month) (Day) (Year)

7. AGE

22 Yrs. Mos. ds.IF LESS than 1 day
how many hrs. or min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)**At Home Farming**

9. BIRTHPLACE

(State or Country)

Idh

10. NAME OF FATHER

Robert Johnstone Lind

11. BIRTHPLACE OF FATHER

(State or Country)

Scotland

12. MAIDEN NAME OF MOTHER

Christine McLeish

13. BIRTHPLACE OF MOTHER

(State or Country)

Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Robert J Lind

(Address)

Jerome

15.

Filed

June 14 1922

1922

E. D. Pfeiffer M. D.

Local Registrar

16. DATE OF DEATH

April 10 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from **Mar 26 1922** to **April 10 1922**, that I last saw him alive on **April 9 1922** and that death occurred on the date stated above, at **152a** M.

The CAUSE OF DEATH* was as follows:

Pneumonia(Duration) Yrs. mos. **14** ds.Contributory (Secondary) **Acute Gastric Enteritis**

(Duration) Yrs. mos. ds.

(Signed) **John P. Chambers** M. D.c. 1922 (Address) **Jerome Idh**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Jerome Cemetery**4-12 1922**

20. UNDERTAKER

ADDRESS

D. A. Harrison Jerome

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

RECEIVED

Registration District No. 23

County of

Jerome

Primary Registration District No.

1017-2017

City of

Jerome

(Not for use in St.)

File No.

38535

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lily Agnes Shaver

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married

6. DATE OF BIRTH.

June 11

(Month) (Day)

1880 (Year)

7. AGE

41

Yrs.

11

Mos.

ds.

IF LESS than 1 day
how many.....hrs. or
.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Leonard Perry Kychroff

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Alice L. Shaver

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

E. E. Shaver

(Address)

Jerome

15.

Filed

June 14

1912

E. D. Piper M.D.

Local Registrar

16. DATE OF DEATH

May 11

(Month)

(Day)

1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar. 5

1922

to May 11

1922

that I last saw him alive on May 8 1922

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Mutual Resuscitation followed by Cardiac Dilatation

(Duration) 12 Yrs. mos. ds.

Contributory (Secondary)

Acute Arteriosclerosis

Rheumatoid Arthritis

(Duration) yrs. mos. ds.

(Signed)

Chas. S. Zeller

M. D.

5/11 1922 (Address) Jerome, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Jerome Cemetery

5/14 1922

20. UNDERTAKER

ADDRESS

D. L. Housh

Jerome

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. _____
 County of Jerome Primary Registration District No. _____
 City of Jerome (St.) _____

File No. 38536

Registered No. _____

If death occurs away from
usual residence, give facts
called for under special
information.

2. FULL NAME

Jennie May Dirk

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Married

6. DATE OF BIRTH

Nov 30 1945
 (Month) (Day) (Year)

7. AGE

36 Yrs. 5 Mos. 26 ds.

IF LESS than 1 day
how many hrs. or
..... min.]

8. OCCUPATION

(a) Trade, profession or
particular kind of work.....
 (b) General nature of in-
dustry, business, or estab-
lishment in which employ-
ed (or employer).....

Housewife

9. BIRTHPLACE

(State or Country)

Penn.

10. NAME OF FATHER

Elisia Himminger

11. BIRTHPLACE OF FATHER

(State or Country)

Penn

12. MAIDEN NAME OF MOTHER

Margaret Van Horn

13. BIRTHPLACE OF MOTHER

(State or Country)

Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

J. S. Dirk

(Address)

Jerome

15. FILED

June 14 1922E. D. Pifer M.D.

Local Registrar

16. DATE OF DEATH

May 6 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb. 20 1922, to May 1 1922that I last saw her alive on May 1 1922and that death occurred on the date stated above, at 4 a M.

The CAUSE OF DEATH* was as follows:

Enterofelar, miscarriage, Influenza
followed by pneumonia, finally
Cardiac failure

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas. F. Zetter M. D.7/6 1922 (Address) Jerome, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death.....yrs.....mos.....days State.....yrs.....mos.....days

Where was disease contracted
if not at place of death?.....

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Jerome cemeteryMay 7 1922

20. UNDERTAKER

ADDRESS

Dr. L. H. HarrisonJerome

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 23County of JeromeRegistration District No. 1017-2017City of Jerome

St.)

File No. 38537

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Blanche Irene Gallen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

FemaleWhiteSingle

6. DATE OF BIRTH.

Sept 13 1899

(Month)

(Day)

(Year)

7. AGE

22 Yrs. 7 Mos. 20 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)Book keeper

9. BIRTHPLACE

(State or Country)

Viola, Mo

10. NAME OF FATHER

B A Gallen

11. BIRTHPLACE OF FATHER

(State or Country)

Berryville Ark

12. MAIDEN NAME OF MOTHER

Mary E Ambrose

13. BIRTHPLACE OF MOTHER

(State or Country)

Franklin Rest Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs B A Gallen

(Address)

Jerome

15.

Filed

June 1419122E. D. Piper M.D.

Local Registrar

16. DATE OF DEATH

May Wed 3rd 1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 28 1922 to May 3 1922that I last saw her alive on May 2 1922and that death occurred on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:

Thyro-Toxicosis
Acute Thyroid(Duration) Yrs. 3 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas E. Keller M. D.5/3 1922 (Address) Jerome, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Jerome Cemetery5-8 1922

20. UNDERTAKER

ADDRESS

W. H. Morrison Jerome

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 38538

Registered No. _____

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

1. PLACE OF DEATH.

County of Jerome
City of JeromeIf death occurs away from
usual residence, give facts
called for under special
information.

2. FULL NAME

Manda Eva DeBoard

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Female

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.Single

6. DATE OF BIRTH.

March 8 1902
(Month) (Day) (Year)

7. AGE

20 Yrs. 1 Mos. 22 ds.IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work...
(b) General nature of in-
dustry, business, or estab-
lishment in which employ-
ed (or employer).....

9. BIRTHPLACE

(State or Country) North Carolina10. NAME OF
FATHERJohannathan DeBoard11. BIRTHPLACE
OF FATHER(State or Country) North Carolina12. MAIDEN NAME
OF MOTHERSarilda West13. BIRTHPLACE
OF MOTHER(State or Country) North Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. J. DeBoard(Address) Jerome

15.

Filed Jan 2 14 1922E. D. P. H. M. D.

Local Registrar

16. DATE OF DEATH

May 1 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

..... 191..... to 191.....
that I last saw h..... alive on 191.....
and that death occurred on the date stated above, at 4:30 P. M.

The CAUSE OF DEATH* was as follows:

Strangled to death during
Epileptic seizure
(Duration) Yrs. mos. ds.Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) Wm F. Schenck M. D.19..... (Address) Corona*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted
if not at place of death?.....Former or
usual residence.....

19. PLACE OF BURIAL OR REMOVAL

Jerome Cemetery

DATE OF BURIAL

May 3 1922

20. UNDERTAKER

S. R. Henshaw

ADDRESS

Jerome

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Monteai Registration District No. 30
City of Coeur d'Alene Primary Registration District No. 1057
(State of IDaho)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Name Nancy Leah Lemmon
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

F.W.widow

(Write the word.)

6. DATE OF BIRTH

11 - 8 1899
(Month) (Day) (Year)

7. AGE

62 yrs. 7 mos. 19 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)Housewife

9. BIRTHPLACE

(State or Country)

Mo.

10. NAME OF FATHER

Jas. A. Spunlock

11. BIRTHPLACE OF FATHER

(State or Country)

Tenn.

12. MAIDEN NAME OF MOTHER

Clarinda Talbot

13. BIRTHPLACE OF MOTHER

(State or Country)

Tenn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Clara R. Stockton(Address) Coeur d'Alene, Ida.

15.

Filed

7/71922W. J. Brennan

Local Registrar

16. DATE OF DEATH

June 27 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 31 1922 to June 27 1922
that I last saw him alive on June 27 1922
and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Coronary Arteriosclerosis(Duration) Yrs. 7 mos. 7 ds.Contributory (Secondary) Arteriosclerosis(Duration) Yrs. 7 mos. 7 ds.(Signed) J. C. O'Connell M. D.June 28, 1922 (Address) Coeur d'Alene, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?.....

Former or usual residence.....

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Versailles, Mo.19

20. UNDERTAKER

ADDRESS

C. L. CassidyCoeur d'Alene, Ida.

1. PLACE OF DEATH

County of *Bohemia*
City of *Rathdrum*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Edward Hauscor

CERTIFICATE OF DEATH

Registration District No. *3A*Primary Registration District No. *1051*

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *38540*Registered No. *1081*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

*M**W**Married*
(Write the word.)

6. DATE OF BIRTH

August 9 1881
(Month) (Day) (Year)

7. AGE

40 Yrs. *9* Mos. *22* ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).*Farmer*

9. BIRTHPLACE

(State or Country)

Kansas

10. NAME OF FATHER

Jesse Hauscor

11. BIRTHPLACE OF FATHER

(State or Country)

Iowa

12. MAIDEN NAME OF MOTHER

Mary Miller

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Edw. Hauscor

(Address)

Rathdrum, Idaho

15.

Filed

*1922**P. D. Dunning*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 1 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

*May 25 1922 to June 1 1922*that I last saw him alive on *June 1 1922*and that death occurred on the date stated above, at *4:00* M.

The CAUSE OF DEATH* was as follows:

Typhoid fever(Duration) Yrs. mos. *16* ds.Contributory *Chronic Nephritis*
(Secondary)(Duration) *2 or 3* yrs. mos. ds.(Signed) *Frank K. Henry* M. D.*6/2 1922* (Address) *Rathdrum Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Ritzville Park**6/4 1922*

20. UNDERTAKER

ADDRESS

*Constance L. Casper**Rathdrum Idaho*

1. PLACE OF DEATH

County of *Hotenai*City of *Kathlamet*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Eric Lundin

CERTIFICATE OF DEATH

Registration District No. *30*Primary Registration District No. *1051*

St. (No.)

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *38541*Registered No. *7082*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

May
(Month)*13*
(Day)*1913*
(Year)

7. AGE

9 Yrs. *0* Mos. *21* ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).*Scholar*

9. BIRTHPLACE

(State or Country)

W =

10. NAME OF FATHER

Fred Lundin

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME OF MOTHER

Selma Lundström

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Fred Lundin

(Address)

15.

Filed *7/7*19 *22*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June
(Month)*3*
(Day)*1922*
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 27 1922, to *June 3* 1922that I last saw him alive on *June 2* 1922,and that death occurred on the date stated above, at *1:00* M.

The CAUSE OF DEATH* was as follows:

Scarlet fever(Duration) _____ Yrs. _____ mos. *9* ds.Contributory (Secondary) *Ant. Endocarditis*

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) *Frank Henry* M. D.*7/3* 1922 (Address) *Kathlamet, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Kathlamet, Idaho

DATE OF BURIAL

6/4 1922

20. UNDERTAKER

Constance L. Cassidy

ADDRESS

Kathlamet, Idaho

1. PLACE OF DEATH

County of Boise
City of Rathdrum

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Frank Covey

CERTIFICATE OF DEATH

Registration District No. 30
Primary Registration District No. 1051
(No. St.)State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 38542
Registered No. 1083

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year) 1871

7. AGE

51 Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Jay Purington

(Address)

15.

Filed 7/7 19 22

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 4 19 22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct. 10. 1921 to June 4. 1922
that I last saw him alive on June 3. 1922
and that death occurred on the date stated above, at 8:00 M.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease(Duration) 2 Yrs. mos. ds.Contributory General Anasarca
(Secondary)(Duration) 2 yrs. mos. ds.(Signed) Frank Wenz M. D.6/4 1922 (Address) Rathdrum, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rathdrum Ida 6/5 1922

20. UNDERTAKER

ADDRESS

Ed Casey Rathdrum Ida

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Keokuk Registration District No. 30
 City of Post Falls Primary Registration District No. 1051
 State of Idaho (No. _____) St. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Luella Amell

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 38543

Registered No. 1084

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED single
 (Write the word.)

6. DATE OF BIRTH May 29 1922
 (Month) (Day) (Year)

7. AGE 0 Yrs. 0 Mos. 12 ds. IF LESS than 1 day
 how many _____ hrs.
 or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE Post Falls
 (State or Country)

10. NAME OF FATHER Frank Amell

11. BIRTHPLACE OF FATHER Wis
 (State or Country)

12. MAIDEN NAME OF MOTHER Hattie Darlan

13. BIRTHPLACE OF MOTHER Mich
 (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Frank Amell
 (Address) _____

15. Filed 7/7 19 22 Local Registrar _____

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 10 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 8 1922 to June 9 1922
 that I last saw her alive on June 9 1922
 and that death occurred on the date stated above, at 10 P M.
 The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
 (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) H. H. Brennan M. D.

6/10 19 22 (Address) Corn & Allen

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Post Falls DATE OF BURIAL 5-10 1922

20. UNDERTAKER C. Carney ADDRESS CDalme

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH
in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Kootenai Registration District No. 30
City of Pathtum Primary Registration District No. 1051
St. Pathtum

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Samuel Hays

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 38544Registered No. 1075

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDMaleWhiteMarried
(Write the word.)

6. DATE OF BIRTH

June 4 4 1856
(Month) (Day) (Year)

7. AGE

56 Yrs. 5 Mos. 7 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer).Farmer

9. BIRTHPLACE

(State or Country)

N. Y.10. NAME OF
FATHERSamuel Hays11. BIRTHPLACE
OF FATHER

(State or Country)

Germany12. MAIDEN NAME
OF MOTHERMagdalena Haller13. BIRTHPLACE
OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Magdalena M. Hays

(Address)

Pathtum, Idaho

15.

Filed

7/7 1922D. J. Hays

Local Registrar

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 11 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Dec. 22 1921 to June 11 1922

that I last saw him alive on June 9 1922
and that death occurred on the date stated above, at 8:00 M.

The CAUSE OF DEATH* was as follows:

Chronic Pyelitis (both
Kidneys)

(Duration) Yrs. 4 mos. ds.Contributory (Secondary) Chronic Rheumatism(Duration) 3 yrs. mos. ds.(Signed) Frank Henry M. D.

6/13 1922 (Address) Pathtum, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Pathtum6/14 1922

20. UNDERTAKER

ADDRESS

E. L. CassidyPathtum

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Hood River Registration District No. _____
City of Soundalime Primary Registration District No. 1-51
(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John J. RivalFile No. 38545
Registered No. 1886

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widower
(Write the word.)6. DATE OF BIRTH Nov. 14 1840
June 11 1922
(Month) (Day) (Year)7. AGE 81 Yrs. 7 Mos. _____ ds.
IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Labourer

9. BIRTHPLACE

(State or Country)

Norway

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ed J. Rival
(Address) _____15. Filed 7/7 19 22 P. B. Mooney
Local Registrar

16. DATE OF DEATH

June 11 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from June 2 1922 to June 10 1922
that I last saw him alive on June 10 1922
and that death occurred on the date stated above, at 8:4 M.
The CAUSE OF DEATH* was as follows:Pneumonia

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) P. B. Mooney M. D.6/10 1922 (Address) Soundalime

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Forest Cemetery 6/12 1922

20. UNDERTAKER ADDRESS

P. B. Mooney C. D. G.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

30 ✓

State of Idaho
BOARD OF HEALTH

Bureau of Vital Statistics

File No. 38546

Registered No. 1088

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of

Registration District No.

Primary Registration District No.

(No.)

City of
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Erwin R. Williams

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

widowed

(Write the word.)

6. DATE OF BIRTH

Nov.

26

1854

(Month)

(Day)

(Year)

7. AGE

67

3

Mos. 23

ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Hanibal, Oswego Co.
New York

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

191

Local Registrar

MEDICAL CERTIFICATE OF DEATH

92

16. DATE OF DEATH

Mar

19th

1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar 17

1922

to Mar 19

1922

that I last saw him alive on

Mar 19

1922

and that death occurred on the date stated above, at

8:30 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration)

Yrs.

mos.

3

ds.

Contributory
(Secondary)

Influenza

(Duration)

Yrs.

mos.

8

ds.

(Signed)

J. L. McCauley D.

3/20/22 (Address)

Post Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death yrs. mos. days, State yrs. mos. days

Where was disease contracted

if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

Post Falls Ida.

DATE OF BURIAL

3/26 1922

20. UNDERTAKER

W. H. Doney Power of Attorney

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bolema
City of Bolema

Registration District No. 30
Primary Registration District No. 1027
(No. 1027 St.)

File No. 38547
Registered No. 38547

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Adolphus Garrison

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH

April 10 1837
(Month) (Day) (Year)

7. AGE

85 Yrs. 2 Mos. 12 ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Retired

9. BIRTHPLACE

(State or Country)

Maryland

10. NAME OF FATHER

Joseph Garrison

11. BIRTHPLACE OF FATHER

(State or Country)

Virginia

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

E. T. Garrison
Courts' Alene Idaho

15.

Filed

11/4

19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

120

16. DATE OF DEATH

June 22 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 1 1922, to June 22 1922
that I last saw him alive on June 19 1922
and that death occurred on the date stated above, at..... M.
The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. D. Wynn

M. D.

6/23 1922 (Address) Courts' Alene Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Forest Cemetery

6/24 1922

20. UNDERTAKER

ADDRESS

E. Cassidy

Courts' Alene

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Boise
City of RathdrumRegistration District No. 30Primary Registration District No. 1051

(No. _____)

St.)

File No. 38548Registered No. 1090

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George M. Fox

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M4. COLOR OR RACE W5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDWidowed
(Write the word.)

6. DATE OF BIRTH

Feb.291857
(Month) (Day) (Year)

7. AGE

65Yrs. 3Mos. 21

ds.

IF LESS than 1 day

how many _____ hrs.

or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Colo.

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. George Fox(Address) East Falls, Id.

15.

Filed 7/719 22Local Registrar per E. L. Cassidy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 20.

(Month)

(Day)

1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb. 5.19 21

to

June 20.19 22

that I last saw him alive on

June 20.19 22and that death occurred on the date stated above, at 3:45 M.

The CAUSE OF DEATH* was as follows:

Cerebro-spinal Sclerosisabout 2-3 Yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Frank H. H. H. M. D.6/21/1922 (Address) Rathdrum, Id.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Rathdrum

DATE OF BURIAL

6/22/1922

20. UNDERTAKER

E. L. Cassidy

ADDRESS

Rathdrum, Id.

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 30
County Kootenai Primary Registration District No. 1051
City of Neenah Post Falls (No. Neenah Post Falls St.)

File No. 38549
Registered No. 1091

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Irvin A Libby

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH

July 7 1860
(Month) (Day) (Year)

7. AGE

61 Yrs. 11 Mos. 19 ds.
IF LESS than 1 day how many... hrs. or... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Farmer
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) New Hampshire

10. NAME OF FATHER

William Libby

11. BIRTHPLACE OF FATHER

(State or Country) Maine

12. MAIDEN NAME OF MOTHER

Julia Rucker

13. BIRTHPLACE OF MOTHER

(State or Country) New Hampshire

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) R. E. Libby
(Address) Post Falls, Ida.

15. Filed 7/7 19 22 Local Registrar

MEDICAL CERTIFICATE OF DEATH

82

16. DATE OF DEATH

June 76 19 22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 5 19 22, to June 12 19 22 that I last saw him alive on June 12 19 22 and that death occurred on the date stated above, at 2 P.M.
The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis.

(Duration) Yrs. mos. 21 ds.
Contributory (Secondary) Acute dilatation of heart

(Duration) yrs. 1 mos. 1 ds.

(Signed) John O. Wood M. D.
June 29 19 22 (Address) Coeur d'Alene, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death... yrs. mos. days. In the State 16 yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Post Falls Ida DATE OF BURIAL 7/2 19 22

20. UNDERTAKER R B Mooney ADDRESS Coeur d'Alene

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 38550
Registered No. 1092

PLACE OF DEATH

Registration District No. 30
County of Kootenai Primary Registration District No. 1051
City of Boeur d'Alene St. N. Pacific Depot (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jacob Flores

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Divorced
(Write the word.)

6. DATE OF BIRTH

(Month) June (Day) 27 (Year) 1922

7. AGE

36 Yrs. 6 Mos. 2 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Door Inspector
Northern Pacific R.R.

9. BIRTHPLACE

(State or Country) ✓

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country) ✓

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country) ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. D. White(Address) Boeur d'Alene, Ida

15.

Filed 7/7 19 22Local Registrar A. D. White

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 27 19 22
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from June 27 19 22 to June 27 19 22that I last saw him alive on June 27 19 22
and that death occurred on the date stated above, at 9:30 AM.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage(Duration) Was seen by me only, few minutes prior Yrs. 0 mos. 0 ds.
Contributory (Secondary) to death(Duration) 0 Yrs. 0 mos. 0 ds.(Signed) J. D. Meyer M. D.(Address) Boeur d'Alene, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos. 3 days

Where was disease contracted if not at place of death?

Former or usual residence Boeur d'Alene, Ida

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Boeur d'Alene, Ida 6/29 19 22

20. UNDERTAKER

ADDRESS

1313 Mooney P.O. Box 229

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Boone
City of Coeur d'AleneRegistration District No. 30
Primary Registration District No. 1051
(No. St.)File No. 38551
Registered No. 1087

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

James Wilford Elder

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH

Dec 29 1850
(Month) (Day) (Year)

7. AGE

71 Yrs. 5 Mos. 20 ds. 20
IF LESS than 1 day how many.....hrs or.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Retired

9. BIRTHPLACE

(State or Country)

Marion Ky.

10. NAME OF FATHER

Henry Elder

11. BIRTHPLACE OF FATHER

(State or Country)

Ky.

12. MAIDEN NAME OF MOTHER

Mary Bigham

13. BIRTHPLACE OF MOTHER

(State or Country)

Ky.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Robert Elder

(Address)

Coeur d'Alene Idaho

15.

Filed

7/7 1922 at Boone
Local Registrar

16. DATE OF DEATH

June 14 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 10 1922 to June 14 1922that I last saw him alive on June 13 1922and that death occurred on the date stated above, at 10 A M.

The CAUSE OF DEATH* was as follows:

Pernicious anemia.(Duration) Yrs. ? mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

John Wood M. D.(Address) Coeur d'Alene Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Coeur d'AleneJune 18 1922

20. UNDERTAKER

ADDRESS

R B MooneyCoeur d'Alene

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of.....

City of.....

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. Hauser Lake St.)

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Mrs. Ellen Y. Todd

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw her alive on

and that death occurred on the date stated above, at 11:45 P.M.

The CAUSE OF DEATH* was as follows:

Atherosclerosis

(Duration) 10 Yrs. mos. ds.

Contributory
(Secondary)

(Duration) 3 yrs. mos. ds.

(Signed) J. L. Patterson M. D.

1922 (Address) Spokane, Wa.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

FORM N. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **38553**

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Kootenai Registration District No. 26
City of Dudley Primary Registration District No. 2204
(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Norton

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH

6/10 November 22 1865
(Month) (Day) (Year)

7. AGE

65 Yrs. 5 Mos. 4 ds.
IF LESS than 1 day how many.....hrs. or.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....Farmer

9. BIRTHPLACE

(State or Country) Chattanooga, Tennessee

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country) _____

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country) _____

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Eora E. Norton
(Address) Dudley, Idaho

15. FU

7-1 22 1922

Local Registrar

16. DATE OF DEATH

April 27 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from 191 to 191, that I last saw him alive on 191, and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Death without medical attendance
Probable acute dilatation of the heart.(Duration) Yrs. mos. ds.
Contributory History of heart trouble over a
(Secondary) period of twenty years
(Duration) Yrs. mos. ds.
(Signed) L. J. Stauffer M. D.
19 (Address) Ross Lake, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Kingston, Idaho

DATE OF BURIAL

Apr 29, 1922

20. UNDERTAKER

M. C. Thornbier

ADDRESS

Helena

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 126County of KootenaiPrimary Registration District No. 2204City of Dudley(No. 301)

St.)

File No. 38554Registered No. 1

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Carl Eric Kamlin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3: SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married

(Write the word.)

6. DATE OF BIRTH.

Feb191865

(Month)

(Day)

(Year)

7. AGE

57 Yrs. 2 Mos. 27 ds.IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).Farmer

9. BIRTHPLACE

(State or Country)

Sweden.

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Maggie Kamlin

(Address)

Dudley, Idaho

15.

Filed

7-11922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May161922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from May 16, 1922 to 191that I last saw him alive on May 16 1922
and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Cancer of the liver(Duration) 4 yrs. 4 mos. 4 ds.Contributory
(Secondary)(Duration) 4 yrs. 4 mos. 4 ds.

(Signed)

L. J. Stauffer

M. D.

May 19, 1922 (Address) 2 Rose Lake, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rose Lake, IdahoMay 18, 1922

20. UNDERTAKER

ADDRESS

M. P. ThonhilaIdaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 26County of Kootenai
City of Rose LakePrimary Registration District No. 2204

(No. _____)

St.)

File No. 38555

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

George Ward

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.malewhitesingle
(Write the word.)

6. DATE OF BIRTH.

August
(Month)1871
(Day)26
(Year)

7. AGE

51

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....Rancher

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

Albert Ward

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. Guy Swain

(Address)

Rose Lake, Idaho

15.

Filed

7-11922

Local Registrar

16. DATE OF DEATH

June
(Month)11
(Day)1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 9, 1922 to June 11, 1922that I last saw him alive on June 10, 1922

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Tuberculosis pulmonis(Duration) 2 Yrs. mos. ds.Contributory
(Secondary)(Duration) 2 Yrs. mos. ds.

(Signed)

June 11, 1922

(Address)

L. J. Stauffer M. D.
Rose Lake, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death.....yrs.....mos.....days

In the

State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rose Lake, IdaJune 12, 1922

20. UNDERTAKER

ADDRESS

none

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County

City of

Registration District No.

Primary Registration District No.

(No.)

(St.)

File No.

Registered No.

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF
FATHER11. BIRTHPLACE
OF FATHER

(State or Country)

12. MAIDEN NAME
OF MOTHER13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

19

Local Registrar

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

March 3rd 1922 to June 29 1922

that I last saw him alive on June 29 1922

and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Valvular lesion of heart

Several years
(Duration) Yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) T. M. Leitch M. D.

6-30 1922 (Address) Moscow Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)At place In the
of death.....yrs.....mos.....days. State.....yrs.....mos.....daysWhere was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Moscow 7/2 1922

20. UNDERTAKER

ADDRESS

Elev Rice Moscow

FORM V. S. No. 5-A-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH *Idaho*
 County of *Idaho* Registration District No. *61*
 City of *Moscow* Primary Registration District No. *1011*
 (No. St.)

File No. *38557*
 Registered No. *39*

If death occurs away from
 usual residence, give facts
 called for under special in-
 formation.

2. FULL NAME

Allan Oswald Larson

If death occurred in a hos-
 pital, institution or camp,
 give its NAME instead of
 street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED *Single*
 (Write the word.)

6. DATE OF BIRTH *May 27 1907*
 (Month) (Day) (Year)

7. AGE *15* IF LESS than 1 day
 Yrs. Mos. ds. how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or
 particular kind of work.
 (b) General nature of in-
 dustry, business or estab-
 lishment in which employ-
 ed (or employer).

Student

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Lars G. Larson

11. BIRTHPLACE OF FATHER

(State or Country)

Michigan

12. MAIDEN NAME OF MOTHER

Amelia Nigand

13. BIRTHPLACE OF MOTHER

(State or Country)

Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Lars G. Larson*
 (Address) *Moscow*

15. Filed *6/28* 19 *1907*
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *June 27 1922*
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
June 16 1922 to *June 27 1922*
 that I last saw him alive on *June 26 1922*
 and that death occurred on the date stated above, at *5:47 A.M.*

The CAUSE OF DEATH* was as follows:

Diphtheria

(Duration) Yrs. mos. *10* ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. H. Clark M. D.
4/28/22 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state
 (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
 if not at place of death?

Former or
 usual residence

19. PLACE OF BURIAL OR REMOVAL *Moscow* DATE OF BURIAL *6/28 1922*

20. UNDERTAKER *Green Price* ADDRESS *Moscow*

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics1. PLACE OF DEATH
County of *Idaho*
City of *Moscow*Registration District No. *61*
Primary Registration District No. *1011*
(No. St.)File No. *38558*
Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jennie L. Ellsworth
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED *Married*

6. DATE OF BIRTH

Jan 21 1892
(Month) (Day) (Year)

7. AGE

30 Yrs. *4* Mos. *28* ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)*House wife*

9. BIRTHPLACE

(State or Country)

Maine

10. NAME OF FATHER

Wayne Bunker

11. BIRTHPLACE OF FATHER

(State or Country)

Maine

12. MAIDEN NAME OF MOTHER

Carrie Woodward

13. BIRTHPLACE OF MOTHER

(State or Country)

Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Clarence Ellsworth
Moscow

15.

Filed

6/19 22

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 18 22
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
Nov. 1 24 to *June 18 1922*that I last saw her alive on *June 18 1922*
and that death occurred on the date stated above, *11:00* P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(Duration) *7* Yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. H. Clarke M. D.
6/19/22 (Address) *Moscow*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted
not at place of death?former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Edmonds, Wash. *19*

20. UNDERTAKER

ADDRESS

Shu Price *Moscow*

FORM V. S. No. 1-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

Registration District No.

Primary Registration District No.

(No.

St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Insignant)

Address

15.

Filed

1922

Local Registrar

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. W. McCutcheon, M. D.

6/22/22 (Address) Moscow, Id.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics1. PLACE OF DEATH *Idaho*
County of *Moose* Registration District No. *61*
City of *Moose* Primary Registration District No. *1011*
(No. _____) (St. _____)File No. *38580*
Registered No. *36*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Edna Anna Wilson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *F* 4. COLOR OR RACE *W.* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

DEC. 25, 1922
(Month) (Day) (Year)

7. AGE

2 Yrs. *5* Mos. *20* ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Frank Wilson

11. BIRTHPLACE OF FATHER

(State or Country)

Illinois

12. MAIDEN NAME OF MOTHER

Andrew Burr

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Frank Wilson

(Address)

Moose

15.

Filed

6/15 22 *M. H. Hovatter*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 14, 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 1, 1922 to *June 14, 1922*
that I last saw him alive on *June 14, 1922*
and that death occurred on the date stated above, at *6:20 P.M.*

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia(Duration) _____ Yrs. _____ mos. *14* ds.Contributory
(Secondary)

(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed)

J. H. Clarke

M. D.

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Moose *6/15 22*

UNDERTAKER

ADDRESS

John Price, Moose

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
38561 BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 61

County of Latah

Primary Registration District No. 1011

City of Moscow

(No. _____, _____ St.)

File No. _____

Registered No. 35

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jonas Sahlin

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widowed

6. DATE OF BIRTH

August 6th

1843

(Month)

(Day)

(Year)

7. AGE

79 yrs.

11 mos.

5 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

Retired Farmer

9. BIRTHPLACE

(State or Country)

Sweden

10. NAME OF FATHER

John Sahlin

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME OF MOTHER

Don't Know

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. J. Johnson

(Address)

Idaho

15.

Filed June 30 1912

W. J. Johnson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

125

16. DATE OF DEATH

June 11

(Month)

(Day)

1912

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 26 1912, to June 11 1912

that I last saw him alive on June 11 1912

and that death occurred on the date stated above, at 4:00 M.

The CAUSE OF DEATH* was as follows:

Cystitis

(Duration) 2 yrs. _____ mos. _____ ds.

Contributory Enlargement of Prostate
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W. J. Baruthers M. D.

June 11 1912 (Address) Moscow Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____

of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, _____

If not at place of death? _____

Former or _____

usual residence. _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

C. H. J. Pickett

1912

20. UNDERTAKER ADDRESS

Idaho

Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH *Latah* JUL 10 1922
County of *Latah* BUREAU OF VITAL STATISTICS
City of *Moscow* Registration District No. *61*
Registration District No. *1011* (No. _____ St.)

File No. *38562*
Registered No. *34*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Margaret A. Steinbock

If death occurred in a hospital, institution or camp, give its NAME instead of number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *F* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED *Widowed*
(Write the word.)

6. DATE OF BIRTH *Nov 15 1879*
(Month) (Day) (Year)

7. AGE *72* Yrs. *6* Mos. *21* ds. IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION *House wife,*
(a) Trade, profession, particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE *Virginia,*
(State or Country)

10. NAME OF FATHER *James Bales,*

11. BIRTHPLACE OF FATHER *Virginia,*
(State or Country)

12. MAIDEN NAME OF MOTHER *Mary Perkey,*

13. BIRTHPLACE OF MOTHER *Virginia*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Thomas Steinbock*
(Address) *Moscow*

15. *6/6* Filed *19 22* *H. H. Baxters*
Local Registrar

16. DATE OF DEATH *June 5 22*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 19 _____, to _____ 19 _____
that I last saw him _____ alive on _____ 19 _____
and that death occurred on the date stated above, at *5 P* M.
The CAUSE OF DEATH* was as follows:

Probably Apoplexy
No. August Field, R
(Duration) _____ yrs. _____ mos. _____ ds.

Contributor (Secondary) *John Hillman*
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) *John Hillman*
6/6 19 22 (Address) *Moscow*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL *Moscow*

20. UNDERTAKER *John Hillman*

DATE OF BURIAL *6/7 19 22*

ADDRESS *Moscow*

CERTIFICATE OF DEATH

38563

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Latah*City of *Brill*Registration District No. *66*Primary Registration District No. *2146*

(No.)

St.)

File No. *5*

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Robert Mikulich

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

*White*5. SINGLE, MARRIED, WID-
OWED OR DIVORCED*Single*
(Write the word.)

6. DATE OF BIRTH

Don't know

(Month)

(Day)

(Year)

7. AGE

39

Yrs.

Mos.

ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Woodman

(b) General nature of industry, business or establishment in which employed (or employer)

Ruthledge Lumber Co.

9. BIRTHPLACE

(State or Country)

Austria

10. NAME OF FATHER

Don't know

11. BIRTHPLACE OF FATHER

(State or Country)

Don't know

12. MAIDEN NAME OF MOTHER

Don't know

13. BIRTHPLACE OF MOTHER

(State or Country)

Don't know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Joe Parricich

(Address)

Elk River Idaho

15.

Filed *June 23* 19 *22**Wm J. Gibson*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June

(Month)

22 -

(Day)

19 *22*
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 22 - 1922, to *June 22 - 1922*that I last saw him alive on *June 22 - 1922*and that death occurred on the date stated above, at *5 P.* M.

The CAUSE OF DEATH* was as follows:

Ruptured Gastric Ulcer

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. C. Gibson

M. D.

6/23/1922 (Address) *Brill, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Brill Idaho

DATE OF BURIAL

6/23 19 *22*

20. UNDERTAKER

Glen Grice

ADDRESS

Moscow Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of *Idaho*
City of *Idaho Falls*
Registration District No. *61*
Primary Registration District No. *1011*
St. (No.) _____ St. _____

File No. *38564*
Registered No. *33*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Chester Leon Vincent*
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *M*
4. COLOR OR RACE *W*
5. SINGLE, MARRIED, WIDOWED OR DIVORCED
(Write the word.)

16. DATE OF DEATH

6. DATE OF BIRTH
Nov 18 1915
(Month) (Day) (Year)

June 2 1922
(Month) (Day) (Year)

7. AGE
3 6 15
Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

I HEREBY CERTIFY, That I attended deceased from
June 1 1922 to *June 2 1922*
that I last saw him alive on *June 2 1922*
and that death occurred on the date stated above, at *11:57 A*

8. OCCUPATION

The CAUSE OF DEATH* was as follows:

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Disease unknown. Probably pyrophosphorus.
(Duration) Yrs. mos. ds.

9. BIRTHPLACE

Contributory (Secondary)

(State or Country) *Oregon*

10. NAME OF FATHER
Chester Leon Vincent

(Duration) yrs. mos. ds.

11. BIRTHPLACE OF FATHER
(State or Country) *Oregon*

(Signed) *Chas. L. Gutman* M. D.

12. MAIDEN NAME OF MOTHER
Grace L. Beaman

6/2 1922 (Address) *Moscow*

13. BIRTHPLACE OF MOTHER
(State or Country) *Minnesota*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *Chester L. Vincent*
(Address) _____

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

15. Filed *June 2 1922* *W. H. Baithers*
Local Registrar

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Woodburn *June 2 1922*

20. UNDERTAKER ADDRESS
Green Tree Moscow

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Latah Registration District No. 61
City of Viola Primary Registration District No. 2141
St. BURLEYFile No. 38565
Registered No. 22

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

John Kurber

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH

Sept 12 1926
(Month) (Day) (Year)

7. AGE

76 Yrs. 7 Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Farmer

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Switzerland

10. NAME OF FATHER

John Kurber

11. BIRTHPLACE OF FATHER

(State or Country)

Switzerland

12. MAIDEN NAME OF MOTHER

Helen Kurber

13. BIRTHPLACE OF MOTHER

(State or Country)

Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John Kurber

(Address)

Viola

15.

Filed May 29 1922W. H. Carithers

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 29 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 1 1921 to May 1922
that I last saw him alive on Nov 2 1921,
and that death occurred on the date stated above, at 1 AM.

The CAUSE OF DEATH* was as follows:

chronic interstitial nephritis(Duration) 1 1/2 Yrs. about mos. ds.Contributory
(Secondary)advanced age(Duration) Yrs. mos. ds.

(Signed)

J. H. Clarke

M. D.

19

(Address)

Moscow Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

ViolaMay 31, 1922

20. UNDERTAKER

ADDRESS

E. H. KurberPalouse

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Idaho

County of

City of Moscow

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No.)

(St.)

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

19

Local Registrar

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. H. Clarke M. D.

(Address) Moscow Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

Clarke

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH *Salah*
 County of *Moscow*
 City of *Moscow*
 Registration District No. *61*
 Primary Registration District No. *1011*
 (State)

File No. *38567*
 Registered No. *18*

If death occurs away from
 usual residence, give facts
 called for under special in-
 formation.

2. FULL NAME

Tom Lyden

If death occurred in a hos-
 pital, institution or camp,
 give its NAME instead of
 street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

40

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED *Married*
 (Write the word.)

6. DATE OF BIRTH *March 22 1874*
 (Month) (Day) (Year)

7. AGE *48* Yrs. *1* Mos. *14* ds. IF LESS than 1 day
 how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or
 particular kind of work.
 (b) General nature of in-
 dustry, business or estab-
 lishment in which employ-
 ed (or employer)

House wife

9. BIRTHPLACE

(State or Country)

Norway

10. NAME OF FATHER

Not known

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

As per Lyden
Moscow

15. *May 8* 19 *22* *Moscow*
 File Local Registrar

16. DATE OF DEATH

May 6 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
May 22 1922 to *May 6* 1922
 that I last saw him alive on *May 5* 1922
 and that death occurred on the date stated above, at *6:30* M.
 The CAUSE OF DEATH* was as follows:

Cancer of liver

(Duration) Yrs. *6* mos. ds.

Contributory
 (Secondary)

(Duration) yrs. mos. ds.

(Signed) *J. N. Clarke* M. D.

578 1922 (Address) *Moscow Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state
 (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
 if not at place of death?

Former or
 usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Moscow *5/10* 19 *22*

20. UNDERTAKER

ADDRESS

Allen Price *Moscow*

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

Registration District No.

Primary Registration District No.

St.)

File No.

Registered No.

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF
FATHER11. BIRTHPLACE
OF FATHER

(State or Country)

12. MAIDEN NAME
OF MOTHER13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

April 20 1922 to May 4 1922

that I last saw him alive on May 4 1922

and that death occurred on the date stated above, 11/30/22

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Signed)

1922

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
 County of Idaho Registration District No. 61
 City of Moscow Primary Registration District No. 1011
 (St.)

File No. 38569
 Registered No. 21

If death occurs away from
 usual residence, give facts
 called for under special in-
 formation.

2. FULL NAME

Dale Walton

If death occurred in a hos-
 pital, institution or camp,
 give its NAME instead of
 street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED Single
 (Write the word.)

6. DATE OF BIRTH

Jan 31 1899
 (Month) (Day) (Year)

7. AGE

23 Yrs. 3 Mos. 16 ds.

IF LESS than 1 day
 how many..... hrs.
 or..... min.?

8. OCCUPATION

(a) Trade, profession or
 particular kind of work
 (b) General nature of in-
 dustry, business or estab-
 lishment in which employ-
 ed (or employer)

Farm
Labourer

9. BIRTHPLACE

(State or Country)

Nebraska

10. NAME OF FATHER

Henry Walton

11. BIRTHPLACE OF FATHER

(State or Country)

Nebraska

12. MAIDEN NAME OF MOTHER

Effie Williams

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Mrs Effie Richards
Moscow

15.

Filed

5/17 22
1922
W. G. Richards
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 16 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
May 5 1922 to May 15 1922
 that I last saw him alive on May 6 1922
 and that death occurred on the date stated above, at 11 P.M.
 The CAUSE OF DEATH* was as follows:

Tuberculosis

(Duration) 1 Yrs. mos. ds.

Contributory
 (Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. G. Richards

M. D.

5/17 1922

(Address) Moscow

*State the Disease Causing Death; or in deaths from Violent Causes, state
 (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted
 if not at place of death?

Former or
 usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Moscow 5/18 22
1922
 20. UNDERTAKER Ellis Price ADDRESS Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH
 in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of LatahCity of Julietta

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 68Registration District No. 68

BUREAU OF VITAL STATISTICS

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 38570

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Isabelle Millard

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widow Write the word.)

6. DATE OF BIRTH

January 22 1890
(Month) (Day) (Year)

7. AGE

82 Yrs. 3 Mos. 22 ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Housekeeper

9. BIRTHPLACE

(State or Country)

Wisconsin

10. NAME OF FATHER

Andrew Lockwood

11. BIRTHPLACE OF FATHER

(State or Country)

Don't know

12. MAIDEN NAME OF MOTHER

Moser

13. BIRTHPLACE OF MOTHER

(State or Country)

Don't know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

James Herbert Millard

(Address)

Julietta

15.

Filed

May 14 1922C. F. Peppel
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 11 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 9 1922, to May 10 1922
that I last saw her alive on May 10 1922,
and that death occurred on the date stated above, at 4:54 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) Yrs. mos. ds.

Contributory
(Secondary)Nephritis, Uremia

(Duration) yrs. mos. ds.

(Signed)

Andrew Otterman, D.

5/11/1922 (Address) Kendrick, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Julietta 5-14 1922

20. UNDERTAKER

ADDRESS

H. C. Grouck Julietta, Idaho

FORM V. S. No. 5-A-25 M. 1-19.

1. PLACE OF DEATH

County of *Idaho*City of *Moscow*

If death occurs away from usual residence, give facts called for under special information.

RECEIVED CERTIFICATE OF DEATH

Registration District No. *61*Primary Registration District No. *2141*

STATE OF IDAHO

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *38571*Registered No. *20*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Infant Headrick

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE/MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

*May**9**1922*

7. AGE

Yrs.

Mos.

ds.

IF LESS than 1 day
how many.....hrs.
or.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

James I Headrick

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Mattie Goss

13. BIRTHPLACE OF MOTHER

(State or Country)

Texas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

James I. Headrick

(Address)

Moscow

15.

Filed

*5/11**1922**M. H. Baithers*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

*May**10**1922*

17. I HEREBY CERTIFY, That I attended deceased from

May 9, 1922 to *May 11, 1922*that I last saw him alive on *May 9, 1922* and that death occurred on the date stated above, at *11* M.

The CAUSE OF DEATH* was as follows:

Conjunctive Heart Disease

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

*Virgil M. Gilchrist, M. D.**5/11, 1922* (Address) *Moscow, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Burhaman Green**5/11, 1922*

20. UNDERTAKER

ADDRESS

*Ellen Juice**Moscow*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Deliver This Certificate to Your Local Registrar. Not to the State Board of Health.

PLACE OF DEATH

Washington, State Board of Health

38572
Record No.County of Latah

BUREAU OF VITAL STATISTICS

City or Town of Palouse, Ind. R. & D.

CERTIFICATE OF DEATH

Registered No.

Registration Dist. No. 65.(No. 1)

St.; _____ Ward)

[If death occurs away
from USUAL RESIDENCE
give facts called for under
item 18.]

FULL NAME

Lanita R. Barnes[If death occurred in a
Hospital or Institution give
its NAME instead of street
and number.]

Personal and Statistical Particulars

3 Sex <u>Female</u>	4 Color or Race <u>White</u>	5 Single, Married, Widowed, or Divorced (Write the word) <u>Infant.</u>
------------------------	---------------------------------	---

6 Date of Birth Feb 13, 1920
(Month) (Day) (Year)7 Age 2 yrs. 7 mos. 5 ds. If LESS than 1 day, ____ hrs. ____ min?8 Occupation
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)
Infant.9 Birthplace (State or country)
Ida

PARENTS

10 Name of Father
J A Barnes11 Birthplace of Father (State or country)
Ida12 Maiden name of Mother
Jacquita Wolphert13 Birthplace of Mother (State or country)
Ida

14 The above is true to the best of my knowledge

(Informant) B F Wolphert(Address) Palouse15 Filed June 20, 1922 D J W. Thompson

I HEREBY CERTIFY, That I have been unable to secure answers to Questions

Medical Certificate of Death

105

16 Date of Death June 18, 1922
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from June 14, 1922, to June 18, 1922
that I last saw him alive on June 18, 1922and that death occurred, on the date above, at 1:30 a. m.

The CAUSE OF DEATH* was as follows:

Acute ileocolitis(Duration) ____ yrs. ____ mos. 4 ds.

Contributory (Secondary)

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) P. E. W. W. W., M. D.June 18, 1922 (Address) Garfield Wash

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 Length of Residence (For Hospitals, Institutions, Transients, or Recent Residents)

At Place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 Place of Burial or Removal

Date of Burial

Frege hem June 19, 1922

20 Undertaker

Address

Palouse

(Insert numbers of unanswered questions)

(Signature of Undertaker)

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **38573**

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of **Latah**
City of **Potlatch**Registration District No. **65**Primary Registration District No. **2146**

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Searg H Pasco

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED**Male****White****Widowed**
(Write the word.)

6. DATE OF BIRTH

Aug 17 1845
(Month) (Day) (Year)

7. AGE

76 Yrs. 9 Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Unlabeled

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

N. Y.

10. NAME OF FATHER

Levi Pasco

11. BIRTHPLACE OF FATHER

(State or Country)

Not known

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mattie M. Morris

(Address)

Potlatch, Idaho

15.

Filed **June 5th 1922****D. W. Thompson**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

40

16. DATE OF DEATH

June 4 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 10 1922, to June 4 1922
that I last saw him alive on **June 4 1922**
and that death occurred on the date stated above, at **5 P.M.**

The CAUSE OF DEATH* was as follows:

Cancer of Stomach(Duration) **1** Yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

D. W. Thompson

M. D.

6/5/1922 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Potlatch Ida June 8 1922

20. UNDERTAKER

ADDRESS

E. H. Quinn Palmer

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH
in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Lewish Registration District No. 41
City of Sahuan Registration District No. 2116
St.)

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Walter Laven Thompson

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 38574

Registered No. _____

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDMarried
(Write the word.)

6. DATE OF BIRTH

49 July 21 1874
Month Day Year

7. AGE

47 Yrs. 10 Mos. 9 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer).Quartz miner

9. BIRTHPLACE

(State or Country)

Colo10. NAME OF
FATHERAlbert Thompson11. BIRTHPLACE
OF FATHER

(State or Country)

Iowa12. MAIDEN NAME
OF MOTHERJennie Taylor13. BIRTHPLACE
OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wm Thompson(Address) Sahuan, Idaho.

15.

Filed

June 10 1922

W. C. Bellamy
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May - 30 1922
Month Day Year

17. I HEREBY CERTIFY, That I attended deceased from

.....19....., to19.....

that I last saw h..... alive on.....19.....

and that death occurred on the date stated above, at 10:15 AM.

The CAUSE OF DEATH* was as follows:

Accidentally
electrocuted by coming in
contact with high tension wire
(Duration) Yrs. mos.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) W. C. Doebler, Coroner

5-31-1922 (Address) Sahuan Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. State.....yrs.....mos.....days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Sahuan Cemetery

DATE OF BURIAL

5-31-1922

20. UNDERTAKER

Wm C Doebler

ADDRESS

Sahuan, Idaho

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Lehr
 City of Salmon

RECEIVED
 JUN 24 1922
 BUREAU OF VITAL STATISTICS
 (No. 8)

Registration District No.

Primary Registration District No.

St.)

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 38576

Registered No.

If death occurs away from
 usual residence, give facts
 called for under special in-
 formation.

2. FULL NAME

Charles Leighton Rowe

If death occurred in a hos-
 pital, institution or camp,
 give its NAME instead of
 street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDMaleWhiteSingle
(Write the word.)

6. DATE OF BIRTH

October
(Month)27
(Day)1922
(Year)

7. AGE

One Yrs. six Mos. 26 ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer).

9. BIRTHPLACE

(State or Country)

Salmon Idaho10. NAME OF
FATHERChester Rowe11. BIRTHPLACE
OF FATHER

(State or Country)

Montana12. MAIDEN NAME
OF MOTHERRuth Manfull13. BIRTHPLACE
OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Victor Durand
Baker, Idaho

(Address)

15.

Filed

June 10 1922Cliff C. Bellamy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

169

16. DATE OF DEATH

May 25
(Month)

(Day)

1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

.....19....., to19.....

that I last saw h..... alive on.....19.....

and that death occurred on the date stated above, at.....M.

The CAUSE OF DEATH* was as follows:

Accidentally
drowned by falling into
irrigation ditch
(Duration).....Yrs.....mos.....ds.Contributory
(Secondary)

.....(Duration).....yrs.....mos.....ds.

(Signed)

J. C. Jacobs
5-26-1922 (Address) Salmon Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state
 (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted
 if not at place of death?

Former or
 usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Salmon Cemetery5-27-1922

20. UNDERTAKER

ADDRESS

J. C. JacobsSalmon Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 38577

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH. *Levis* Registration District No. *49*
County of *Levis* Primary Registration District No. *242*
City of *Hammond* (City or Town) _____ St.) _____
if death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Nessa Smith*

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. *Single*
(Write the word.)

6. DATE OF BIRTH. *May 20 1922*
(Month) (Day) (Year)

7. AGE *Died at birth* IF LESS than 1 day how many _____ hrs. or _____ min. >]
Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...

child

9. BIRTHPLACE
(State or Country)

Kanich Ida

10. NAME OF FATHER *Mitchell A Smith*

11. BIRTHPLACE OF FATHER
(State or Country)

Colo

12. MAIDEN NAME OF MOTHER *Frances Ellis*

13. BIRTHPLACE OF MOTHER
(State or Country)

Colo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mitchell A Smith*
(Address) *Kanich Ida*

15. *5/21* 19*22* *J. Johnson*
Filed _____ 19*22* _____
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *May 20 1922*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Birth* 191... to 191...
that I last saw him alive on 191...
and that death occurred on the date stated above, at *10 pm* M.
The CAUSE OF DEATH* was as follows:

Pneumonia, 7 yrs.

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) *C. H. Bryder* M. D.

722 1922 (Address) *Hammond, Id.*
*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death... yrs... mos... days In the State... yrs... mos... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *St. Ann. Kanich Ida* DATE OF BURIAL *5/21 1922*

20. UNDERTAKER *J. Johnson* ADDRESS *Kanich*

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Leviston Registration District No. 47
County of Lewis City of Wapenam (No. 2 St.)
BUREAU OF VITAL STATISTICS

File No. 38578
Registered No. 81

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Matha Ta na ludimikt

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE Red 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widowed

6. DATE OF BIRTH. May 26 1845
(Month) (Day) (Year)

7. AGE 77 Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)

Farming

9. BIRTHPLACE

(State or Country)

Leviston Idaho

10. NAME OF FATHER

Mathus

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Simon Matthews
(Address) Wey Pierce

15. Filed 6-18 1912 Albert Huff
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 26 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 26 1922 to 26 1922, that I last saw him alive on 26 1922 and that death occurred on the date stated above, at 2 P. M.
The CAUSE OF DEATH* was as follows:

Contributory (Secondary)

(Duration) Yrs. mos. ds.
(Signed) Wey Pierce M. D.

622 1922 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death... yrs. mos. days In the State... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Albert Huff 6-28 1922

20. UNDERTAKER ADDRESS

Albert Huff Wey Pierce

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **38579**
Registered No. **137**

1. PLACE OF DEATH **Shoshone**
County of **Shoshone** Registration District No. **16**
City of **Shoshone** Registration District No. **1016** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Alice B Osbourn**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **F** 4. COLOR OR RACE **W** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
widow
(Write the word.)

6. DATE OF BIRTH **Feb 14 1874**
(Month) (Day) (Year)

7. AGE **48** Yrs. **3** Mos. **20** ds.
IF LESS than 1 day how many hrs. or min. >

8. OCCUPATION

(a) Trade, profession or particular kind of work... **Housewife**
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country) **Texas**

10. NAME OF FATHER

Jack Osbourn

11. BIRTHPLACE OF FATHER

(State or Country) **West India Islands**

12. MAIDEN NAME OF MOTHER

Alice Osbourn

13. BIRTHPLACE OF MOTHER

(State or Country) **Texas**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) **Jack J. Osbourn**
(Address)

15. Filed **June 11** 19**22** **J. L. Turo**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **June 10 1922**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **June 8 1922** to **June 10 1922**, that I last saw him alive on **June 10 1922** and that death occurred on the date stated above, at **12 A.M.**

The CAUSE OF DEATH* was as follows:

Shock from ruptured heart bladder

(Duration) Yrs. mos. ds.
Contributory (Secondary) **Ear stones**

(Duration) Yrs. mos. ds.
(Signed) **J. L. Turo** M. D.
June 10 1922 (Address) **Shoshone**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **Shoshone, Idaho** DATE OF BURIAL **6-11 1922**

20. UNDERTAKER **O. J. Minnow** ADDRESS **Shoshone**

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 16County of LatahJUN Primary Registration District No. 1016City of ShoshoneBUREAU (No. 1016)

St.)

File No. 38580Registered No. 12

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Joseph M. Ritchey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH.

8 of July 1846

(Month)

(Day)

(Year)

7. AGE

76 Yrs.11 Mos.14 ds.IF LESS than 1 day
how many.....hrs. or
.....min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).Farmer

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

unknown

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Perry H. Ritchey

(Address)

Garnett Idaho

15.

Filed

June 2d 19121912J. H. Sweeney

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 31 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 28 1922 to May 31 1922that I last saw him alive on May 28 1922and that death occurred on the date stated above, at 11-A M.

The CAUSE OF DEATH* was as follows:

Spotted Fever

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

June 2 1922 (Address)

M. D.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death.....yrs.....mos.....days

In the

State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Shoshone1912

20. UNDERTAKER

ADDRESS

Shoshone

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFAADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

 1. PLACE OF DEATH. Lincoln Registration District No. 16
County of Shoshone Primary Registration District No. 1016
City of Shoshone ST. Idaho

 File No. 38581
Registered No. 17

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Geo Bates

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

 3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED. married
(Write the word.)

 6. DATE OF BIRTH. Feb 26 1875
(Month) (Day) (Year)

 7. AGE 47 Yrs. 3 Mos. 8 ds.
IF LESS than 1 day how many hrs. or min.

8. OCCUPATION

 (a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)
Farmer
a Rancher

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Orron P Bates

11. BIRTHPLACE OF FATHER

(State or Country)

Illinois

12. MAIDEN NAME OF MOTHER

Elizabeth Brown

13. BIRTHPLACE OF MOTHER

(State or Country)

Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Miller Warr Bates

(Address)

Shoshone Idaho

15.

Filed June 22 19122J. H. Green

Local Registrar

 16. DATE OF DEATH May 31 1922
(Month) (Day) (Year)

 17. I HEREBY CERTIFY, That I attended deceased from May 27 1922 to May 31 1922, that I last saw him alive on May 31 1922 and that death occurred on the date stated above, at 3 a.m.

The CAUSE OF DEATH* was as follows:

Injury in auto accident
causing traumatic pneumonia(Duration) Yrs. mos. 6 ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed)

June 19 1922 (Address) Shoshone Idaho M. D.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death... yrs... mos... days In the State... yrs... mos... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Toole Utah

191

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 1-16-13

CERTIFICATE OF DEATH.

1. PLACE OF DEATH *Lincoln* Registration District No. *16*
County of *Shoshone* Primary Registration District No. *1016*
City of *Shoshone* (No. *1016* St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Chas Bell

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. *38582*Registered No. *77*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. *Single*
(Write the word.)

6. DATE OF BIRTH. *unknown*

(Month) (Day) (Year)

7. AGE *about 45**45* Yrs. *00* Mos. *00* ds.

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...

Shry. Shaver

9. BIRTHPLACE

(State or Country)

Kentucky

10. NAME OF FATHER

no information

11. BIRTHPLACE OF FATHER

(State or Country)

11

12. MAIDEN NAME OF MOTHER

11

13. BIRTHPLACE OF MOTHER

(State or Country)

11

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

O. J. Bruman

(Address)

Shoshone

15. Filed

*May 27 1922**J. L. Turner*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 25

(Month)

(Day)

1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 11 1922 to *May 25 1922*that I last saw him alive on *May 26 1922*and that death occurred on the date stated above, at *6:30 A.M.*

The CAUSE OF DEATH* was as follows:

Spotted fever

(Duration)

Yrs.

mos.

14 ds.

Contributory (Secondary)

by exposure

(Duration)

Yrs.

mos.

14 ds.

(Signed)

May 27 1922

(Address)

O. J. Bruman M. D.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death.....yrs.....mos.....days

In the

State.....yrs.....mos.....days

Where was disease contracted
if not at place of death?

Former or usual residence

Phoenix Arizona

19. PLACE OF BURIAL OR REMOVAL

Shoshone

DATE OF BURIAL

May 27 1922

20. UNDERTAKER

O. J. Bruman

ADDRESS

Shoshone

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH **RECEIVED**
 Registration District No. 16
 County of Lingoh JUN 22 1922
 Primary Registration District No. 1016
 City of Shoshone BUREAU OF VITAL STATISTICS

 File No. 38583
 Registered No. 10

If death occurs away from usual residence, give facts called for under special information.

 2. FULL NAME Harriett Willson Maywell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

 3. SEX ♀ 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. widow
 (Write the word.)

 6. DATE OF BIRTH July 18 1869
 (Month) (Day) (Year)

 7. AGE 53 Yrs. 10 Mos. 3 ds.
 IF LESS than 1 day how many hrs. or min.

OCCUPATION

 (a) Trade, profession or particular kind of work.
 (b) General nature of industry, business, or establishment in which employed (or employer).

Housewife

 9. BIRTHPLACE Wisconsin
 (State or Country)

 10. NAME OF FATHER Ford Willson

 11. BIRTHPLACE OF FATHER Vermont
 (State or Country)

 12. MAIDEN NAME OF MOTHER Emily Barber

 13. BIRTHPLACE OF MOTHER N.Y. State
 (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

 (Informant) Mrs. Byron W. Gaden
 (Address) Shoshone, Idaho

 15. Filed May 20 1922 J. L. Green
 Local Registrar
MEDICAL CERTIFICATE OF DEATH 164
 16. DATE OF DEATH May 19 1922
 (Month) (Day) (Year)

 17. I HEREBY CERTIFY, That I attended deceased from May 18 1922, to May 19 1922
 that I last saw him alive on May 18 1922
 and that death occurred on the date stated above, at 5:30 A.M.

The CAUSE OF DEATH* was as follows:

Cardiac failure following
thrombosis

 (Duration) Yrs. 7 mos. 7 ds.
 Contributory (Secondary) Thrombosis

 (Signed) W. L. Green M. D.
 (Address) Shoshone, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

 19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL 191

 20. UNDERTAKER ADDRESS O. J. Burman Shoshone

MARGIN RESERVED FOR BINDING

 WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

38584

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of *Shoshone* Registration District No. *16*
City of *Shoshone* Primary Registration District No. *1010* St.)

File No. _____
Registered No. *14*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Narvan R. Surfia

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. *Child*

(Write the word.)

6. DATE OF BIRTH *Nov-7 1921*
7 (Month) *18* (Day) *1* (Year)

7. AGE

Yrs. *7* Mos. *00* ds.

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... *none*
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country) *Shoshone Idaho*

10. NAME OF FATHER

Joe Surfia

11. BIRTHPLACE OF FATHER

(State or Country) *Idaho*

12. MAIDEN NAME OF MOTHER

Effie Prok

13. BIRTHPLACE OF MOTHER

(State or Country) *Idaho*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address) *Shoshone*

15.

Filed

June 6 1922 J. L. Turner

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

6 (Month) *5* (Day) *1922* (Year)

17. I HEREBY CERTIFY, That I attended deceased from *6-4-1922* to *6-5-1922*

that I last saw him alive on *6-5-1922*

and that death occurred on the date stated above, at *3.50 P.M.*

The CAUSE OF DEATH* was as follows:

Meningitis

(Duration) Yrs. *10* mos. *10* ds.

Contributory *Streptococcal Infection*
(Secondary)

(Duration) yrs. *10* mos. *10* ds.

(Signed) *Herbert C. Dray* M. D.

1922 (Address) *Shoshone Idaho*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Shoshone Idaho

DATE OF BURIAL

6-7-1922

20. UNDERTAKER

O. J. Brunner Shoshone

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Madison
City of RexburgRegistration District No. 100
Primary Registration District No. 2178
(No. _____ St.)File No. 38585
Registered No. 41

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME David A. Ricks

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Single
(Write the word.)

6. DATE OF BIRTH

December 12th 1909
(Month) (Day) (Year)

7. AGE

12 Yrs. 4 Mos. 21 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Student

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Orson Ricks

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Margaret Archibald

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Orson Ricks
Hubbard, Ida.

15.

Filed 6/519 22

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 3rd 19 22
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from 4-28- 1922, to 6-3- 1922that I last saw h. l. m. alive on 6-3- 1922 P.
and that death occurred on the date stated above, at 4:35 M.

THE CAUSE OF DEATH* was as follows:

Diffuse Septic Peritonitis(Duration) Yrs. 1 mos. 6 ds.
Contributory (Secondary) ruptured appendix
(Duration) Yrs. _____ mos. _____ ds.

(Signed)

6/5 1922

(Address)

Orson Ricks
Rexburg Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

REXBURG, IDA.

DATE OF BURIAL

6/5 19 22

20. UNDERTAKER

DAVID R. YOUNG

ADDRESS

REXBURG

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics1. PLACE OF DEATH,
County of Madison
City of LamarRegistration District No. 100
Primary Registration District No. 2178
(No. _____ St.)File No. 38586
Registered No. 39

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William M. Simmons

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.
Bale
(Write the word.)

16. DATE OF DEATH

6. DATE OF BIRTH.

June 4 1922
(Month) (Day) (Year)June 4 1922
(Month) (Day) (Year)

7. AGE

If LESS than 1 day
how many _____ hrs. or
_____ min.?17. I HEREBY CERTIFY, That I attended deceased from
June 4 1922 to June 4 1922
that I last saw h _____ alive on _____ 191 _____
and that death occurred on the date stated above, at 6:30 P.M.

8. OCCUPATION

The CAUSE OF DEATH* was as follows:

(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....BaleInhalation Pneumonia

9. BIRTHPLACE

(State or Country) Idaho (Lamar)(Duration) _____ Yrs. _____ mos. 1 da

10. NAME OF FATHER

Asael R. SimmonsContributory
(Secondary)

11. BIRTHPLACE OF FATHER

(State or Country) Lamar Idaho

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Carley Nelson M. D.(Address) 6-5 1922 (Address) R. Chas. Idaho

12. MAIDEN NAME OF MOTHER

Molly M. Smith

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

13. BIRTHPLACE OF MOTHER

(State or Country) Richmond Utah

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Asael R. Simmons

(Address)

Lamar Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Filed

6/5191 22W. M. Simmons

Local Registrar

20. UNDERTAKER

W. L. Morris

ADDRESS

Richmond

Earl. Bristle

Bele

Reyes Idaho

James E. Battie

[Handwritten signature]

ME
3
Susan, Enair

Country) *Multiplied 20*

Thomas E. Butler

Rel Reling

200 1922

This document was filed with the Clerk of the Court on January 18, 1922.
 (Month) (Day) (Year)

June 15 1947 to June 18 1947

7-10-68

that I last saw him alive on June 18 1942

and that death occurred on the date stated above, at 10:45 M.

The CAUSE OF DEATH was as follows:

USE OF DEATH: was as follows:

Premature birth

(Duration) Yrs. mos. ds.

Contributory (Secondary) - "Contributed" under 5945. From

(Duration 1 yrs 1 mos 0 ds.

(Signed) W. R. Kauter M. D.

1001

Mr. J. A. ... (Address) ...

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death	In the State
1	2
3	4
5	6
7	8
9	10
11	12
13	14
15	16
17	18
19	20
21	22
23	24
25	26
27	28
29	30
31	32
33	34
35	36
37	38
39	40
41	42
43	44
45	46
47	48
49	50
51	52
53	54
55	56
57	58
59	60
61	62
63	64
65	66
67	68
69	70
71	72
73	74
75	76
77	78
79	80
81	82
83	84
85	86
87	88
89	90
91	92
93	94
95	96
97	98
99	100

Where was disease contracted if not at place of death? same place as death

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL

B. 5 6/10 1022

101

20. UNDERTAKER	ADDRESS

At Young	Ok Cas
----------	--------

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

1. PLACE OF DEATH.

County of Madison
City of Payson

Registration District No. 100
Primary Registration District No. 2178
(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William Beattie

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 38588
Registered No. 41

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH. June 18 1922
(Month) (Day) (Year)

7. AGE _____
Yrs. _____ Mos. _____ ds.
IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...

Boiler

9. BIRTHPLACE

(State or Country)

Payson Idaho

10. NAME OF FATHER

Thomas E Beattie

11. BIRTHPLACE OF FATHER

(State or Country)

Payson Idaho

12. MAIDEN NAME OF MOTHER

Russena Innes

13. BIRTHPLACE OF MOTHER

(State or Country)

Smithfield Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thomas E Beattie
(Address) R. 1 - Payson

15.

Filed 6/20 1922 Payson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

151a

16. DATE OF DEATH

June 18 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 18 1922 to June 18 1922
that I last saw him alive on June 18 1922
and that death occurred on the date stated above, at 11 P. M.
The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration)

Yrs. Few minutes mos. _____ ds. _____

Contributory
(Secondary)

(Duration)

Yrs. _____ mos. _____ ds. _____

(Signed)

M. D. Luther Lane M. D.

6/18/22 (Address) Payson Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Burton

6/19 1922

20. UNDERTAKER

ADDRESS

Payson

Payson

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 100County of JeffersonPrimary Registration District No. 2178City of Bozeman

(No. _____)

St.)

File No. 38589Registered No. 42
 If death occurs away from
 usual residence, give facts
 called for under special
 information.

2. FULL NAME

Jack Howe Campbell
 If death occurred in a hos-
 pital, institution or camp,
 give its NAME instead of
 street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.MaleWhiteSingle
(Write the word.)

6. DATE OF BIRTH.

June
(Month)29
(Day)1921
(Year)

7. AGE

12
 IF LESS than 1 day
 how many hrs. or
 min.

8. OCCUPATION

 (a) Trade, profession or
 particular kind of work.
 (b) General nature of in-
 dustry, business, or estab-
 lishment in which employ-
 ed (or employer).
Infant

9. BIRTHPLACE

(State or Country)

Jefferson County10. NAME OF
FATHERRay J. Campbell11. BIRTHPLACE
OF FATHER

(State or Country)

Idaho12. MAIDEN NAME
OF MOTHERLeorial Howe13. BIRTHPLACE
OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Manda Mackenzie

(Address)

Bozeman Idaho

15.

Filed

6/2219122W. L. Young

Local Registrar

16. DATE OF DEATH

June
(Month)21
(Day)1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 181912to June 211912

that I last saw him alive on

June 211912and that death occurred on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Acute Gastric Enteritis

(Duration)

Yrs.

mos.

13 ds.Contributory
(Secondary)

(Duration)

Yrs.

mos.

6 ds.

(Signed)

W. L. Young

M. D.

6/22/22 (Address)Bozeman
 *State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
 MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.
18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place

In the

of death.....yrs.....mos.....days State.....yrs.....mos.....days

Where was disease contracted
if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bozeman Idaho6/23 19122

20. UNDERTAKER

ADDRESS

W. L. YoungBozeman

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Pahure

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.

100

County of

Madison

Primary Registration District No.

2178

City of

Archer Puerit

St.)

File No.

38590

Registered No.

43

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John W. Kingman Wilcox

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

154

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married

(Write the word.)

6. DATE OF BIRTH

April 23

1843

(Year)

16. DATE OF DEATH

April 23

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

last seen alive on

April 23, 1922

and that death occurred on the date stated above, at

Archer Puerit, Idaho

The CAUSE OF DEATH was as follows:

General Debility

(Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

Signed and sworn to before me on

April 23, 1922

(Address)

Archer Puerit, Idaho

State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death

In the State

yrs. mos. ds.

Where was disease contracted

If not at place of death

former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Archer Puerit

DATE OF BURIAL

April 23, 1922

20. UNDERTAKER

Address

Archer Puerit

Local Registrar

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Madison
City of RexburgRegistration District No. _____
Primary Registration District No. 2176
(No. _____ St.)File No. 38591
Registered No. 44If death occurs away from
usual residence, give facts
called for under special in-
formation.2. FULL NAME Dwen Nicholas AllermundIf death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED, OR DIVORCED Baba
(Write the word.)

6. DATE OF BIRTH

April 27 1921
(Month) (Day) (Year)

7. AGE

1 Yrs. 2 Mos. 3 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer).Child

9. BIRTHPLACE

(State or Country)

Rexburg, Ida.10. NAME OF
FATHERNicholas Allermund11. BIRTHPLACE
OF FATHER

(State or Country)

Denmark12. MAIDEN NAME
OF MOTHERClara Jensen13. BIRTHPLACE
OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed 6/30 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 30th 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
June 20 1922, to June 30 1922
that I last saw him alive on June 30 1922
and that death occurred on the date stated above, at 12:30 P

The CAUSE OF DEATH* was as follows:

Acute Nephritis - (Primary)(Duration) Yrs. mos. 8 ds.Contributory
(Secondary)(Duration) yrs. mos. 2 ds.

(Signed)

M. D.6/30/1922 (Address) Rexburg Idaho*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Rexburg, Ida.

DATE OF BURIAL

7/1 1922

20. UNDERTAKER

David Young

ADDRESS

Rexburg, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **38592**
Registered No. **22**

1. PLACE OF DEATH

Registration District No. **19**
County of **Minidoka** Primary Registration District No. **2013**
City of **Boise** (No. **192**) St.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

DURE

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female white married
(Write the word.)

6. DATE OF BIRTH

March 9 1897
(Month) (Day) (Year)

7. AGE

45 Yrs. **3** Mos. **7** ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

House wife

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Alma Taylor

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Minnie Taylor

13. BIRTHPLACE OF MOTHER

(State or Country)

Central Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Mrs. L. E. Clifford**
(Address) **Boise Idaho**

15.

Filled **June 17 1922** **Ed E. Clifford**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 16 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 16 1922 to **June 16 1922**
that I last saw him alive on **June 16 1922**
and that death occurred on the date stated above, at **2 P. M.**

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) **Robert L. Lipp** M. D.6-17-1922 (Address) **Robert L. Lipp**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Green City Utah 19

20. UNDERTAKER

ADDRESS

Alvin Keller **Robert L. Lipp**

FORM V. S. No. 5-25 M. 1-19.

RECEIVED CERTIFICATE OF DEATH

 udomb
 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Minidoka*Registration District No. *19*City of *Rampah*Primary Registration District No. *2015*

(No. St.)

File No. *38593*Registered No. *23*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary Jungkars

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female White

(Write the word.)

6. DATE OF BIRTH

Sept 29 1861
(Month) (Day) (Year)

7. AGE

60 Yrs. *7* Mos. *16* ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

House wife

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Hungary

10. NAME OF FATHER

Walter Lulius

11. BIRTHPLACE OF FATHER

(State or Country)

Hungary

12. MAIDEN NAME OF MOTHER

Mary Lulius

13. BIRTHPLACE OF MOTHER

(State or Country)

Hungary

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Walter Jungkars

(Address)

Rampah Idaho

15.

Filed *June 20 1922**E. D. Elmer*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 15 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 6 1922 to *May 15 1922*
that I last saw him alive on *May 14 1922*
and that death occurred on the date stated above, at *12 M.*
The CAUSE OF DEATH* was as follows:*Pneumo-pneumonia*(Duration) Yrs. mos. *7* ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

*H. P. O'Connell, M. D.**June 19 1922* (Address) *Rampah, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Catholic Cemetery**May 16 1922*

20. UNDERTAKER

ADDRESS

W. G. Goodman Rampah, Idaho

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH
in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of MinidokaCity of Paul

If death occurs away from
usual residence, give facts
called for under special in-
formation.

Registration District No. 19Primary Registration District No. 2015

(No. _____ St.)

File No. 38594Registered No. 24

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

2. FULL NAME Allen Yates

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDMarried (the word.)

6. DATE OF BIRTH

Nov 25 1853
(Month) (Day) (Year)

7. AGE

69 Yrs. 5 Mos. 25 ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of workFarmer(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country) Tennessee10. NAME OF
FATHERDont know11. BIRTHPLACE
OF FATHER

(State or Country) " "

12. MAIDEN NAME
OF MOTHER

(State or Country) " "

13. BIRTHPLACE
OF MOTHER

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Louis Yates(Address) Paul Idaho

15.

Filed June 20 1922

E. D. Elmore
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 20 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 15 1922 to May 20 1922
that I last saw him alive on May 19 1922
and that death occurred on the date stated above, at 7 A.M.
The CAUSE OF DEATH* was as follows:
Flu

(Duration) Yrs. 2 mos. _____ ds.

Contributory
(Secondary)

(Duration) yrs. _____ mos. _____ ds.

(Signed) A. J. Adams, M. D.

June 15 1922 (Address) Paul, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted
if not at place of death? _____

Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Paul Cemetery

DATE OF BURIAL

May 23 1922

20. UNDERTAKER

W. A. Goodman

ADDRESS

Refert

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of MinidokaCity of Rupert

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 19Primary Registration District No. 2016(No. 19)

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 38585Registered No. 25

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Fred Larson

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Male

4. COLOR OR RACE

White5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Widower

(Write the word.)

6. DATE OF BIRTH

Oct 24th 1853
(Month) (Day) (Year)

7. AGE

68 Yrs. 3 Mos. 2 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Sweden

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ida E Carlson(Address) Rupert Idaho

15.

Filed June 20 1922 800 Elmore

Local Registrar

16. DATE OF DEATH

Jan 23 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Nov. 1921, to Jan. 20 1922, that I last saw him alive on Jan. 20 1922 and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Cor. diac. dilation

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) V. P. Kilbr

M. D.

19. (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Rupert Cemetery

DATE OF BURIAL

Jan 26 1922

20. UNDERTAKER

W. A. Hochman

ADDRESS

Rupert

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **38596**
Registered No. **26**

1. PLACE OF DEATH
County of **Minidoka** Registration District No. **19**
City of **Reupert** Primary Registration District No. **2016**
(No.) (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Margaret Bell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Single**
(Write the word.)

6. DATE OF BIRTH

Jan 16 1922
(Month) (Day) (Year)

7. AGE

2 25
Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Child

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

J F Bell

11. BIRTHPLACE OF FATHER

(State or Country)

Kansas

12. MAIDEN NAME OF MOTHER

May Barker

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

James F Bell

(Address)

Reupert Idaho

15.

Filed

June 20 1922

W. A. Enoch

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 11 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **April 6 - 1922** to **April 10 1922**
that I last saw h. **En** alive on **April 10 1922**
and that death occurred on the date stated above, at **M.**

The CAUSE OF DEATH* was as follows:

Meningitis

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

V. P. Kilian

M. D.

19 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bearburn Conn

April 12 1922

20. UNDERTAKER

ADDRESS

W. A. Enoch

Reupert

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 38597

Registered No. 27

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Minidoka

City of Rupert

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 19

Primary Registration District No. 2015

(No. St.)

2. FULL NAME

Hella F. Stevenson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married

6. DATE OF BIRTH

July 25 1883
(Month) (Day) (Year)

7. AGE

38 Yrs. 10 Mos. 3 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

House Wife

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Kansas

10. NAME OF FATHER

Ben Sautter

11. BIRTHPLACE OF FATHER

(State or Country)

Kan

12. MAIDEN NAME OF MOTHER

Margaret Sauer

13. BIRTHPLACE OF MOTHER

(State or Country)

Kan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Frank Harris

(Address) Rupert Idaho

Filed June 20th 1922Ed Elmore
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 28 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 1 1922 to May 28 1922
that I last saw him alive on May 28 1922
and that death occurred on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:

Eclampsia

(Duration) Yrs. mos. ds.

Contributory (Secondary) pregnancy

(Duration) Yrs. mos. ds.

(Signed) M. D.

6-21-1922 (Address) Rupert Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Hayburn Cemetery June 1, 1922

20. UNDERTAKER

W. G. Goodman Rupert

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 38558
Registered No. 28

1. PLACE OF DEATH

County of MinidokaCity of Arpa

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 19Primary Registration District No. 2015(No. 192)

St.)

2. FULL NAME

Nels Pedersen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married

(Write the word.)

6. DATE OF BIRTH

March
(Month)25
(Day)1879
(Year)

7. AGE

43 Yrs. 2 Mos. 27 ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Farmer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Denmark

10. NAME OF FATHER

Lars Pedersen

11. BIRTHPLACE OF FATHER

(State or Country)

Denmark

12. MAIDEN NAME OF MOTHER

Dorthea Andersen

13. BIRTHPLACE OF MOTHER

(State or Country)

Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Gusta Sophia Pedersen(Address) Arpa R.F.D.

15.

Filed June 30 1922E. O. Elenore

Local Registrar

MEDICAL CERTIFICATE OF DEATH

30

16. DATE OF DEATH

(Month)

(Day)

1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1 1922 to June 21 1922

that I last saw him alive on June 21 1922

and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Tubercular Meningitis

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) R. P. Ross M. D.6-23-22 (Address) Arpa R.F.D.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Arpa CemeteryJune 23 1922

20. UNDERTAKER

ADDRESS

Admission

FORM V. S. No. 5-25 M. 1-19.

RECEIVED CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Nevada Registration District No. 128
 City of Culdesa Idaho St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ethel Napwell

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 38509

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female Red 1/16Single
(Write the word.)

6. DATE OF BIRTH

June 26 1922
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day
how many 7 hrs.
or min.?

Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Martin Napwell

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Kioma Ward

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Kioma Ward

(Address)

Culdesa Idaho

15.

Filed June 19 22 George Gagnard
Local Registrar

16. DATE OF DEATH

June 26 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 26 1922 to June 26 1922
that I last saw her alive on June 26 1922

and that death occurred on the date stated above, at 4:45 P.M.

The CAUSE OF DEATH* was as follows:

Premature birth

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

George Gagnard M. D.June 19 22 (Address) Culdesa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sweetwater Ida. June 27 1922

20. UNDERTAKER

ADDRESS

Wann Lafayette

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Key Perce
City of Lafuawai Ida

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Minnie Jack

CERTIFICATE OF DEATH

District No. 128Primary Registration District No. 1(No. Caldwell St.)State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 38500

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

Red

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

July — 1916
(Month) (Day) (Year)

7. AGE

5 Yrs. 10 Mos. ds.IF LESS than 1 day
how many hrs.
or min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

none

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

James Jack
Idaho

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Potatoes
Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Potatoes
Lafuawai Ida

15.

Filed

May 22 1922
George Gagnard
Local Registrar

MEDICAL CERTIFICATE OF DEATH

30

16. DATE OF DEATH

May 31 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 30, 1922 to May 30, 1922
that I last saw her alive on May 30, 1922
and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Tubercular Meningitis(Duration) Yrs. mos. 13 ds.Contributory
(Secondary)Tuberculosis
(Duration) yrs. mos. ds.

(Signed)

George Gagnard M. D.
May 19, 1922 (Address) Caldwell Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lafuawai Ida June 1, 1922

20. UNDERTAKER

ADDRESS

Wm Lafuawai

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Naz Perce* BUREAU OF VITALS District No. *128*
 City of *Lapwai Ida.* (No. *2*) Registration District No. *Caldesee*
 (St.) *Idaho*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary J. Wilson

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. *38602*

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Female White

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married Widowed
(Write the word)

6. DATE OF BIRTH

Dec. 21 1855
 (Month) (Day) (Year)

7. AGE

67 Yrs. *5* Mos. *3* ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Pennesse

10. NAME OF FATHER

James Byrd

11. BIRTHPLACE OF FATHER

(State or Country)

Virginia

12. MAIDEN NAME OF MOTHER

Nancy Byrd

13. BIRTHPLACE OF MOTHER

(State or Country)

Pennesse

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mr. Carl Cunningham

(Address)

Lapwai Ida.

15.

Filed

May 22 1922
George Gaignard
 Local Registrar

16. DATE OF DEATH

May 18 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

*March 18 1922 to May 18 1922*that I last saw her alive on *May 18 1922*and that death occurred on the date stated above, at *7 P. M.*

The CAUSE OF DEATH* was as follows:

Diabetes(Duration) *One Yr.* mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

George Gaignard M. D.*May 19 22* (Address) *Caldesee Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Julietta

DATE OF BURIAL

May 20 1922

20. UNDERTAKER

Nassar Comp

ADDRESS

Lewiston

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Nez Perce
City of Lafayette, IdaRegistration District No. 128
Registration District No. Caldesee
(No. vicinity St.)File No. 38603
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Cornelius W. Wilson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

Sept. 30 1847
(Month) (Day) (Year)

7. AGE

74 Yrs. 7 Mos. 9 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Tennessee

10. NAME OF FATHER

William S. Wilson

11. BIRTHPLACE OF FATHER

(State or Country)

Tennessee

12. MAIDEN NAME OF MOTHER

Elizabeth Hicks

13. BIRTHPLACE OF MOTHER

(State or Country)

Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Anna Cunningham

(Address)

Lafayette, Ida

15.

Filed

May 19 22 George Gaignard
Local Registrar

16. DATE OF DEATH

May 8 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 8 1922 to May 9 1922that I last saw him alive on May 9 1922and that death occurred on the date stated above, at 3:45 PM

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed)

George Gaignard M. D.May 19 22 (Address) Caldesee, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ Yrs. _____ mos. _____ days. In the State _____ Yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Fuldaetta, IdaMay 11 1922

20. UNDERTAKER

ADDRESS

Vassar Corp Lewiston, Ida

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Kee Perce Registration District No. 128
City of Caldwell Ida (No Caldwell & Vicinity St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Floyd MusicFile No. 38004
Registered No. 38004

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widowed
(Write the word.)

6. DATE OF BIRTH

March 26 1858
(Month) (Day) (Year)

7. AGE

64 Yrs. 9 Mos. 9 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Hard Rock Miner
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) West Virginia

10. NAME OF FATHER

Not Known

11. BIRTHPLACE OF FATHER

(State or Country) Virginia

12. MAIDEN NAME OF MOTHER

Not Known

13. BIRTHPLACE OF MOTHER

(State or Country) Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James H. Music
(Address) Caldwell Ida.

15.

Filed April 4 1922 George Gaignard
Local Registrar

MEDICAL CERTIFICATE OF DEATH

79

16. DATE OF DEATH

April 3rd 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Feb. 21, 1921, to March 31, 1922
that I last saw him alive on March 31, 1922
and that death occurred on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

George Gaignard M. D.
April 1922 (Address) Caldwell Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Lewiston Ida.

DATE OF BURIAL

4/5/1922

20. UNDERTAKER

James Underdaker Lewiston

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

JUL 5 1922 CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Key Pierce Registration District No. 128
City of near Shoshone, Id. (No. vicinity St.)
If death occurs away from usual residence, give facts called for under special information.File No. 38805
Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Martha E. Love

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

120

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widowed
(Write the word.)

6. DATE OF BIRTH

May 16 1842
(Month) (Day) (Year)

7. AGE

79 Yrs. 9 Mos. 23 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)none

9. BIRTHPLACE

(State or Country)

Mississippi

10. NAME OF FATHER

B. H. Benson

11. BIRTHPLACE OF FATHER

(State or Country)

Not known

12. MAIDEN NAME OF MOTHER

Martha E. Williams

13. BIRTHPLACE OF MOTHER

(State or Country)

Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. V. Laramore

(Address)

Culdesac, Id.

15.

Filed

Feb 1922 George Gaignard
Local Registrar

16. DATE OF DEATH

Feb 9 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 9 1922 to Feb 9 1922
that I last saw her alive on Feb 9 1922
and that death occurred on the date stated above, at 4:10 PM
The CAUSE OF DEATH* was as follows:
Rephritis(Duration) Yrs. 2 mos. _____ ds.
Contributory (Secondary) Cardiac Dilatation(Duration) Yrs. _____ mos. 1 day
(Signed) George Gaignard M. D.Feb 19 22 (Address) Culdesac Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Summerville Ore 2/14/ 1922

20. UNDERTAKER

ADDRESS

L. B. Wann Lapwai

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

(3300007)
State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.

County of Nezperce Primary Registration District No.City of Lewiston (No.) (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wilburta May TertelingFile No. 38506
Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED
(Write the word.)

6. DATE OF BIRTH

May 15th 1922
(Month) (Day) (Year)

7. AGE

6 yrs. 6 mos. 6 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Infant

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

H. P. Terteling

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Marie P. Phillips

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H. P. Terteling(Address) Lewiston Idaho

15.

Filed June 9. 1922 F.T. Harris, M.D.

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 24th 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 18 1922, to May 24 1922that I last saw him alive on May 18 1922and that death occurred on the date stated above, at 12:00 PM

The CAUSE OF DEATH* was as follows:

Toxemia of nephritis(Duration) Yrs. mos. 6 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) E. S. Braddock M. D.May 24 1922 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Lewiston Idaho 5-25 1922

20. UNDERTAKER

ADDRESS

Lewiston Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Boise
City of Boise

RECEIVED
JUN 2 1922
BUREAU

Registration District No.
Primary Registration District No.
(No. St.)

File No. 38507
Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John W. Kutzner

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married

6. DATE OF BIRTH

June 24th 1922
(Month) (Day) (Year)

7. AGE

61 Yrs. 10 Mos. 9 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work R.R. Conductor (Freight)
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Wis

10. NAME OF FATHER

John Kutzner

11. BIRTHPLACE OF FATHER

(State or Country) unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs J W Kutzner
(Address) Leavitt St Idaho

15.

Filed June 9. 1922 F.T. Harris, M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

79

16. DATE OF DEATH

May 3 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 25 1922 to April 27 1922
that I last saw him alive on May 27 1922
and that death occurred on the date stated above, at 12:00 P. M.

The CAUSE OF DEATH* was as follows:

Heart insufficiency

..... (Duration) Yrs. 2 mos. ds.

Contributory (Secondary) Influenza

..... (Duration) yrs. 2 mos. ds.

(Signed) J. B. Harris

M. D.

May 9 1922 (Address) Leavitt St Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Spokane

19

20. UNDERTAKER

ADDRESS

Leavitt St Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic); "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

2

6

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Nezperce
City of Lewiston

Registration District No.

Primary Registration District No.

(No. St.)

File No. 38608

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Fatima Alden Brooks

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
(Write the word.)6. DATE OF BIRTH Oct 4 1853
(Month) (Day) (Year)7. AGE 68 7 2 IF LESS than 1 day
Yrs. Mos. ds. how many. hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

Father

9. BIRTHPLACE

(State or Country)

Cherokee Co. Texas

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

Texas

12. MAIDEN NAME OF MOTHER

Mason Wilson

13. BIRTHPLACE OF MOTHER

(State or Country)

Texas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs F. A. Brooks

(Address)

Lewiston Ida.

15.

Filed June 9. 1922 F. T. Harris, M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

10

16. DATE OF DEATH

May 6 22
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
19..... to 19.....that I last saw him alive on 19.....
and that death occurred on the date stated above, at 10 M.

The CAUSE OF DEATH* was as follows:

Dead when arrived
muscle weakness
following influenza
(Duration) Yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) John H. Alley M. D.5/6/22 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Clarkston Ash

DATE OF BURIAL

5/8 1922

20. UNDERTAKER

H. P. Merchant

ADDRESS

Clarkston

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of HaywardCity of San Francisco

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No. 1Primary Registration District No. 1(No. 1 St.)Full Name ElizabethCode CodeState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 38509Registered No. 122

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widowed

6. DATE OF BIRTH

Dec. 13th 1915
(Month) (Day) (Year)

7. AGE

76 Yrs. 4 Mos. 24 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)At Home

9. BIRTHPLACE

(State or Country)

Penn.

10. NAME OF FATHER

Reuben W. Randall

11. BIRTHPLACE OF FATHER

(State or Country)

Maine

12. MAIDEN NAME OF MOTHER

Catharine Fisher

13. BIRTHPLACE OF MOTHER

(State or Country)

Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. J. P. Code

(Address)

San Francisco, Cal.

15.

Filed June 9 1922F. T. Harris, M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 7th 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 6 1922 to May 7 1922that I last saw her alive on May 7 1922and that death occurred on the date stated above, at 12 A.M.

The CAUSE OF DEATH* was as follows:

HematuriaOr (Duration) Or Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed)

J. M. Harris M.D.
May 1922 (Address) P. Lewis in Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

San Francisco, Cal.

DATE OF BURIAL

5-9 1922

20. UNDERTAKER

Vassar Undertaking Co

ADDRESS

San Francisco, Cal.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 38810

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Myer
City of Lewiston

Registration District No.

Primary Registration District No.

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Dillow

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Bachelor
(Write full word.)

6. DATE OF BIRTH

June 19, 1869
(Month) (Day) (Year)

7. AGE

62 Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)Carpenter

9. BIRTHPLACE

(State or Country)

Sweden

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

John Louder
Craigmont Idaho

15.

Filed June 9, 1922 F.T. Harris, M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 14, 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to May 14, 1922that I last saw him alive on May 14, 1922and that death occurred on the date stated above, at 6-30 A.M.The CAUSE OF DEATH* was as follows: operation for removal of prostate gland and prostate gland followed by uremic chills(Duration) 2 Yrs. mos. ds.Contributory Uremic Chills
(Secondary)(Duration) 2 yrs. mos. ds.(Signed) D. H. Chourne M. D.1922 (Address) Lewiston, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Craigmont Idaho19

20. UNDERTAKER

ADDRESS

Lewiston Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of *Boise*

Primary Registration District No.

City of *Boise*

(No.)

St.)

File No. *38611*

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Helen Yellowface

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

28

3. SEX

F

4. COLOR OR RACE

Indian

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED.

Single

(Write the word.)

6. DATE OF BIRTH.

*November**1902*

(Month)

(Day)

(Year)

7. AGE

20

Yrs.

Mos.

ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

Indian School girl

9. BIRTHPLACE

(State or Country)

North Dakota

10. NAME OF FATHER

Yellow Face

11. BIRTHPLACE OF FATHER

(State or Country)

North Dakota

12. MAIDEN NAME OF MOTHER

Coming Mather

13. BIRTHPLACE OF MOTHER

(State or Country)

North Dakota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Geo O Kest

(Address)

Lapwai Idaho

15.

Filed

*June 9. 1922**F. T. Harris, M.D.*

Local Registrar

16. DATE OF DEATH

*May**18**1922*

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from *May 10 1922* to *May 18 1922* that I last saw her alive on *May 18 1922* and that death occurred on the date stated above, at *8:30 A.M.*

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration)

2

Yrs.

mos.

ds.

Contributory (Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

May 19 22

(Address)

Lapwai Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....

8

yrs.

In the

10

days

State.....

8

yrs.

10

days

Where was disease contracted if not at place of death?

North Dakota

Former or usual residence

Died at Fort Lapwai, Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Lapwai, ID.**1922*

20. UNDERTAKER

ADDRESS

W. B. Boller, Lapwai, Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Ohio
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 38612

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Wayne; Registration District No. _____
City of Lewiston; Primary Registration District No. _____
St. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

George Maubrey Alfred

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Jan.
(Month)21st
(Day)1864
(Year)

7. AGE

58 Yrs.3 Mos.29 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Publisher Tribune

(b) General nature of industry, business or establishment in which employed (or employer).

Retired

9. BIRTHPLACE

(State or Country)

Texas

10. NAME OF FATHER

Geo F Alfred

11. BIRTHPLACE OF FATHER

(State or Country)

Mo.

12. MAIDEN NAME OF MOTHER

Annie W Maubrey

13. BIRTHPLACE OF MOTHER

(State or Country)

Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mr. E. T. Alfred

(Address)

Lewiston, Idaho

15.

Filed June 9, 1922F. T. Harris, M.D.

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May
(Month)20
(Day)1922
(Year)17. I HEREBY CERTIFY, That I attended deceased from Dec 1919 19 to May 20 1922that I last saw him alive on May 20 1922and that death occurred on the date stated above, at 12:20 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy
right lateral

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed)

John J. Allen M. D.
Lewiston

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Lewiston, Idaho

DATE OF BURIAL

5-21-1922

20. UNDERTAKER

SEAR & SONS CO.

ADDRESS

Lewiston, Idaho

CERTIFICATE OF DEATH

(Johnston)
State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Thayer Registration District No. _____
City of Levinston Primary Registration District No. _____
(No. _____) (St. _____)

If death occurs away from usual residence, give facts called for under special information.

File No. 38513

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robert T. Dodge

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single

6. DATE OF BIRTH

Feb 16 1897
(Month) (Day) (Year)

7. AGE

26 Yrs. 3 Mos. 5 ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Fireman

(b) General nature of industry, business or establishment in which employed (or employer) R.R. Locomotive.

9. BIRTHPLACE

(State or Country) Montana

10. NAME OF FATHER

E. Dodge

11. BIRTHPLACE OF FATHER

(State or Country) Vermont

12. MAIDEN NAME OF MOTHER

Battie Sullivan

13. BIRTHPLACE OF MOTHER

(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. E. Sullivan
(Address) Levinston Idaho

15.

Filed June 9. 1922 F.T. Harris, M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

28

16. DATE OF DEATH

May 21 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 7, 1922 to May 21, 1922
that I last saw him alive on May 21, 1922
and that death occurred on the date stated above, at 90 M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 Yrs. 1 mos. 1 ds.
Contributory (Secondary) Tubercular intestinal
catarrh

(Duration) 1 Yrs. 1 mos. 1 ds.
(Signed) Paul Johnston

5/22/22 (Address) Clatskanie Wash

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. 20 days. In the State _____ yrs. _____ mos. 20 days

Where was disease contracted if not at place of death? was working on R.R.

Former or usual residence various places
Parents at Orofino Idaho

19. PLACE OF BURIAL OR REMOVAL Levinston Idaho DATE OF BURIAL May 23rd 1922

20. UNDERTAKER _____ ADDRESS Levinston Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **38614**

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of *Benjamin*City of *Benjamin*

Registration District No.

Primary Registration District No.

(No.)

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Sister Mary Loyola

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

June
(Month)*2nd*
(Day)*1871*
(Year)

7. AGE

50 Yrs.*11* Mos.*27* ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

Sister St Joseph Teacher

9. BIRTHPLACE

(State or Country)

Wis

10. NAME OF FATHER

Samuel Fenimore

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Margaret McQuinn

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

S. J. Fuller

(Address)

Benjamin Idaho

15.

Filed *June 9.* 19 *22**F.T. Harris, M.D.*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May
Month*9th*
(Day)*1922*
(Year)17. I HEREBY CERTIFY, That I attended deceased from *May 15* 19*22* to *May 29th* 19*22* that I last saw her alive on *May 29th* 19*22* and that death occurred on the date stated above, at *9 P.* M. The CAUSE OF DEATH* was as follows:*Parenchymatous inflammation of kidneys*

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Dr. J. J. Harris

M. D.

19*22* (Address) *Benjamin Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Benjamin Idaho

DATE OF BURIAL

5-31 19 *22*

20. UNDERTAKER

ADDRESS

Benjamin Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **38615**

Registered No. _____

1. PLACE OF DEATH

Registration District No. _____

County of **Nezperce** Primary Registration District No. _____City of **Leicester** (No. _____) St. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Margaret Ella Smith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F.

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCED**Married**
(Write the word.)

6. DATE OF BIRTH

Nov- 10 1874
(Month) (Day) (Year)

7. AGE

48 Yrs. 6 Mos. 18 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

At Home

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Madison Co. Mo.

10. NAME OF FATHER

Carter Myers

11. BIRTHPLACE OF FATHER

(State or Country)

Madison Co. Mo.

12. MAIDEN NAME OF MOTHER

Sennie Berrett

13. BIRTHPLACE OF MOTHER

(State or Country)

Madison Co Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

James T. Smith
Leicester Ida

15.

Filed **June 9. 1922.****F. T. Harris, M. D.**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

5- 29 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

5-26 1922 to 5-27 1922that I last saw **her** alive on **5-28 1922**and that death occurred on the date stated above, at **12:15 M.**

The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis following Heroin for Hall Blows
(Duration) _____ Yrs. _____ mos. _____ ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

John H. Kelly, M. D.
599 27 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho **5/30 22**

20. UNDERTAKER

ADDRESS

H. H. Merchant **Leicester**

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Neperce

Registration District No.

City of Turkston

Primary Registration District No.

File No. 38617

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Richard Vernon Newland

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

June (Month) 1922 (Year)
1922 (Day)

7. AGE

10 Yrs. 25 Mos. ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Infant

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

E. C. Newland

11. BIRTHPLACE OF FATHER

(State or Country)

Wash.

12. MAIDEN NAME OF MOTHER

Fannie Platt

13. BIRTHPLACE OF MOTHER

(State or Country)

Wash.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. C. Newland

(Address)

Kossbia Idaho

15.

Filed June 9. 1922E. T. Harris M.D.

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May (Month) 14 (Day) 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 7 1922, to May 14 1922that I last saw him alive on May 14 1922and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

meningitis(Duration) 2 Yrs. 2 mos. ds.Contributory
(Secondary)(Duration) 2 Yrs. 2 mos. ds.

(Signed)

J. M. Lyle M. D.5:15 1922(Address) Turkston

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Kossbia Idaho19

20. UNDERTAKER

ADDRESS

Nassau Undertaking CoTurkston Idaho

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH RECEIVED
County of Oneida JUL 1
City of Malad BUREAU (No. 2069 St.)
Registration District No. 26
Primary Registration District No. 2069

File No. 38619Registered No. 19

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph B M^c Kay

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH 44

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Widowed

6. DATE OF BIRTH

March 17 1884
(Month) (Day) (Year)

7. AGE

88 Yrs. 2 Mos. 18 ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Rock Mason

9. BIRTHPLACE

(State or Country)

Belfast Ireland

10. NAME OF FATHER

Joseph M^c Kay

11. BIRTHPLACE OF FATHER

(State or Country)

Isle of Man

12. MAIDEN NAME OF MOTHER

Martha Blair

13. BIRTHPLACE OF MOTHER

(State or Country)

Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Joseph M^c Kay

(Address)

Malad Ida

15.

Filed July 6 1922Local Registrar W. H. Jones M. S.

16. DATE OF DEATH

June 5 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 19 21 to June 5 1922

that I last saw him alive on June 5 1922and that death occurred on the date stated above, at 11 P M.

The CAUSE OF DEATH* was as follows:

Cancer of Lip and Chin.(Duration) 2 Yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

J. M. Kerns M. D.Malad Ida (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Malad Ida 6-8 1922

20. UNDERTAKER

ADDRESS

D. E. Johnson Malad

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FOR 1922—25 M. 1-19.

CERTIFICATE OF DEATH

38621

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. CAUSE OF DEATH

County *Andia*
City *Stons*

RECEIVED
JUN 22 1922

Registration District No. *26*
Primary Registration District No. *2069*
(No.) (St.)

File No. *15*
Registered No. *15*

away from
give facts
special in-

BUREAU
STATES

2. FULL NAME

James Thomas Carter

If death occurred in a ho-
pital, institution or care-
give its NAME instead of
street and number

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED *Married*
(Write the word.)

6. DATE OF BIRTH
2 a.m. September 8th 1860
(Month) (Day) (Year)

7. AGE *61* Yrs. *5* Mos. ds. IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. *Farming*
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE
(State or Country) *Bloomfield Iowa*

10. NAME OF FATHER *Jasper Carter*

11. BIRTHPLACE OF FATHER
(State or Country) *Springfield Ill.*

12. MAIDEN NAME OF MOTHER *Martha Ann Thorp*

13. BIRTHPLACE OF MOTHER
(State or Country) *Savis Co. Iowa*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *Lillie Jane Carter*
(Address) *S. E. Carter*

15. Filed *June 15 1922* *R. T. Mauer M.D.*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
7 a.m. April 8
(Month) (Day)

17. I HEREBY CERTIFY, That I attended deceased
..... 19..... to
that I last saw h..... alive on.....
and that death occurred on the date stated above, at.....
The CAUSE OF DEATH* was as follows:

*Spanish Influenza followed by
Pneumonia*
(Duration) Yrs. mos. ds. *6*

Contributory
(Secondary)
(Duration) yrs. mos. ds.
(Signed) *R. T. Mauer* M. D.
June 19 22 (Address) *Malad, Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Holbrook, Ida* DATE OF BURIAL *April 10 1922*

20. UNDERTAKER *Holbrook* ADDRESS *Holbrook*

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Inside Registration District No. 26
 City of Malad Primary Registration District No. 2069
 (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Martha Lewis

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 38622Registered No. 98

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED Widow

6. DATE OF BIRTH

April 25 1855
 (Month) (Day) (Year)

7. AGE

67 Yrs. 16 Mos. 2 ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

House wife

9. BIRTHPLACE

(State or Country)

Wales

10. NAME OF FATHER

John Reynolds

11. BIRTHPLACE OF FATHER

(State or Country)

Wales

12. MAIDEN NAME OF MOTHER

Catherine Williams

13. BIRTHPLACE OF MOTHER

(State or Country)

Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. Reynolds

(Address)

Malad Ida.

15. Filed

June 15 1922

Waver M-11

Local Registrar

16. DATE OF DEATH

May 11 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 11 1922 to May 11 1922
 that I last saw her alive on May 11 1922
 and that death occurred on the date stated above, at 2:30 P.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) Yrs. mos. ds.

Contributory
 (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. F. Altman M. D.

5-14-1922 (Address) Malad

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Malad May 14 1922

20. UNDERTAKER

ADDRESS

J. J. Berryman Malad Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

JUL 5 1922

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

Registration District No.

Registration District No.

(No.)

(St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

June 17 1922 to June 19 1922
that I last saw him alive on June 19 1922
and that death occurred on the date stated above, at 8 P. M.
The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 4 Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Simon Hopper M. D.

19 (Address) Homedale

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Canyon Hill

6-30 1922

20. UNDERTAKER

ADDRESS

C. V. Blackham Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

RECORDED
JUL 6 CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Payette
County of Payette Registration District No. _____
City of Frankland (No. _____) Primary Registration District No. _____
(St. _____)

File No. 38625

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles J. Humber

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married

6. DATE OF BIRTH Oct 4 1835

(Month)

(Day)

(Year)

7. AGE 86 yrs. 8 mos. 9 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 6 yr

9. BIRTHPLACE

(State or Country) Germany

10. NAME OF FATHER Humber

11. BIRTHPLACE OF FATHER

(State or Country) Germany

12. MAIDEN NAME OF MOTHER not known

13. BIRTHPLACE OF MOTHER

(State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. Humber

(Address) Kimberly Ida

15.

Filed June 14 - 1922

C. C. Duxton
Local Registrar

MEDICAL CERTIFICATE OF DEATH. 8

16. DATE OF DEATH June 13 - 1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from June 9 - 1922 to June 13 - 1922

that I last saw him alive on June 12 - 1922
and that death occurred on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) several yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) C. C. Duxton M. D.

6/14/1922 (Address) Frankland Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Payette Ida

1922

20. UNDERTAKER

ADDRESS

C. C. Duxton
Payette Ida

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Payette*City of *Payette*

If death occurs away from usual residence, give facts called for under special information.

Registration District No. *4*Primary Registration District No. *1008*(No. *1008*, St.)State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *38526*Registered No. *29*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED*Male Caucasian**Single*

(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

June 7 1922
(Year)

7. AGE

Four hours

Yrs.

Mos.

ds.

IF LESS than 1 day
how many *4* hrs.
or *1* min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

None

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

H. E. Hart

11. BIRTHPLACE OF FATHER

(State or Country)

Nebraska

12. MAIDEN NAME OF MOTHER

Irue Justice

13. BIRTHPLACE OF MOTHER

(State or Country)

Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Homer E. Hart

(Address)

Payette, Idaho

15.

Filed *June 8 1922**J. B. Woodward*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

June 7 1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 7 1922, to *June 7 1922*,that I last saw him alive on *June 7 1922*,and that death occurred on the date stated above, at *10³⁰ A.M.*

The CAUSE OF DEATH* was as follows:

Premature birth

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

O. H. Avery

M. D.

6/8/1922 (Address)*Payette, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

yrs.

In the

days.

State

yrs.

mos.

days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Payette Idaho June 8 1922

20. UNDERTAKER

ADDRESS

Glen C Landon Payette, Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 38527
Registered No. 30

1. PLACE OF DEATH

County of PayetteCity of PayetteRegistration District No. 4Primary Registration District No. 1008(No. 4 St.)

If death occurs away from usual residence give facts called for under special information.

2. FULL NAME

John A Smith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDMaleWhiteMarried
(Write the word.)

6. DATE OF BIRTH

Aug

(Month)

9

(Day)

1860

(Year)

7. AGE

61 Yrs. 10 Mos. 14 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Farmer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Nova Scotia

10. NAME OF FATHER

Leshie Smith

11. BIRTHPLACE OF FATHER

(State or Country)

Nova Scotia

12. MAIDEN NAME OF MOTHER

Elin Skalling

13. BIRTHPLACE OF MOTHER

(State or Country)

Nova Scotia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Florence M. Jones(Address) Payette Idaho

15.

Filed June 28 1922J. C. Woodward
Local Registrar

MEDICAL CERTIFICATE OF DEATH

10

16. DATE OF DEATH

June 26

(Month)

(Day)

22
(Year)17. I HEREBY CERTIFY, That I attended deceased from March 27 1922 to June 25 1922that I last saw him alive on June 25 1922 and that death occurred on the date stated above, at 6:00 P.M.

The CAUSE OF DEATH* was as follows:

Influenza - Left lobe of
pneumonia - Left lobe
pneumothorax

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. C. Woodward M. D.6/28/22 (Address) Payette Id.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bellevue WashJune 30 1922

20. UNDERTAKER

ADDRESS

Glen C LandonPayette Id.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

This patient had whooping
cough for about 3 weeks
and was complicated by
pneumonia, which she had
a bout one week before she
died. Dr. C. F. Schill, who is
out of the city, was in
attendance until Dr. Logan
took charge of the case.
R. F. North, M.D.
Local President

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

1. PLACE OF DEATH.

County of **Power**
City of **American Falls,**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Edna Lorine**Hanson**

CERTIFICATE OF DEATH.

Registration District No.

Primary Registration District No.

2072

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No. **163**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single

(Write the word.)

6. DATE OF BIRTH.

August**3****1921**

(Month)

(Day)

(Year)

7. AGE

10 Mos. 25 ds.

IF LESS than 1 day
how many hrs. or
min. 2)

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

None

9. BIRTHPLACE

(State or Country)

Power Co**Idaho**

10. NAME OF FATHER

G.H. Hanson

11. BIRTHPLACE OF FATHER

(State or Country)

Maine

12. MAIDEN NAME OF MOTHER

Edna M. Guard

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

American Falls, Idaho

15.

Filed

7-1**1922****R. F. Roth**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June

(Month)

28

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 27 1922, to **June 28** 1922.that I last saw her alive on **June 28** 1922.and that death occurred on the date stated above, at **1:15 P.M.**

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration)

Yrs.

mos.

ds.

Contributory (Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

V. G. Logan

M. D.

19 (Address)

Emergency Hall

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....

yrs.....

mos.....

days.....

In the

State.....

yrs.....

mos.....

days.....

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

American Falls, Idaho**June 28, 1922**

20. UNDERTAKER

ADDRESS

Edna M. Guard

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

1. PLACE OF DEATH.

County of **Power**
 City of **American Falls, Idaho**

 If death occurs away from
 usual residence, give facts
 called for under special
 information.

2. FULL NAME

Phila Maria GriswoldRegistration District No. **25**Primary Registration District No. **2072**

File No.

Registered No. **161**
 If death occurred in a hos-
 pital, institution or camp,
 give its NAME instead of
 street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.**Married**
(Write the word.)

6. DATE OF BIRTH.

Dec**7****1883**

(Month)

(Day)

(Year)

7. AGE

38Yrs. **6**Mos. **4**

ds.

 IF LESS than 1 day
 how many hrs. or
 min.

8. OCCUPATION

 (a) Trade, profession or
 particular kind of work...
 (b) General nature of in-
 dustry, business, or estab-
 lishment in which employ-
 ed (or employer).....
House Wife

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF

FATHER

N. Altnyer11. BIRTHPLACE
OF FATHER

(State or Country)

Wis12. MAIDEN NAME
OF MOTHER**Mary Watson**13. BIRTHPLACE
OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

American Falls, Idaho

15.

Filed

6-21**1922****R. I. Roth**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June

(Month)

11

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 21 1922, to June 11 1922,that I last saw her alive on **June 11 1922**and that death occurred on the date stated above, at **7:30 P. M.**

The CAUSE OF DEATH* was as follows:

Puerperal Bacteremia

(Duration)

Yrs.

mos.

ds. **2**Contributory
(Secondary)**Endocarditis**

(Duration)

Yrs.

mos.

ds. **7**

(Signed)

C. F. Schief

M. D.

6/12 1922 (Address) American Falls, Ida.
 *State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
 MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.
18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place

of death.....

Yrs.....

mos.....

days

In the

State.....

Yrs.....

mos.....

days

 Where was disease contracted
 if not at place of death?.....

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

Coggon Iowa

DATE OF BURIAL

191

20. UNDERTAKER

A.W. Davis

ADDRESS

American Falls, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

1. PLACE OF DEATH.

County of PowerCity of American Falls

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Union District No.

Primary Registration District No.

(No. Bethany Hospital St.)not named

38531

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No. 162

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

1 sm

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single

6. DATE OF BIRTH

6 - 20 1922
(Month) (Day) (Year)

7. AGE

..... yrs. mos. ds.

IF LESS than 1 day
how many ... hrs. or
..... mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Joe Melvil Wimmer

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Julia Ann Eastbrook

13. BIRTHPLACE OF MOTHER

(State or Country)

Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Mrs. J. Wimmer
Rockland Ida R 411

15.

Filed

6-211922R. J. Roth

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

6 - 20 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

6-20 1922 to 6-20 1922that I last saw h alive on 6-20 1922and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Premature - about 5 1/2 mos.
uterine gestation

(Duration) yrs. mos. ds.

Contributory
(Secondary)Mother Anemia

(Duration) yrs. mos. ds.

(Signed)

R. J. Roth

M. D.

6-20 1922 (Address) American Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

American Falls

DATE OF BURIAL

6-21 1922

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 25

38632

County of Power

Primary Registration District No. 272

File No. 3

City of American Falls

(No.) St.)

Registered No. 357

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ellen Stanger

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female White

(Write the word.) Single

6. DATE OF BIRTH

April 30 1922
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day
how many hrs. or
mins.?

_____ yrs. _____ mos. _____ ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

at home

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

(mark) Matt Elmer Stanger

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Mable Harmsen

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mable Stanger

(Address) American Falls, Ida.

15.

Filed 6-8 1922 R. H. North

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 30 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 30 1922 to April 30 1922

that I last saw him alive on April 30 1922

and that death occurred on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH* was as follows:

Premature birth
by caesarean (6 1/2) months of
utero gestation

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

J. H. Legan

M. D.

6-6-1922 (Address) American Falls, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Amer. Falls.

191

20. UNDERTAKER

ADDRESS

Form V. S. No. 5 20M.1-16-12

RECEIVED
JUN 22 1922

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of *Power*Registration District No. *29*

38633

City of *American Falls*Primary Registration District No. *2012*File No. *4*Registered No. *358 358*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Hellen Stanger

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

April 30 1922
(Month) (Day) (Year)

7. AGE

yrs. mos. ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

at home

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho
(mark)

10. NAME OF FATHER

Maed Elmer Stanger

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Mable Harmisson

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mable Stanger

(Address)

American Falls, Ida.

15.

Filed

6-8

1922

R. K. Noll

Local Registrar

MEDICAL CERTIFICATE OF DEATH

1510

16. DATE OF DEATH

April 30 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 30 1922, to April 30 1922
that I last saw *him* alive on *April 30 1922*and that death occurred on the date stated above, at *2 P.M.*

The CAUSE OF DEATH* was as follows:

Premature birth
in 6 1/2 months gestation
(Duration) yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

V. J. Ryan

M. D.

6-6-1922 (Address) *Idaho Falls*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

American Falls

191

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **38635**
Registered No. **175-C**

1. PLACE OF DEATH

County of **Shoshone**
City of **Malheur**Registration District No. **1922**
Primary Registration District No. **1922**
St. **Bullman Road**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Badie Hall Schmidt

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

F.

4. COLOR OR RACE

white5. SINGLE, MARRIED, WID-
OWED OR DIVORCED**married**
(Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

42

Yrs. — Mos. — ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)**at Home**

9. BIRTHPLACE

(State or Country)

Oregon

10. NAME OF FATHER

George Hall

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Sarah Lowery

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Mrs. Hest Conelson**
(Address) **Malheur 2nd**15. **ma 3**
Filed **ma 3** 19 **22**

Local Registrar

16. DATE OF DEATH

May 2 22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19
that I last saw him on 19
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Acute myocardial infarction
Chronic degenerative
arteriosclerosis

(Duration)

Contributory
(Secondary)

(Duration)

yrs. mos. ds.

(Signed)

1922 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

Malheur Idaho

19. PLACE OF BURIAL OR REMOVAL

Baker City Oregon

DATE OF BURIAL

May 2 1922

20. UNDERTAKER

Hardy & Co

ADDRESS

Malheur 2nd

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **38636**Registered No. **29**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Shoshone
City of BurkeRegistration District No. 10Primary Registration District No. 10(No. Residence St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Finley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

white5. SINGLE, MARRIED, WIDOWED OR DIVORCED
(Write the word.)
married

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

61 Yrs. — Mos. — ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)mines

9. BIRTHPLACE

(State or Country)

Newfoundland

10. NAME OF FATHER

John Finley

11. BIRTHPLACE OF FATHER

(State or Country)

Newfoundland

12. MAIDEN NAME OF MOTHER

Mary Trainer

13. BIRTHPLACE OF MOTHER

(State or Country)

Newfoundland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Jack Finley

(Address)

Wallace Idaho

15. Filed

19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

29

16. DATE OF DEATH

(Month) (Day) (Year)

May 4 1922

17. I HEREBY CERTIFY, That I attended deceased from

Jan 1922, to May 4 1922that I last saw him alive on May 4 1922and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

acute myocardial infarction

(Duration) Yrs. mos. ds.

Contributory
(Secondary)Influenza

(Duration) yrs. mos. ds.

(Signed) Chas. A. Dutton M. D.May 4 1922 (Address) Burke Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

Burke Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wallace IdahoMay 6 1922

20. UNDERTAKER

ADDRESS

Ward and CoWallace Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 38537

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Shoshone
City of Nallaee

Registration District No.

Primary Registration District No.

(No. Canyon av St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Charles H. Phillips

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH

April 11 1894
(Month) (Day) (Year)

7. AGE

48 Yrs. — 23 Mos. 23 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).engineer in mine

9. BIRTHPLACE

(State or Country)

Michigan

10. NAME OF FATHER

Chester Phillips

11. BIRTHPLACE OF FATHER

(State or Country)

New York

12. MAIDEN NAME OF MOTHER

Sarah White

13. BIRTHPLACE OF MOTHER

(State or Country)

New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. Charles H. Phillips
(Address) Nallaee Idaho15. M. 19 22

Local Registrar

MEDICAL CERTIFICATE OF DEATH

40

16. DATE OF DEATH

May 4 22
(Month) (Day) (Year)17. I HEREBY CERTIFY That I attended deceased from April 20 1922 to May 4 1922that I last saw him alive on May 4 1922 and that death occurred on the date stated above, at 5:45 P.M.

The CAUSE OF DEATH* was as follows:

Ch. Croup of Stomach
(Duration) 7 yrs. 10 mos. 10 ds.

Contributory (Secondary)

(Duration) 7 yrs. 10 mos. 10 ds.(Signed) Dr. H. W. Wall M. D.1922 (Address) Nallaee Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 7 yrs. 10 mos. 10 days. In the State 7 yrs. 10 mos. 10 days.

Where was disease contracted if not at place of death?

Former or usual residence Nallaee Idaho

19. PLACE OF BURIAL OR REMOVAL

Nallaee Idaho May 7 1922

20. UNDERTAKER

Hard Wood Co Nallaee Idaho

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED
JUN 22 1922

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 38638
Registered No. 426

1. PLACE OF DEATH
County of Shoshone Registration District No. 70
City of Mallard Primary Registration District No. 1011
213 Bank St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Margaret Fox

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX F. 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED widowed
(Write the word.)

6. DATE OF BIRTH
(Month) (Day) (Year)

7. AGE 87 Yrs. — Mos. — ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. As House
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Ireland

10. NAME OF FATHER Wm Gibbons

11. BIRTHPLACE OF FATHER
(State or Country) Ireland

12. MAIDEN NAME OF MOTHER Sarah Farrell

13. BIRTHPLACE OF MOTHER
(State or Country) Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Clara Leary
(Address) Burke Idaho

15. May 15 1922
Filed Local Registrar

16. DATE OF DEATH
May 12 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1 1922 to May 12 1922
that I last saw h. alive on May 12 1922
and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:
Cerebral Thrombosis

(Duration) Yrs. mos. ds.
Contributory (Secondary) Arterio Sclerosis

(Duration) yrs. mos. ds.
(Signed) Wm T. Smith M. D.
May 15 1922 (Address) Mallard Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?
Former or usual residence Mallard Idaho

19. PLACE OF BURIAL OR REMOVAL Mallard Ida DATE OF BURIAL May 15 1922

20. UNDERTAKER Ward and Co ADDRESS Mallard Ida

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **38539**
Registered No. **48**

1. PLACE OF DEATH

County of **Mullan**
City of **Shoshone**
Registration District No. **20**
Primary Registration District No. **10**
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Frank Isaac Priesting

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Married**
(Write the word.)

6. DATE OF BIRTH

July 4 1884
(Month) (Day) (Year)

7. AGE

37 Yrs. **10** Mos. **11** ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).**Farming**

9. BIRTHPLACE

(State or Country)

Finland

10. NAME OF FATHER

Samuel Priesting

11. BIRTHPLACE OF FATHER

(State or Country)

Finland

12. MAIDEN NAME OF MOTHER

Amalia Krew

13. BIRTHPLACE OF MOTHER

(State or Country)

Finland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Theodore Peterson

(Address)

Mullan, Ida15. **May 18** 19**22**
File

Local Registrar

MEDICAL CERTIFICATE OF DEATH

30

16. DATE OF DEATH

5 **15** **1922**
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from **May 9 1922**, to **May 15 1922** that I last saw him alive on **13 of May 1922** and that death occurred on the date stated above, at **11:25 A.M.**

The CAUSE OF DEATH* was as follows:

Tubercular Meningitis**about** (Duration) Yrs. mos. **14** ds.
Contributory **Pulmonary Tuberculosis**
(Secondary)(Duration) Yrs. mos. ds.
(Signed) **F H Ralph** M. D.**5/15** 19**22** (Address) **Mullan, Ida**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death **Provident Hospital Wallace** yrs. mos. **7** days. State yrs. mos. daysWhere was disease contracted if not at place of death? **Working in mines**

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Mullan Idaho

DATE OF BURIAL

May 18 1922

20. UNDERTAKER

Ward's Undertaking Co. Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Shoshone*
City of *Wallace*Registration District No. *70*Primary Registration District No. *9*(No. *Providence Hospital*)File No. *38649*Registered No. *2*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ida Grace Hemmood

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

Nov 18 1866
(Month) (Day) (Year)

7. AGE

55 Yrs. *6* Mos. *1* ds. *X*IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)*Housewife*

9. BIRTHPLACE

(State or Country)

Washington

10. NAME OF FATHER

Richard Siebert

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Fails

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. T. Hemmood
*Kellogg Ida*Filed *May* 19 *22*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 19 22
(Month) (Day) (Year)17. I HEREBY CERTIFY That I attended deceased from *May 14 22* to *May 19 22*that I last saw *her* alive on *May 19 22*and that death occurred on the date stated above, at *3:45* P.M.

The CAUSE OF DEATH* was as follows:

Myocarditis, Pericarditis, Suppurative(Duration) Yrs. mos. ds. *5*
Contributing (Secondary) *Suppurative*(Duration) Yrs. mos. ds. *2*(Signed) *J. T. Hemmood* M.D.19 *22* (Address) *Wallace Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Kellogg Ida 5-19-22

20. UNDERTAKER

B. Norwalk Wallace

FORM V. S. No. 3-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **38641**

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of *Shoshone*City of *Wallace*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No. _____

Precinct Registration District No. _____

(Name) *Wallace Hospital* (St.)*James Nicholls*

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

*male white**single*
(Write the word)

6. DATE OF BIRTH

July 13 1860
(Month) (Day) (Year)

7. AGE

61 Yrs. *10* Mos. *6* ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

miner

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

Henry Nichols

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Anna Thomas

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wallace Hospital
(Address) *Wallace, Idaho*15. *ma*

FNU

19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

28

16. DATE OF DEATH

May 19 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

4/22 19*21*, to *5/19/21* 19*21*that I last saw him alive on *5/19/21* 19*21*and that death occurred on the date stated above, at *10³⁰* M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(Duration) *1* yrs. *0* mos. *0* ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Wm. E. Thurman

M. D.

19

(Address)

Wallace, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Wallace Idaho

DATE OF BURIAL

5-22-1921

20. UNDERTAKER

B. G. Morrell

ADDRESS

Wallace

FORM V. S. No. 3-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Shoshone
County of
City of Wallace

Registration District No.

Primary Registration District No.

File No. 38642

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Saltara

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-OWED OR DIVORCED

male white

(Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

82

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

none

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Finland

10. NAME OF FATHER

not known

11. BIRTHPLACE OF FATHER

(State or Country)

u

u

12. MAIDEN NAME OF MOTHER

u

u

13. BIRTHPLACE OF MOTHER

(State or Country)

u

u

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Rosalie H. Saltara
Wallace Id

(Address)

Filed

19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 21 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 4 1922, to May 21 1922

that I last saw him alive on May 20 1922
and that death occurred on the date stated above, at 6:45 P.

The CAUSE OF DEATH* was as follows:

Fractured Hip

(Duration) Yrs. 3 mos. ds.

Contributory (Secondary)

Fractured Hip

(Duration) Yrs. 3 mos. ds.

(Signed)

James R. Bean

M. D.

(Address)

Wallace

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Wallace Id

DATE OF BURIAL

May 2 1922

20. UNDERTAKER

B. G. Morrell

ADDRESS

Wallace

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH *Shoshone*
 County of *Shoshone* Registration District No. *7*
 City of *Burke* Primary Registration District No. *1*
 (No. *1* St.)

File No. *38643*
 Registered No. *151-6*

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Alda Monegles

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M.* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *single*
 (Write the word.)
 6. DATE OF BIRTH *May 14 1922*
 (Month) (Day) (Year)
 7. AGE *2* yrs. *2* mos. *2* ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

none

9. BIRTHPLACE

(State or Country)

Burke Idaho

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

John Monegles
Italy

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Eva Rhena
Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

John Monegles
Burke Ida.

15. *May 8* 19*22*
 Filed *May 8* 19*22*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 16 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *May 14 1922* to *May 16 1922*
 that I last saw *him* alive on *May 16 1922*
 and that death occurred on the date stated above, at *2:30 PM*.

The CAUSE OF DEATH* was as follows:

Congenital atelectasis
lung(Duration) *2* yrs. *2* mos. *2* ds.

Contributory (Secondary)

(Duration) *2* yrs. *2* mos. *2* ds.

(Signed)

2/17 1922 (Address) *Wallace Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

none

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wallace Ida *May 18 1922*

20. UNDERTAKER

ADDRESS

Ward and Co *Wallace*
Ida

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **38544**Registered No. **7**

1. PLACE OF DEATH

County of **Shoshone**
City of **Mullan**Registration District No. **72**Primary Registration District No. **72**(No. **72**, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Helen Ambrosia Freestig

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Girl

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Dec 10 1922
(Month) (Day) (Year)

7. AGE

Yrs. 5 Mos. 24 da.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

Infant

9. BIRTHPLACE

(State or Country)

Shoshone Co Ida

10. NAME OF FATHER

Frank Isaac Freestig

11. BIRTHPLACE OF FATHER

(State or Country)

Finland

12. MAIDEN NAME OF MOTHER

Hilda Peterson

13. BIRTHPLACE OF MOTHER

(State or Country)

Finland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Theodore Peterson

(Address)

Mullan Ida15. **May 11 1922**

19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 15 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 11 1922 to May 15 1922
that I last saw her alive on **May 15 1922**
and that death occurred on the date stated above, at **8:20 P.M.**

The CAUSE OF DEATH* was as follows:

Pneumonia(Duration) Yrs. mos. ds.
Contributory **Pulmonary Tuberculosis**
(Secondary)(Duration) Yrs. mos. ds.
At(Signed) **F W Ralph** M. D.**5/15 1922** (Address) **Mullan Ida**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

At home

Former or usual residence

Mullan Ida

19. PLACE OF BURIAL OR REMOVAL

Mullan Ida

DATE OF BURIAL

May 15 1922

20. UNDERTAKER

Ward W. Tohy

ADDRESS

Wallace Id

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No.

Primary Registration District No.

(No.)

(St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Signed)

4/14/22

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs mos days In the State yrs mos days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 123County of Shoshone

Primary Registration District No. _____

City of Kellogg

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lula Nadine FisherFile No. 38646Registered No. 23

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

F.whitesingle
(Write the word.)

6. DATE OF BIRTH

Mar
(Month)2
(Day)1922
(Year)

7. AGE

Yrs1Mos21dsIF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

at home

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Kellogg, Ida

10. NAME OF FATHER

Floyd D. Fisher

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Eldora Newman

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Floyd Fisher

(Address)

Kellogg, Idaho

15.

Filed

June 14 / 1922E. E. Harg

Local Registrar

16. DATE OF DEATH

Apr
(Month)23
(Day)1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar 2 1922 to Apr 21 1922that I last saw her alive on Apr 21 1922

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Malnutrition

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

J. R. Mason

M. D.

5/2 1922 (Address) Kellogg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Kellogg, IdahoApr 25, 1922

20. UNDERTAKER

ADDRESS

W. C. Horn Kellogg, Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **38647**
Registered No. **19**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH *Shoshone* Registration District No. *123*
 County of *Shoshone* Registration District No. *123*
 City of *Kellogg* (St.)
 If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Allen Manfred Rose*

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*
 (Write the word.)

6. DATE OF BIRTH *March 20 1922*
 (Month) (Day) (Year)

7. AGE *27* yrs. *27* mos. *27* ds.
 IF LESS than 1 day
 how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE *Kellogg Idaho*
 (State or Country)

10. NAME OF FATHER *Carl H Rose*

11. BIRTHPLACE OF FATHER *Sweden*
 (State or Country)

12. MAIDEN NAME OF MOTHER *Hannah Victoria Nelson*

13. BIRTHPLACE OF MOTHER *So. Dakota*
 (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Carl H. Rose*
 (Address) *Kellogg Idaho*

15. Filed *4/17/1922* *E E Hard*
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *April 16 1922*
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *April 14 1922* to *April 14 1922*
 that I last saw him alive on *April 14 1922*
 and that death occurred on the date stated above, at *M.*

The CAUSE OF DEATH* was as follows:

Septic Arthritis
 (Duration) yrs. mos. ds.

Contributory *myocarditis*
 (Secondary)

(Duration) yrs. mos. ds.

(Signed) *E E Hard* M. D.

4/17/1922 (Address) *Kellogg Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Idaho* DATE OF BURIAL *4/19 1922*

20. UNDERTAKER *No Undertaker* ADDRESS

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

Registration District No.

Registration District No.

(No.)

(St.)

File No.

Registered No.

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF
FATHER11. BIRTHPLACE
OF FATHER

(State or Country)

12. MAIDEN NAME
OF MOTHER13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

June 14 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. P. Mason M. D.

57/10.2.2 (Address) Kellogg,

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Registration District No.

Primary Registration District No.

(No. 321-2 Division St.)

File No.

Registered No.

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF
FATHER11. BIRTHPLACE
OF FATHER

(State or Country)

12. MAIDEN NAME
OF MOTHER13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

JUN 23 1922

Registration District No. 123

County of

Primary Registration District No.

City of

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

File No. 38650
Registered No. 28

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED
married
(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15. Filled

June 14 1922

E. E. Hardy

Local Registrar

16. DATE OF DEATH

Apr. 26 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 24 — 1922, to April 26 — 1922

that I last saw her alive on April 26 — 1922 and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Peritonitis following
Septic Abortion self induced(Duration) Yrs. mos. 2 ds.
Contributory (Secondary) Abortion(Duration) Yrs. mos. 7 ds.
(Signed) E. E. Hardy M. D.

4/27/1922 (Address) Kellogg Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Kellogg, Wash

4/29/22

20. UNDERTAKER

ADDRESS

M. C. Shawnee

Kellogg Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 36

County of Twin Falls

Primary Registration District No.

City of Kimberly

(No. , St.)

File No. 38653

Registered No. 9

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emma Maria Morrill

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

female

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

S (Write the word.)

6. DATE OF BIRTH

May 26 1921
(Month) (Day) (Year)

7. AGE

1 yrs. 5 mos. 5 ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Rupert Morrill

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Zella Miller

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Rupert Morrill

(Address) Kimberly, Idaho

15.

Filed June 2, 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH. qv

16. DATE OF DEATH

June

1

1922

(Month)

(Day)

191

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Seen after death

191

that I last saw h. alive on 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

probable cause :-

pneumonia

(Duration) yrs. mos. 3 ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

M. D.

6/2 1922 (Address) Kimberly, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

yrs. mos. days.

In the State

yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Twin Falls

June 2 1922

20. UNDERTAKER

ADDRESS

FORM V. S. No. 5-A—25 M. 1-19.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No. 36

Primary Registration District No.

(No.)

38654

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

1922 to 1922

that I last saw him alive on 6/19/1922

and that death occurred on the date stated above, at 6:20 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) Yrs. mos. ds.

Contributory (Secondary) Birth injuries

(Duration) Yrs. mos. ds.

(Signed) W. G. Taylor M. D.

6/20/1922 (Address) Twin Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

J. N. DAVIS, M. D.
KIMBERLY, IDAHO

July 5, 1922

State Registrar :-

I do not believe that Pindick baby is n
given correct for as near as I can get the situation they
are not married and these people simply gave his name as the
most probable father of the baby.

Yours,

J. N. Davis

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No. 37

Primary Registration District No. 1085

(No.)

(St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 38657

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

av

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed June 9 1922

Local Registrar

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from
April 30th 1922 to May 19th 1922
that I last saw her alive on May 19th 1922
and that death occurred on the date stated above, at 10 P.M.
The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

5/22 1922 (Address) Twin Falls, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

FORM V. S. No. 5-A-25 M. 1-19.

RECEIVED
JUN 23 1922

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 38658
Registered No.1. PLACE OF DEATH
County of Twin Falls
City of Twin Falls
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

James Richard Speraw

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-OWED OR DIVORCED Single
(Write the word.)
6. DATE OF BIRTH July 8 1922
(Month) (Day) (Year)
7. AGE 73 Yrs. 10 Mos. 7 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Farmer

9. BIRTHPLACE

(State or Country)

Kan

10. NAME OF FATHER

E. S. Speraw

11. BIRTHPLACE OF FATHER

(State or Country)

Kan

12. MAIDEN NAME OF MOTHER

Mary Holloway

13. BIRTHPLACE OF MOTHER

(State or Country)

Ind.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. D. J. Smith

(Address)

Twin Falls, Ida.

15.

Filed June 9 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

159

16. DATE OF DEATH

May 10 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19
that I last saw h. alive on 19
and that death occurred on the date stated above, at 7 A. M.

The CAUSE OF DEATH* was as follows:

Gun shot wound through heart.
Suicidal

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

J. F. Grossman, Coroner

5/11/1922

(Address)

Twin Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Twin Falls, Ida.

5/14/1922

20. UNDERTAKER

ADDRESS

J. F. Grossman

Twin Falls, Ida.

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Twin Falls* Registration District No. *37*
 City of *Knoll* Primary Registration District No. *2085*
 (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Alvin Holloway

Bieles
 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. *38659*
 Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male White Married (Write the words)

6. DATE OF BIRTH

April 6 1928
 (Month) (Day) (Year)

7. AGE

74 Yrs. *1* Mos. *30* ds.

IF LESS than 1 day
 how many _____ hrs.
 or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

Farmer retired

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

David Holloway

11. BIRTHPLACE OF FATHER

(State or Country)

Tenn.

12. MAIDEN NAME OF MOTHER

Mary B. Blakey

13. BIRTHPLACE OF MOTHER

(State or Country)

Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Alvin Holloway

(Address)

Knoll, Ida.

15.

Filed *June 9-22* 19 *22*

John B. Knapton
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 5 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan. 1920 19 to *June 1922*
 that I last saw him alive on *May 28 1922*
 and that death occurred on the date stated above, at *12:00 P.M.*

The CAUSE OF DEATH* was as follows:

Dilatation, chronic cardiac

(Duration) _____ Yrs. *6* mos. _____ ds.
 Contributory (Secondary) *Arteriosclerosis, hypertension*

(Duration) *15* yrs. _____ mos. _____ ds.
 (Signed) *Hal Bieles M. D.*

June 7 1922 (Address) *Twin Falls, Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Twin Falls June 6 1922

20. UNDERTAKER ADDRESS

W. J. Harrison Twin Falls

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Twin Falls* Registration District No. *37*
 City of *BUR* Primary Registration District No. *1085*
 (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Matthew Batty

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. *38660*
 Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *m* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*
 (Write the word.)

6. DATE OF BIRTH

Nov 5 1850
 (Month) (Day) (Year)

7. AGE

72 Yrs. Mos. ds.

IF LESS than 1 day
 how many hrs.
 or min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

farmer

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

Geo Batty

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Encara Woodcock

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Grant Batty

(Address)

15.

Filed *June 9 1922*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 31 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 25th 1922 to May 31st 1922
 that I last saw him alive on *May 31st 1922*
 and that death occurred on the date stated above, at *2 P.M.*
 The CAUSE OF DEATH* was as follows:

apoplexy

(Duration) Yrs. *1* mos. *6* ds.

Contributory
 (Secondary)

arterio Sclerosis (Duration) Yrs. *?* mos. *?* ds.

(Signed)

Duncan L. Alexander M.D.

1922 (Address) *Twin Falls Id.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Twin Falls *June 2 1922*

20. UNDERTAKER

ADDRESS

J. E. Hunt *Twin Falls*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 38661
Registered No.

1. PLACE OF DEATH

Registration District No. 37
County of Miss Falls Primary Registration District No. 1085
City of Miss Falls (No. 1085 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mattie A. Savage

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married

6. DATE OF BIRTH Dec 20 1864
(Month) (Day) (Year)

7. AGE 57 Yrs. 5 Mos. 7 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Housewife

9. BIRTHPLACE

(State or Country) Oregon

10. NAME OF FATHER

William F. Rose

11. BIRTHPLACE OF FATHER

(State or Country) Mo.

12. MAIDEN NAME OF MOTHER

Sarah A. Price

13. BIRTHPLACE OF MOTHER

(State or Country) Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) M. E. Savage
(Address) Kirkley Court #2

15. Filed June 9 1922
H. W. F. Goughlin
Local Registrar

MEDICAL CERTIFICATE OF DEATH

91

16. DATE OF DEATH May 27 1922
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from May 11, 1922 to May 26 1922, that I last saw h.w. alive on May 26 1922, and that death occurred on the date stated above, at 2 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia, m.m.

(Duration) Yrs. mos. 14 ds.
Contributory (Secondary) Meningitis

(Duration) Yrs. mos. 2 ds.
(Signed) O. F. Passer M. D.

May 29, 1922 (Address) Miss Falls, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Miss Falls May 29 1922

20. UNDERTAKER

ADDRESS

P. J. Roseman Miss Falls

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 37

County of

Primary Registration District No. 1085

City of

(No.

St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mrs Elvie L. Hayden

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female

White

Married
(Write the word.)

6. DATE OF BIRTH

Dec

28

1893
(Month) (Day) (Year)

7. AGE

28

Yrs.

4

Mos.

29

ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Neb.

10. NAME OF FATHER

John Lockwood.

11. BIRTHPLACE OF FATHER

(State or Country)

Mich.

12. MAIDEN NAME OF MOTHER

Not known

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

L. M. Hayden

(Address)

Buhl, Ida

15.

Filed June 9 1922

J. B. Brough
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May

27

1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 23 1922 to May 27 1922

that I last saw him alive on May 26 1922

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Ovarian tumor & Pyosalpinx

(Duration) 2 Yrs. mos. ds.

Contributory (Secondary) Laparotomy

(Duration) Yrs. mos. ds.

(Signed) C. J. McCluskey M. D.

May 27 1922 (Address) Buhl, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Beldord, Iowa

19

20. UNDERTAKER

ADDRESS

J. B. Brough

CERTIFICATE OF DEATH

1. PLACE OF DEATH

Registration District No. 37
 County of Terrell Primary Registration District No. 1085
 City of Terrell (No. 1 St.)

If death occurs away from
 usual residence, give facts
 called for under special in-
 formation.

2. FULL NAME

Margarett Dugman

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 38663
 Registered No. _____

If death occurred in a hos-
 pital, institution or camp,
 give its NAME instead of
 street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED Married

6. DATE OF BIRTH

(Month) _____ (Day) _____ (Year) _____

7. AGE

47 Yrs. _____ Mos. _____ ds.

IF LESS than 1 day
 how many _____ hrs.
 or _____ min.?

8. OCCUPATION

(a) Trade, profession or
 particular kind of work.
 (b) General nature of in-
 dustry, business or estab-
 lishment in which employ-
 ed (or employer)

House Wife

9. BIRTHPLACE

(State or Country)

Mo.

10. NAME OF FATHER

Thomas Lawton

11. BIRTHPLACE OF FATHER

(State or Country)

Ill.

12. MAIDEN NAME OF MOTHER

Elizabeth Whelan

13. BIRTHPLACE OF MOTHER

(State or Country)

Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wm. H. Dugman

(Address)

Terrell Falls, Idaho

15.

Filed June 9-22 1922

John F. Long
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May

12 (Month) 22 (Day) 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 1-4 1920, to May 12 1922
 that I last saw h- alive on May 11 1922
 and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus(Duration) Yrs. 18 mos. _____ ds.Contributory (Secondary) Carcinoma of uterus (removed)(Duration) yrs. 6 mos. _____ ds.(Signed) W. G. T. M. D.s/p/1922 (Address) Terrell Falls, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state
 (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted
 if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Niantic, Ill.19

20. UNDERTAKER

ADDRESS

J. F. Grossman Terrell Falls, Idaho

1. PLACE OF DEATH *Twain Falls*
 County of *Twain Falls*
 City of *"*
 (No. *301 5th Ave W* St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Chas Wilson Strain

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. *38664*
 Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*
 (Write the word.)

6. DATE OF BIRTH *Sept 20 1858*
 (Month) (Day) (Year)

7. AGE *63* Yrs. *7* Mos. *29* ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

Merchant
Produce Buyer

9. BIRTHPLACE

(State or Country)

Ill.

10. NAME OF FATHER

James Harvey Strain

11. BIRTHPLACE OF FATHER

(State or Country)

Ind.

12. MAIDEN NAME OF MOTHER

Lidia Wisman

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

O. E. Dillard

(Address)

Burley, Idaho

15.

Filed *June 9* 19 *22*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

91

16. DATE OF DEATH

May 18 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *May 16 1922* to *May 18 1922* that I last saw him alive on *May 18 1922* and that death occurred on the date stated above, at *10 A.M.*

The CAUSE OF DEATH was as follows:

Broncho-pneumonia

(Duration) *3* mos. *3* ds.
 Contributory (Secondary) *apoplexy*

(Duration) *4* yrs. *4* ds.
 (Signed) *H. E. Ogden* M. D.

5-20-1922 (Address) *Twain Falls, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death *3* yrs. *3* mos. *3* days. In the State *3* yrs. *3* mos. *3* days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Twain Falls, Idaho *May 21 1922*

20. UNDERTAKER

ADDRESS

P. J. Grossman *Twain Falls, Idaho*

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH *RECEIVED*
 County of *Twin Falls* Registration District No. *37*
 Primary Registration District No. *1085*
 City of *"* (No. *BUREAU OF STATE* County Hospital *"* St.)

 File No. *38665*
 Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME *Mrs Edith Malmgren*

PERSONAL AND STATISTICAL PARTICULARS

 3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*
 (Write the word.)

 6. DATE OF BIRTH *June 23 1903*
 (Month) (Day) (Year)

 7. AGE *18* Yrs. Mos. ds. IF LESS than 1 day
 how many hrs. or min.?

8. OCCUPATION

 (a) Trade, profession or particular kind of work *House wife*
 (b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Utah.

10. NAME OF FATHER

John A. Grant

11. BIRTHPLACE OF FATHER

(State or Country)

Utah.

12. MAIDEN NAME OF MOTHER

Elizabeth Hendrickson

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *E. H. Malmgren*(Address) *Ames, Idaho*
 15. Filed *June 9* 19 *22*
Local Registrar *John F. Coughlin*

MEDICAL CERTIFICATE OF DEATH

 16. DATE OF DEATH *May 22 1922*
 (Month) (Day) (Year)

 17. I HEREBY CERTIFY, That I attended deceased from *May 22, 1922*, to *May 22, 1922*, that I last saw him alive on *May 22, 1922*, and that death occurred on the date stated above, at *9 P.* M. The CAUSE OF DEATH* was as follows:
Malposition of baby at delivery.

 (Duration) Yrs. mos. ds.
 Contributory *shock & hemorrhage*
 (Secondary)

(Duration) yrs. mos. ds.

(Signed) *D. J. J. J.* M. D.
 (Address) *Twin Falls*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Levan, Utah

19

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 37

County of

Primary Registration District No. 1085

City of

(No. County Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

George Wesley Hartley

File No.

38666

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

6. DATE OF BIRTH

Oct

16

1922

(Month)

(Day)

(Year)

7. AGE

11 Yrs. 6 Mos. 22 ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

School Boy

9. BIRTHPLACE

(State or Country)

La Grande, Oregon

10. NAME OF FATHER

Grover J. Hartley

11. BIRTHPLACE OF FATHER

(State or Country)

Wyo.

12. MAIDEN NAME OF MOTHER

Laura Nettie Large

13. BIRTHPLACE OF MOTHER

(State or Country)

Wyo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Grover J. Hartley

(Address)

Eaton

15.

Filed June 9 1922

John H. Long

Local Registrar

MEDICAL CERTIFICATE OF DEATH

79

16. DATE OF DEATH

May 8th

(Month)

(Day)

1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 7 1922, to May 8th 1922that I last saw him alive on May 8th 1922

and that death occurred on the date stated above, at 441 M.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) Yrs. mos. 14 ds.

Contributory (Secondary)

Scarlet Fever

(Duration) Yrs. mos. ds.

(Signed)

J. H. Long M. D.

58 1922 (Address) Twin Falls, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Twin Falls, Idaho

May 13 1922

20. UNDERTAKER

ADDRESS

J. F. Rozman

Twin Falls, Idaho

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
JUN 22 1922

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

Registration District No. 37

Primary Registration District No. 1085

File No.

38667

City of

(No.

St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Abraham M. Hilary

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

M

white

Married
(Write the word.)

6. DATE OF BIRTH

Mar 1

(Month)

(Day)

1843
(Year)

7. AGE

79

Yrs.

Mos.

ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

farmer

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Ida

10. NAME OF FATHER

John Hilary

11. BIRTHPLACE OF FATHER

(State or Country)

not known

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. W. Hilary
Twin Falls, Ida

(Address)

15.

Filed June 9-22 19

John F. Houghton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 7

(Month)

(Day)

1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

1917

to

6/7

1922

that I last saw him alive on

6/7

1922

and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Paralysis agitans

(Duration)

8

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

B. S. Weaver

M. D.

19

(Address)

Twin Falls,

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Twin Falls

DATE OF BURIAL

6-9-22

20. UNDERTAKER

B. S. Weaver

ADDRESS

Twin Falls

RECEIVED CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 37
County of *Juniper* Primary Registration District No. 1085
City of *Juniper* No. *1085* St.)File No. *38868*
Registered No. *38868*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Norman Lillmore

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male white white (Write the word.)

6. DATE OF BIRTH

March 1 1888
(Month) (Day) (Year)

7. AGE

*74 Yrs. 3 Mos. 6 ds.*IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

farmer

9. BIRTHPLACE

(State or Country)

Iris

10. NAME OF FATHER

Wilton Lillmore

11. BIRTHPLACE OF FATHER

(State or Country)

Nat Knowen

12. MAIDEN NAME OF MOTHER

June Shodba

13. BIRTHPLACE OF MOTHER

(State or Country)

Nat Knowen

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Q. E. Lillmore*
(Address)

15.

Filed *June 9-22* 19*22**John F. Campbell*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

92

16. DATE OF DEATH

June 6 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

*6-2 1922 to 6-6 1922*that I last saw him alive on *6-6 1922*and that death occurred on the date stated above, at *PM*

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

T. S. Mason M. D.19. (Address) *Juniper Falls*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Juniper Falls

DATE OF BURIAL

6 11 1922

20. UNDERTAKER

J. E. Hart

ADDRESS

Juniper Falls

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of

Registration District No.

37

Primary Registration District No.

1085

City of

State (No.

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Thomas Baynes

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

38669

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Not Known

(Month)

(Day)

(Year)

7. AGE

15

Yrs.

Mos.

ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Furniture

(b) General nature of industry, business or establishment in which employed (or employer)

Laborer

9. BIRTHPLACE

(State or Country)

Not Known

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

June 9-22

Filed

19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

120

16. DATE OF DEATH

June

(Month)

2nd

(Day)

1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 29, 1922, to June 2, 1922

that I last saw him alive on June 2, 1922

and that death occurred on the date stated above, at 1:00 P.M.

The CAUSE OF DEATH* was as follows:

Acute Poisoning

(Duration) Yrs. mos. ds.

Contributory Chronic Nephritis

(Secondary)

(Duration) yrs. mos. ds.

(Signed) Joseph Orpel M. D.

19 (Address) Twin Falls, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Twin Falls

June 6, 1922

20. UNDERTAKER

ADDRESS

J. C. Grossman

Twin Falls

CERTIFICATE OF DEATH

1. PLACE OF DEATH
 County of Twin Falls Registration District No. 37
 City of Idaho Primary Registration District No. 1080
 (State) (City) (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Chas Sam Pawson

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 38670

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male White Married
 (Widow or Divorced)

6. DATE OF BIRTH

Aug 19 1884
 (Month) (Day) (Year)

7. AGE

37 Yrs. 8 Mos. 11 ds.

IF LESS than 1 day
 how many _____ hrs.
 or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Farmer
 (b) General nature of industry, business or establishment in which employed (or employer) Owner

9. BIRTHPLACE

(State or Country) Wis.

10. NAME OF FATHER

W. F. Pawson.

11. BIRTHPLACE OF FATHER

(State or Country) Eng.

12. MAIDEN NAME OF MOTHER

Martha Gardner

13. BIRTHPLACE OF MOTHER

(State or Country) Wis.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Chas Pawson.

(Address) Twin Falls Ida.

15.

Filed June 14 1922

John L. Goughlin
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 12 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 7, 1922 to June 12, 1922
 that I last saw him alive on June 12, 1922
 and that death occurred on the date stated above, at 10:30 A.M.

The CAUSE OF DEATH* was as follows:

Rocky Mountain Spotted Fever.

(Duration) _____ Yrs. _____ mos. 4 weeks.
 Contributory (Secondary) kidney dilatation.

(Duration) _____ Yrs. _____ mos. _____ ds.
 (Signed) W. F. Pawson M. D.

June 14, 1922 (Address) Twin Falls Id.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Twin Falls Ida.

5/4 1922

20. UNDERTAKER

P J Grossman

ADDRESS

June 14, 1922

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 34
County of Twin Falls Primary Registration District No. 1080
City of Idaho Falls (No. 1180) St.)File No. 38572
Registered No. 38572

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary Elizabeth Conway

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH

Aug. 22 1956
(Month) (Day) (Year)

7. AGE

52 Yrs. 10 Mos. 22 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).House Wife

9. BIRTHPLACE

(State or Country)

Montana

10. NAME OF FATHER

W. G. Edwards

11. BIRTHPLACE OF FATHER

(State or Country)

Don't know

12. MAIDEN NAME OF MOTHER

Mary E. Harris

13. BIRTHPLACE OF MOTHER

(State or Country)

Don't know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

E. R. Conway
Twin Falls

15.

Filed June 15 1922John F. Coughlin
Local Registrar

16. DATE OF DEATH

June 14 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19..... to 19.....
that I last saw him alive on 19.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Cerebral Palsy

(Duration) Yrs. mos. ds.

Contributory Secondary Infection Infectious
(Secondary) teeth trouble & high blood pressure
(Duration) Yrs. mos. ds.(Signed) Dr. J. R. Morgan M. D.June 15, 1922 (Address) Twin Falls, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Twin Falls, Ida.June 15, 1922

20. UNDERTAKER

ADDRESS

J. P. BowmanTwin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Jun Falls Registration District No. 34
Primary Registration District No. 1085
City of Jun Falls (No. 3105 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Nile J. KraussFile No. 38673

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDM white Married
(Write the word.)

6. DATE OF BIRTH

Sep 7 1922
(Month) (Day) (Year)

7. AGE

1 Yrs. 9 Mos. 8 ds.
IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Infant

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Sherman Krauss

11. BIRTHPLACE OF FATHER

(State or Country)

Iowa

12. MAIDEN NAME OF MOTHER

Lura Maud

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Sherman Krauss

(Address)

320 Quincy St

15.

Filed 6 16 1922John F. Coughlin
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

6 15 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 27 1922 to June 15 1922
that I last saw him alive on June 15 1922
and that death occurred on the date stated above, at 11 AM.

The CAUSE OF DEATH* was as follows:

Surg. Shock.(Duration) Yrs. mos. 30 min.
Contributory Pneumonia Empyema
(Secondary) Pneumonia Empyema
(Duration) Yrs. mos. 6 weeks(Signed) CA. Emur. M. D.45 1922 (Address) Jun Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Jun Falls 6 18 1922

20. UNDERTAKER

ADDRESS

HE & CO. Jun Falls

CERTIFICATE OF DEATH

1. PLACE OF DEATH
 County of Twin Falls Registration District No. 37
 City of Twin Falls Primary Registration District No. 1082
 (State) Idaho (No.) 1082 (City) Twin Falls (St.) Idaho
 BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. Edna Miller

Coughlin
 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 38574
 Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married (See word.)

6. DATE OF BIRTH
March 17 1894
 (Month) (Day) (Year)

7. AGE 28 Yrs. 2 Mos. 29 ds.
 IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Housewife
 (b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE
 (State or Country) Iowa

10. NAME OF FATHER
Martin Craig

11. BIRTHPLACE OF FATHER
 (State or Country) Iowa

12. MAIDEN NAME OF MOTHER
Ella Ruckman

13. BIRTHPLACE OF MOTHER
 (State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Lloyd Miller
 (Address) Twin Falls Idaho

15. John H. Coughlin
 Filed June 17 1922 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
June 16 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 11 1922 to June 16 1922
 that I last saw her alive on June 16 1922
 and that death occurred on the date stated above, at 11:45 AM

The CAUSE OF DEATH* was as follows:

Peritonitis
 (Duration) Yrs. mos. 24 hrs.
rupture of abscess in abdomen
 (Secondary)
 (Duration) Yrs. mos. 10 ds.
 (Signed) C. Coughlin M. D.
4/6 1922 (Address) Twin Falls Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Creston Iowa 19

20. UNDERTAKER ADDRESS
J. J. Green Twin Falls

RECEIVED
JUL 1922

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Twin Falls.City of Twin Falls.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John S KimesRegistration District No. 37Primary Registration District No. 1080No. 37108

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 38675

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married (word.)

6. DATE OF BIRTH

Oct61845

(Month)

(Day)

(Year)

7. AGE

76

Yrs.

6

Mos.

6

ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry, business or establishment in which employed (or employer)

Retired

9. BIRTHPLACE

(State or Country)

Ky.

10. NAME OF FATHER

Andy Kimes

11. BIRTHPLACE OF FATHER

(State or Country)

Ky.

12. MAIDEN NAME OF MOTHER

Not Known

13. BIRTHPLACE OF MOTHER

(State or Country)

" "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John S Kimes Jr

(Address)

Twin Falls, Ida.

15.

Filed June 17 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June

(month)

12

(Day)

19

22

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 11th 1922 to June 12 1922that I last saw him alive on June 12 1922and that death occurred on the date stated above, at 6:45 M.

The CAUSE OF DEATH* was as follows:

Peritonitis & acute

(Duration)

Yrs.

mos.

13 ds.Contributory
(Secondary)Perforated gastric ulcer

(Duration)

Yrs.

mos.

4 ds.

(Signed)

Samuel L. Hixson D.y/s 1922

(Address)

Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Boise Idaho

19

20. UNDERTAKER

ADDRESS

W. J. GroenmanTwin Falls

RECORDED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Twin FallsRegistration District No. 37

City of " " (No.) (St.)

Primary Registration District No. 1085File No. 38576

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hosea D. Whitzel

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married

(Write the word.)

6. DATE OF BIRTH

April11856

(Month)

(Day)

(Year)

7. AGE

66218

ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Gardner

(b) General nature of industry, business or establishment in which employed (or employer)

Landscape.

9. BIRTHPLACE

(State or Country)

Ohio.

10. NAME OF FATHER

Jessie D Whitzel

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio.

12. MAIDEN NAME OF MOTHER

Zura Folden

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Robert Whitzel(Address) Twin Falls, Ida.

15.

Filed 6 17 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb. 9 1921, to June 16 1922that I last saw him alive on June 16 1922and that death occurred on the date stated above, at 1230 a. M.

The CAUSE OF DEATH* was as follows:

Melanotic Sarcoma, multiple.(Duration) 1 Yrs. 5 mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

H. W. Wilson M. D.(Address) Twin Falls, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Twin Falls, Ida.June 22, 1922

20. UNDERTAKER

ADDRESS

P J GrossmanTwin Falls, Ida.

CERTIFICATE OF DEATH

1. PLACE OF DEATH *Twin Falls*
 County of *Twin Falls* Registration District No. *34*
 City of *Twin Falls* Primary Registration District No. *1085*
 (No. *VITAL* St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Bertha Cook

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. *38678*
 Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*
 (Write the word.)

6. DATE OF BIRTH *Jan 27 1892*
 (Month) (Day) (Year)

7. AGE *30* Yrs. *4* Mos. *23* ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

Housewife

9. BIRTHPLACE

(State or Country)

Ark.

10. NAME OF FATHER

Mark Twinstone

11. BIRTHPLACE OF FATHER

(State or Country)

Ga.

12. MAIDEN NAME OF MOTHER

Not known

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

I B Cook

(Address)

Eden, Ida.

15.

Filed *6 21 1922*

John H. Coughlin

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *June 20 1922*
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *June 16 - 1922* to *June 20 1922*
 that I last saw him alive on *June 19 1922*
 and that death occurred on the date stated above, at *12:30 pm*

The CAUSE OF DEATH* was as follows:

Peritonitis acute Streptococci

(Duration) Yrs. mos. ds.
 Contributory *Miscarriage 4 1/2 mos.*
 (Secondary) *on June 4/1922*
 (Duration) Yrs. mos. ds.

(Signed) *Wm. C. L. Thompson, M.D.*
June 20 1922 (Address) *Wm. C. L. Thompson*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Twin Falls Ida. DATE OF BURIAL *June 20 1922*

20. UNDERTAKER

J. J. Groves ADDRESS *Twin Falls*

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Timber Falls
City of Timber FallsRegistration District No. 34
Primary Registration District No. 1085
(No. 1085 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Alma RasmussenState of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 38579
Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED W
(Write the word.)

6. DATE OF BIRTH

June 22 1922
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or 20 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Viggo Rasmussen

11. BIRTHPLACE OF FATHER

(State or Country) Denmark

12. MAIDEN NAME OF MOTHER

Bessie Hyde

13. BIRTHPLACE OF MOTHER

(State or Country) La Grand Ore

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Viggo Rasmussen
(Address) Rock Creek, Ida.

15.

Filed 6 23 1922 John F. Coughlin
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 22 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from June 22 1922 to June 22 1922, that I last saw him alive on June 22 1922 and that death occurred on the date stated above, at 109 M.
The CAUSE OF DEATH* was as follows:
Asphyxiated caused by slow delivery.

(Duration) Yrs. mos. ds.

Contributory (Secondary) Unk presentator

(Duration) yrs. mos. ds.

(Signed) J. P. Davis M. D.6/22 1922 (Address) Kimberly Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Timber Falls

DATE OF BURIAL

6-23 1922

20. UNDERTAKER

F. B. Davis

ADDRESS

Timber Falls

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 38680

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of

Registration District No. 34

Primary Registration District No. 1085

City of

(No. 1085)

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1-26-1922

John A. Coughlin

Local Registrar

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

June 21, 1922 to June 26, 1922

that I last saw her alive on June 26, 1922

and that death occurred on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(Duration) Yrs. mos. ds.

Contributory (Secondary) Acute Intestinal Paresis Post-operative

(Duration) Yrs. mos. ds.

(Signed) S. H. Stand M. D.

4/26/22 (Address) Twin Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Twin Falls

6-28-1922

20. UNDERTAKER

ADDRESS

L. E. Deert

Twin Falls

FORM V. S. No. 5-A-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Twins Falls*Registration District No. *34 38*City of *Twins Falls* Primary Registration District No. *2086-1085*City of *BUR (No. 3438)*

St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Mildred M Rue

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

*May**15**1899*

(Month)

(Day)

(Year)

7. AGE

23

Yrs.

1

Mos.

14

ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Housekeeper

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Oklahoma

10. NAME OF FATHER

E E Wilcox

11. BIRTHPLACE OF FATHER

(State or Country)

Illinois

12. MAIDEN NAME OF MOTHER

Anna A Meacock

13. BIRTHPLACE OF MOTHER

(State or Country)

Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E E Wilcox

(Address)

Twins Falls

15.

Filed *June 30* 19 *19*

Local Registrar

John F. Coughlin

SYNOPSIS CO., PRINTERS & BINDERS, NOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 29

(Month)

(Day)

19 *19* (Year)I HEREBY CERTIFY, That I attended deceased from *June 26* 19 *19* to *June 30* 19 *19*that I last saw her alive on *June 29* 19 *19* and that death occurred on the date stated above, at *1 P.* M.

The CAUSE OF DEATH* was as follows:

Acute Aciprogitis

(Duration)

Yrs.

mos.

ds. *7*

Contributory (Secondary)

General Peritonitis

(Duration)

Yrs.

mos.

ds. *4*

(Signed)

A. A. Newberry M. D.

(Address)

Twins Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

1005 Cemetery

DATE OF BURIAL

July 1 19 *19*

20. UNDERTAKER

F. E. Drake

ADDRESS

Twins Falls

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
JUN 22 1922

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of WashingtonCity of Weiser

Registration District No.

Primary Registration District No.

(No.)

St.)

File No. 38582Registered No. 27

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Phebe Ann Woodland

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widow
(Write the word.)

6. DATE OF BIRTH

April 23 1836
(Month) (Day) (Year)

7. AGE

86 Yrs. 0 Mos. 9 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).At Home

9. BIRTHPLACE

(State or Country)

Canada

10. NAME OF FATHER

Silas Wilcox

11. BIRTHPLACE OF FATHER

(State or Country)

New York

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

France

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

E. E. Woodland
Weiser Ida

15.

Filed 5/17 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 12 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 10 1922 to May 12 1922
that I last saw him alive on May 10 1922
and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH was as follows:

Smile(Duration) about 1 hour Yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) G. M. Valukh M. D.May 13 1922 (Address) Weiser Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hillcrest Cemetery5-14-1922

20. UNDERTAKER

ADDRESS

Northam M. C. CarrWeiser Ida

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Washington
City of WenatcheeRegistration District No. 86
Primary Registration District No. 1010
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Elija MayesState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 38883Registered No. 38883

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

Wbr

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widowed
(Write the word.)

6. DATE OF BIRTH

Aug 16 1834
(Month) (Day) (Year)

7. AGE

87 Yrs. 8 Mos. 27 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)Housewife

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

John Satchel

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Mrs. J. E. Ingalls
Wenatchee, Ida.

15.

Filed

5/17 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 13 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 13 1922 to May 13 1922
that I last saw her alive on May 13 1922
and that death occurred on the date stated above, at 10:30 AM

The CAUSE OF DEATH* was as follows:

Sarcoma of the jaw

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

5/14 1922 (Address) Wenatchee, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Stillman Cemetery

DATE OF BURIAL

5/14 1922

20. UNDERTAKER

Northam McLean

ADDRESS

Wenatchee, Ida.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Washington
 City of Weiser

Registration District No. 86Primary Registration District No. 1010

(No. _____)

St. _____

If death occurs away from
 usual residence, give facts
 called for under special in-
 formation.

2. FULL NAME

Ellen Pearl Stover

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 38684Registered No. 29

If death occurred in a hos-
 pital, institution or camp,
 give its NAME instead of
 street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Female White

Widow
 (Write the word.)

6. DATE OF BIRTH

Sept 13 1844
 (Month) (Day) (Year)

7. AGE

77 Yrs. 8 Mos. 7 ds.

IF LESS than 1 day
 how many _____ hrs.
 or _____ min. ?

8. OCCUPATION

(a) Trade, profession or
 particular kind of work.
 (b) General nature of in-
 dustry, business or estab-
 lishment in which employ-
 ed (or employer)

Dressmaker

9. BIRTHPLACE

(State or Country)

Indiana

10. NAME OF
FATHER

Daniel Shaffer

11. BIRTHPLACE
OF FATHER

(State or Country)

12. MAIDEN NAME
OF MOTHER13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. J. J. Grubb

(Address)

Baker Ave.

15.

Filled 6/15 1922

H. P. Hamilton
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

154

16. DATE OF DEATH

5 20 19
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Nov 27 1920 to May 18 1922

that I last saw him alive on May 18 1922
 and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

senility

several Yrs. _____ mos. _____ ds.
 (Duration)

Contributory
(Secondary)

 (Duration) Yrs. _____ mos. _____ ds.

(Signed)

G. M. Mahan M. D.

May 21 1922 (Address) Weiser Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state
 (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted
 if not at place of death? _____

Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hillcrest Cemetery May 22 1922

20. UNDERTAKER

ADDRESS

Northam McCann Weiser

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

Registration District No.

Primary Registration District No.

(No.

St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

6/15

19 22

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed)

M. D.

(Address)

State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Washington
City of WeiserRegistration District No. 86Primary Registration District No. 1010

(No. _____)

St. _____

File No. 38586Registered No. 37

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Sarah Matilda Rambo

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female White

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widow
(Write the word.)

6. DATE OF BIRTH

Sept 30 1848
(Month) (Day) (Year)

7. AGE

73 Yrs. 7 Mos. 24 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

None

(b) General nature of industry, business or establishment in which employed (or employer).

Lived With Daughter

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

James S Phillips

11. BIRTHPLACE OF FATHER

(State or Country)

Ky.

12. MAIDEN NAME OF MOTHER

Nancy Ann. Rains

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Leonard H. Rambo(Address) Walla Walla Wash.

15.

Filed 6/5 19 22W. G. Rambo
Local Registrar

MEDICAL CERTIFICATE OF DEATH

79

16. DATE OF DEATH

May, 27th, 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May, 14th, 1922 to May, 27th, 1922that I last saw her alive on May 27th, 1922,
and that death occurred on the date stated above, at 7/1 PM.

The CAUSE OF DEATH* was as follows:

Myocarditis with Cardiac Dilation
and Valvular Incompetency.(Duration) _____ Yrs. 1 mos. _____ ds.Contributory Hypostatic Pulmonary Congestion
(Secondary)(Duration) _____ Yrs. _____ mos. 10 ds.(Signed) Ernest O. Finney M. D.5/27 1922 (Address) Weiser Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hillcrest Cemetery May 29, 1922

20. UNDERTAKER

ADDRESS

Northam McCarroll Weiser, Idaho

REC. NO. CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 86
County of Washington Primary Registration District No. 1010
City of Wenatchee St. File No. 38687Registered No. 32

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Elvablen Crim

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH

Oct 14 1922
(Month) (Day) (Year)

7. AGE

29 Yrs. 7 Mos. 16 ds. IF LESS than 1 day how many... hrs. or... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Housework

9. BIRTHPLACE

(State or Country)

Indo.

10. NAME OF FATHER

Chas Ingram

11. BIRTHPLACE OF FATHER

(State or Country)

Ky.

12. MAIDEN NAME OF MOTHER

Era. Brauer

13. BIRTHPLACE OF MOTHER

(State or Country)

Indo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Chas Ingram

(Address)

15.

Filed 6/10 1922J. P. Smith
Local Registrar

MEDICAL CERTIFICATE OF DEATH

28

16. DATE OF DEATH

May 30 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1922, to May 30 1922
that I last saw her alive on May 29 1922
and that death occurred on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:

Pulmonary TuberculosisContributory
(Secondary)(Duration) 2 Yrs. 2 mos. 5 ds.(Signed) C. C. R. Smith M. D.

19..... (Address).....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hillcrest Cemetery June 1 1922

20. UNDERTAKER

ADDRESS

Norman McCann Wenatchee, Id.

RECEIVED CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Washington
City of WeiserRegistration District No. 56Primary Registration District No. 1010

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John LoweState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 38588Registered No. 33

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male white Married
(Write the words.)

6. DATE OF BIRTH

Don't know
(Month) (Day) (Year)

7. AGE

About 48 yrs
Yrs. Mos. ds.IF LESS than 1 day
how many _____ hrs.
or _____ min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Laborer
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Virginia

10. NAME OF FATHER

Don't know

11. BIRTHPLACE OF FATHER

(State or Country) " " " "

12. MAIDEN NAME OF MOTHER

" " " "

13. BIRTHPLACE OF MOTHER

(State or Country) " " " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Lowe(Address) Harborside

15.

Filed June 4th 1922Dr. R. H. Havelin
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 30 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from May 22nd 1922, to May 30th 1922 that I last saw him alive on May 28th 1922 and that death occurred on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:

Rocky Mountain Slick Fever(Duration) _____ Yrs. _____ mos. 20 ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Dr. R. H. Havelin M. D.6/1 1922 (Address) Weiser, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hillcrest Cemetery 6-4 1922

20. UNDERTAKER

ADDRESS

Hartham McCann Weiser, Ida

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of AdaCity of Boise

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No. 2Primary Registration District No. 1004(No. 1501 N. 10 St.)

Sylvester R. Wells

38689

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 38689Registered No. 68

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

Sept 24 1840
(Month) (Day) (Year)

7. AGE

81 Yrs. 9 Mos. 15 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Retired

9. BIRTHPLACE

(State or Country)

Illinois

10. NAME OF FATHER

Joshua Wells

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Barbara Taylor

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Adelaide R. Wells(Address) 1501 N. 10th Ave.

15.

Filed 7-10 1922R. H. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 9 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 24 1922, to July 9 1922

that I last saw him alive on July 9 1922

and that death occurred on the date stated above, at 9:30 P.M.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis & Prostatic Hypertrophy

(Duration) 5 Yrs. mos. ds.

Contributory (Secondary) Myocarditis

(Duration) yrs. 2 mos. ds.

(Signed) T. M. Brattain M. D.

July 10 1922 (Address) Casper B. Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery July 11 1922

20. UNDERTAKER

ADDRESS

Mummers & Krebs Boise Idaho

CERTIFICATE OF DEATH

38690

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 38690
Registered No. 173

1. PLACE OF DEATH

County of Ada Registration District No. 2
City of Boise State Idaho

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

BUREAU OF VITAL STATISTICS

Agnes C. O'Brien

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)6. DATE OF BIRTH June 13 1872
(Month) (Day) (Year)7. AGE 50 Yrs. 1 Mos. 1 ds. IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Housewife

9. BIRTHPLACE

(State or Country)

Winn.

10. NAME OF FATHER

Henry Kelly

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Katherine Herald

13. BIRTHPLACE OF MOTHER

(State or Country)

Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Louise J. Kelly
(Address) Carlton Hotel, Portland, Ore.

15.

Filed July 17 1922R. H. Pratt
Local Registrar16. DATE OF DEATH July 15th 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from July 19th 1922 to July 14th 1922
that I last saw her alive on July 14th 1922
and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Hemorrhage from
fibroid tumor of uterus.
(Duration) 2 yrs. 0 mos. 0 ds.Contributory
(Secondary)(Duration) 0 yrs. 0 mos. 0 ds.

(Signed)

John B. Broun M. D.
7-15-1922 (Address) Boise, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 0 yrs. 0 mos. 0 days. In the State 0 yrs. 0 mos. 0 days

Where was disease contracted if not at place of death?

Former or usual residence Boise, Ida.19. PLACE OF BURIAL OR REMOVAL St. John's Cemetery DATE OF BURIAL 1920. UNDERTAKER Schreiber & Hedden, Inc. ADDRESS Boise

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH

County of *Boise*City of *Idaho City*

If death occurs away from usual residence, give facts called for under special information.

RECEIVED

AUG 2 1922

BUREAU OF
STATISTICS

CERTIFICATE OF DEATH

Registration District No. *8*Primary Registration District No. *2008*(No. *near Boston & Idaho Power Plant*)State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *38691*Registered No. *59*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

George Bennett

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married

(Write the word.)

6. DATE OF BIRTH

Jan

(Month)

13th 1869

(Day)

(Year)

7. AGE

53 Yrs. *5* Mos. *21* ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

*carpenter and
cabinetman*

9. BIRTHPLACE

(State or Country)

Philadelphia, Pa.

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

*Dont Know**Dont Know*

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

*Dont Know**Dont Know*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

*A. M. Larnham**Pineville, Ida.*

15.

Filed

*July 9 1922**R. H. Pratt*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 4th 1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

.....19....., to19.....

that I last saw him..... alive on.....19.....

and that death occurred on the date stated above, at.....M.

The CAUSE OF DEATH* was as follows:

Accidental

.....(Duration).....Yrs.....mos.....ds.

Contributory
(Secondary)

.....(Duration).....yrs.....mos.....ds.

(Signed)

George Wilhelm, Esq.

19.....

(Address)

Idaho City, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Marion Hill Cemetery**7/9/22*

20. UNDERTAKER

ADDRESS

Schreiber & Videnshagen, Boise

1. PLACE OF DEATH

County of *Ada*City of *Boise*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No. *9+10*Primary Registration District No. *9+10*

St.)

File No. *26* 19Registered No. *19*38692 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

m.

4. COLOR OR RACE

*W.*5. SINGLE, MARRIED, WID-
OWED OR DIVORCED*Single*
(Write the word.)

6. DATE OF BIRTH

Aug. 31 - 1921
(Month) (Day) (Year)

7. AGE

10 Yrs. *10* Mos. ds.

IF LESS than 1 day

how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

None.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Eagle, Idaho.

10. NAME OF FATHER

J. H. Copeland.

11. BIRTHPLACE OF FATHER

(State or Country)

Id.

12. MAIDEN NAME OF MOTHER

Bertha S. Atkins

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. McBoatney

(Address)

Boise Idaho.

15.

Filed *July 13* 19*22*

Local Registrar

Eagle Idaho.

16. DATE OF DEATH

July - 11 - 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov. 23 19*21*, to *about June 15* 19*22*
that I last saw him alive on *about June 15* 19*22*
and that death occurred on the date stated above, at *Id.* M.

The CAUSE OF DEATH* was as follows:

Hydrocephalus
*Maternal**Smear birth*

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Fredrick K. Livers M. D.*7/12* 19*22* (Address) *Boise Idaho.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Big Creek Cemetery**7/13* 19*22*

20. UNDERTAKER

ADDRESS

*W. McBoatney**Boise Idaho.*

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

38693 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada Registration District No. 9+10
 City of Boise Primary Registration District No. 9+10
 (No. 7 miles W of Boise St.)

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Fong Ying

File No. 20
 Registered No. 20

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

M. Yellow Single (Write the word.)

6. DATE OF BIRTH

1864
 (Month) (Day) (Year)

7. AGE

58 Yrs. Mos. ds. IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
 (b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer).

Laundryman

9. BIRTHPLACE

(State or Country)

China10. NAME OF
FATHERDong. Ock Chun11. BIRTHPLACE
OF FATHER

(State or Country)

China12. MAIDEN NAME
OF MOTHERUnknown13. BIRTHPLACE
OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Harry W. Fong
Boise, Idaho

15.

Filed

July 29 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

About May 25 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I saw attended deceased from
July 24 1922 to 19
 that I last saw him alive on 19

and that death occurred on the date stated above, at M

The CAUSE OF DEATH was as follows:

Found dead in river
Cause of death unknown

(Duration) Yrs. mos. ds.

Contributory
 (Secondary)

(Duration) yrs. mo. ds.

(Signed)

Chas. E. Summers M. D.
Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state
 (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
 if not at place of death?

Former or
 usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Chinese Cemetery July 25 1922

20. UNDERTAKER

ADDRESS

Summers & Wife Boise, Idaho

FORM V. S. No. 5-A—25 M. 1-19

RECEIVED
AUG 2 1922

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics1. PLACE OF DEATH **BUREAU OF VITAL STATISTICS**Registration District No. 2County of AdaPrimary Registration District No. 1004File No. 38694City of Borisi(No. St. Lukes Hospital)Registered No. 162

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Thos. Allen Baum

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDMale White Single
(Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

34 Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)Farmer

9. BIRTHPLACE

(State or Country)

Mo.

10. NAME OF FATHER

Paul Baum

11. BIRTHPLACE OF FATHER

(State or Country)

Penn.

12. MAIDEN NAME OF MOTHER

Clara J. Barrow

13. BIRTHPLACE OF MOTHER

(State or Country)

Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. J. Foley
Kuna, Ida.

15.

Filed July 4 1922

Local Registrar

16. DATE OF DEATH

July 3 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19..... to 19.....

that I last saw him alive on June 30 1922and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH was as follows:

Acute Acedia (?)

(Duration) Yrs. mos. ds.

Contributory Heart & Blood
(Secondary) Condition Cause undetermined

(Duration) Yrs. mos. ds.

(Signed) W. S. Foster M. D.7-4 1922 (Address) Borisi

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Hampe Idaho July 4 1922

20. UNDERTAKER

ADDRESS

W. H. Robinson Hampe

City of Boise BUREAU STATE (No. 470 State) St.) Registered No. 146
 If death occurs away from usual residence, give facts called for under special information.
 2. FULL NAME Forest W. See
 If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
 (Write the word.)

6. DATE OF BIRTH

January 30 1922
 (Month) (Day) (Year)

7. AGE

54 Yrs. 5 Mos. 2 ds.

IF LESS than 1 day
 how many..... hrs.
 or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Wisconsin

10. NAME OF FATHER

Charles B. See

11. BIRTHPLACE OF FATHER

(State or Country)

Wisconsin

12. MAIDEN NAME OF MOTHER

Permelia Ann Emerick
~~XXXXXX~~

13. BIRTHPLACE OF MOTHER

(State or Country)

New York
~~XXXXXXXXXX~~

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Marl E. See
Boise R.D. #5

15.

Filed

7 7 1922

R. H. Rast
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 2 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 1 1922, to July 2 1922,
 that I last saw him alive on July 2 1922,
 and that death occurred on the date stated above, at 12 P.M.

The CAUSE OF DEATH* was as follows:

Diabetic Coma(Duration) Yrs. mos. 4 ds.

Contributory (Secondary)

Diabetes(Duration) yrs. mos. 2 ds.

(Signed)

D. P. Higgs

M. D.

7 4 1922 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

Boise

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery July 3 1922

20. UNDERTAKER

ADDRESS

Thurmond & Krebs, Boise

A F F I D A V I T

STATE OF IDAHO,
COUNTY OF ADA.

} ss.

MERL E. SEE, being first duly sworn upon his oath, deposes and says: That he is a resident and citizen of Ada County, State of Idaho, and is the son of one Forest W. See who died in Ada County, State of Idaho, on or about the 2nd day of July, 1922; that shortly after the death of his said father, Forest W. See, affiant signed a statement to be presented to the Bureau of Vital Statistics of the State of Idaho relative to the death of his said father, Forest W. See.

Affiant further states that said statement was prepared by affiant's uncle, Al. Lunstrum, and handed to affiant for his signature; that in said statement the name of "May Cook" was given as the mother of affiant's father, Forest W. See, instead of the true name "Permelia Ann Emerick," who was affiant's grandmother and the mother of affiant's deceased father, Forest W. See; that the wrong name as indicated was inserted in said statement through mistake, inadvertence and inattention due to the fact that affiant was under a great strain at the time occasioned by the death of his said father, Forest W. See.

Affiant further states that the purpose and object of this affidavit is for the correction of the record as herein mentioned and in order that the true and correct record be given as to the matter herein expressly mentioned and indicated.

Merl E. See

Subscribed and sworn to before me this 31st day of August, 1939.

Ernest Paul Barnes
Notary Public for Idaho,
Residing at Boise, Idaho.

1. PLACE OF DEATH **RECEIVED**
 County of **Ada** AUG 2 1922
 City of **Bureau** (No. **1004**)
 If death occurs away from usual residence, give facts called for under special information.

CERTIFICATE OF DEATH

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. **38696**
 Registered No. **167**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Baby Radloff.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **m.** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Single**

6. DATE OF BIRTH

July 9 - 1922
 (Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Harry R. Radloff

11. BIRTHPLACE OF FATHER

(State or Country)

Michigan

12. MAIDEN NAME OF MOTHER

Muriel Beamer

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

H. R. Radloff

(Address)

15.

Filed

7-11

1922

R. H. Pratt
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 10 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY That I attended deceased from **July 8th 1922** to **July 9th 1922** that I last saw him alive on **July 9th 1922** and that death occurred on the date stated above, at **6:30 P.M.**

The CAUSE OF DEATH* was as follows:

Cerebral compression from hemorrhage

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

Jos. R. Nummery M. D.

7-11 1922

(Address) **Boise Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Morris Hill

DATE OF BURIAL

July 11 1922

20. UNDERTAKER

Summers & Co. Boise Idaho

1. PLACE OF DEATH **RECEIVED** **CERTIFICATE OF DEATH**
 County of Ada Registration District No. 2
 City of Boise Primary Registration District No. 1004
 State Idaho (No. 410 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Vera Agnes Ward

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 38697
 Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single

6. DATE OF BIRTH

May 9 1899
 (Month) (Day) (Year)

7. AGE

23 Yrs. 2 Mos. 10 ds.

IF LESS than 1 day
 how many..... hrs.
 or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

Professional nurse

9. BIRTHPLACE

(State or Country)

Hailey Ida

10. NAME OF FATHER

Henry Martin Ward

11. BIRTHPLACE OF FATHER

(State or Country)

Pennsylvania

12. MAIDEN NAME OF MOTHER

Mary Morris

13. BIRTHPLACE OF MOTHER

(State or Country)

Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

H. L. Bresnahan

(Address)

Hailey Ida

15.

Filed

19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 19 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 19 1922 to July 19 1922
 that I last saw her alive on July 19 1922
 and that death occurred on the date stated above, at 99 M.

The CAUSE OF DEATH* was as follows:

Effects of Ether Anesthesia
causing sudden arrest of
heart action

(Duration) Yrs. mos. ds.

Contributory
 (Secondary)

(Duration) yrs. mos. ds.

(Signed) L. P. McCalla M. D.

7/21/1922 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. John's Cemetery 7 1922

20. UNDERTAKER

ADDRESS

Schneber & Hidenpader Boise

RECEIVED
AUG 2 1922
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 38700

Registered No. 69

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from
usual residence, give facts
called for under special in-
formation.

Registration District No.

Primary Registration District No. 2008

(No. 1/2 Mile West of Cole School)

2. FULL NAME

Cora Mochel Stadler

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Female White Married
(Write the word.)

6. DATE OF BIRTH

May 20 1922
(Month) (Day) (Year)

7. AGE

37 Yrs. 2 Mos. 4 ds.
IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer).

Housewife

9. BIRTHPLACE

(State or Country)

Washington

10. NAME OF
FATHER

Ben Mochel

11. BIRTHPLACE
OF FATHER

(State or Country)

Mo.

12. MAIDEN NAME
OF MOTHER

Sarah Valler

13. BIRTHPLACE
OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Paul Stadler

(Address)

H.R.R. 2 Boise

15. FILED

July 26, 1922 R. H. Pratt
Local Registrar

16. DATE OF DEATH

July 24 1922
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from
July 24, 1922 to July 24, 1922
that I last saw him alive on July 24, 1922
and that death occurred on the date stated above, at 4:30 AM.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) Yrs. mos. ds.

Contributory Cause by Death

(Duration) yrs. mos. ds.

(Signed) John Buck M. D.

7-24-22 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted
if not at place of death?

Former or usual residence Ada County Idaho

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Morris Hill Cemetery 7/27, 1922

20. UNDERTAKER ADDRESS

Schreiber & Hidayatulla Boise, Idaho

Dr. Book.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. NO. 5-25 M. 1-15.

1. PLACE OF DEATH

County of Ada
City of Boise

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District

Primary Registration District No.

(No.)

5 miles S.W. of Boise
Donald McDonald

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 38701Registered No. 64

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single

6. DATE OF BIRTH

Dec-19-1903
(Month) (Day) (Year)

7. AGE

18 Yrs. 7 Mos. 0 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Student

9. BIRTHPLACE

(State or Country)

Illinois

10. NAME OF FATHER

J. J. McDonald

11. BIRTHPLACE OF FATHER

(State or Country)

Indiana

12. MAIDEN NAME OF MOTHER

Minnie Terry

13. BIRTHPLACE OF MOTHER

(State or Country)

Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. J. McDonald
(Address) Boise Idaho R. 2

15.

Filled July 21 1922

R. N. Prady
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 19 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 18 1922 to July 22 1922
that I last saw him alive on July 19 1922
and that death occurred on the date stated above, at 9:30 A.M.

The CAUSE OF DEATH* was as follows:

Fractured skull
skull. skull and skull
cap

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

R. N. Prady M. D.
July 19 22 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery July 22 1922

20. UNDERTAKER

ADDRESS

Chambers & Krebs Boise Idaho

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH

Registration District No. 8
 County of Blaine Primary Registration District No. 2008
 City of Rocky Mountain (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

George A. Lambrix

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 38702
 Registered No. 62

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widower
 (Write the word.)

6. DATE OF BIRTH

Aug 10 1871
 (Month) (Day) (Year)

7. AGE

57 Yrs. — Mos. — ds.

IF LESS than 1 day
 how many..... hrs.
 or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

Miner

9. BIRTHPLACE

(State or Country)

Mich

10. NAME OF FATHER

Joseph Lambrix

11. BIRTHPLACE OF FATHER

(State or Country)

Not obtainable

12. MAIDEN NAME OF MOTHER

"

"

13. BIRTHPLACE OF MOTHER

(State or Country)

"

"

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. H. Hockris

(Address)

Boise, Idaho.

15.

Filed 7-12 1922

R. H. Pratt
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 10 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY That I saw deceased from
dead July 10th 1922
 that I last saw him alive on July 10th 1922
 and that death occurred on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

No doctor in attendance
died suddenly before
Dr. arrived, nearest doctor
70 Miles Yrs. — mos. — ds.
 Contributory Heart failure.
 (Secondary)

(Duration) Yrs. — mos. — ds.

(Signed)

Paul Trusha Partner
Boise, Idaho.

19..... (Address) 223 South 4th St.

*State the Disease Causing Death; or in deaths from violent causes state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... Yrs. — mos. — days. In the State..... Yrs. — mos. — days.

Where was disease contracted if not at place of death?

Former or usual residence

Boise, Idaho.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Grand Rapids Mich 7/12 1922

20. UNDERTAKER

ADDRESS

Schurbe & Widenseder Boise

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 38703

Registered No. 61-2

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Boise
City of Boise
Registration District No. 2008
Primary Registration District No. 2008
Bureau of Vital Statistics
Boise, Idaho

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Dorothy Ruth Kunter

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Aug. 29 - 1921
(Month) (Day) (Year)

7. AGE

10 10
Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

None

9. BIRTHPLACE

(State or Country)

Boise Idaho.

10. NAME OF FATHER

Fred. H. Kunter

11. BIRTHPLACE OF FATHER

(State or Country)

Germany.

12. MAIDEN NAME OF MOTHER

Ruth Larson

13. BIRTHPLACE OF MOTHER

(State or Country)

Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. McBratney

(Address)

Boise, Idaho.

15.

Filed

7-10-1922

R. H. Wall
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

7-9-1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

7-8-1922 to 7-9-1922

that I last saw him alive on 7-8-1922

and that death occurred on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:

meningitis

(Duration) Yrs. mos. ds.

Contributory (Secondary) Operated by Dr. M. H. Tullman

(Duration) yrs. mos. ds.

(Signed) H. F. Neal M. D.

7-10-1922 (Address) Murdock

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Morris Hill Cemetery

DATE OF BURIAL

7-11-1922

20. UNDERTAKER

W. McBratney

ADDRESS

Boise, Idaho

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

Registration District No.

Primary Registration District No.

(No.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw h. a. alive on and that death occurred on the date stated above, at 7:30 A.M.

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Signed)

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 38705
Registered No. 180

1. PLACE OF DEATH Boise
County of Ada Registration District No. 2
City of Boise Primary Registration District No. 1004
(No. 410 State) (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Buckley Broadbent

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH April First 1835
(Month) (Day) (Year)

7. AGE 87 Yrs. 3 ds. 28
IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Jeweler
(b) General nature of industry, business or establishment in which employed (or employer) Retired

9. BIRTHPLACE
(State or Country) England

10. NAME OF FATHER Joseph Broadbent

11. BIRTHPLACE OF FATHER
(State or Country) England

12. MAIDEN NAME OF MOTHER Sarah Buckley

13. BIRTHPLACE OF MOTHER
(State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. A. B. McNeil
(Address) 7928 Fillmore St., San Francisco

15. Filed July 31 1922 R. H. Pratt
Local Registrar

16. DATE OF DEATH July 29 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 4 1922 to July 29 1922
that I last saw him alive on July 29 1922
and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

chronic nephritis

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Geo. Callahan M. D.

19. (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Union Hill Cemetery DATE OF BURIAL 8/1 1922

20. UNDERTAKER Schneiber & Hildebrandt ADDRESS Rome

MARGIN USED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH

County of

City or Town

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No.

Registration District No.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED
(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

16. DATE OF DEATH

I HEREBY CERTIFY, That I attended deceased from
May 1921 to July 24 1922that I last saw him alive on May 20 1922
and that death occurred on the date stated above, at 1 A. M.

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Signed)

19 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs mos days In the State yrs mos days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

FORM V. S. No. 5-24 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No.

Cemetery Registration District No.

(No.)

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from July 28, 1922 to July 29, 1922 that I last saw him alive on July 28, 1922 and that death occurred on the date stated above, at 3:30 A.M.

The CAUSE OF DEATH* was as follows:

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

7.29.1922

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted, if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **38708**
Registered No. **1**

1. PLACE OF DEATH

Registration District No. **2**
County of **Ada** Primary Registration District No. **1004**
City of **Boise** (State) **Idaho**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

BUREAU OF VITAL STATISTICS

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX **Male** 4. COLOR OR RACE **Yellow** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Married**
(Write the word.)

6. DATE OF BIRTH

1846
(Month) (Day) (Year)

7. AGE

76 Yrs. Mos. ds. IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Storekeeper

9. BIRTHPLACE

(State or Country)

China

10. NAME OF FATHER

Don't Know

11. BIRTHPLACE OF FATHER

(State or Country)

China

12. MAIDEN NAME OF MOTHER

Don't Know

13. BIRTHPLACE OF MOTHER

(State or Country)

China

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Fong Tie

(Address)

Boise Idaho

15.

Filed

July 29, 1922 R. H. Pratt

Local Registrar

16. DATE OF DEATH

July 27th 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19
that I last saw him alive on 19
and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis
no Doctor in Attendance

(Duration) **2** Yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Fong Tie19 (Address) **Household of Deceased**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

Boise 25 yrs

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Chinese Cemetery**7/29, 1922**

20. UNDERTAKER

ADDRESS

Schreiber & Hidenfaden Boise, Ida

RECEIVED

AUG 2 1922

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No.

Primary Registration District No.

(No. 817 in 20.

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

July 7th 1922, to July 26th 1922,
that I last saw her alive on July 25th 1922,
and that death occurred on the date stated above, at 5:20 P. M.

The CAUSE OF DEATH* was as follows:

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

7/27/1922 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cem. July 28 1922

20. UNDERTAKER

ADDRESS

Summers & Sons Boise Id.

FORM V. S. No. 5-25 M.-1-19.

RECEIVED

AUG 2 1922

Amended 8/3/82

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of

City of

Registration District No.

Primary Registration District No.

(No. 1919 Hazel St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 38711
Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Dry Creek Cemetery

DATE OF BURIAL

ADDRESS

8/3/82

IDAHO DEPARTMENT OF HEALTH AND WELFARE
Bureau of Vital Statistics, Standards, and Local Health Services

AFFIDAVIT TO CORRECT OR AMEND AN ORIGINAL CERTIFICATE

RECEIVED
BUREAU OF
VITAL STATISTICS

State of Idaho }
County of Ada } ss.

AUG 3 9 29 AM '82

Certificate No. 38711
Date Filed _____

The undersigned does solemnly swear that certain facts on the certificate of death

for Jacob Newell who died on July 20, 1922
(Name on Original Certificate) (Was Born, Died, etc.) (Date of Event)
in _____ are erroneous or were omitted:
(Place of Event)

ITEMS TO BE CORRECTED

FROM

TO

19. Place of BurialMorris Hill CemeteryDry Creek Cemetery

Subscribed and sworn to before me this 3rd day of

August, 1982

Notary Public, Linda Adamson

Residing at Nampa

My commission expires April 3, 1985

(Seal)

Eugene H. Newell
Signature of Applicant
Sweet - Idaho - 83670
Street Address, City, State

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of _____ }
County of _____ } ss.

(Must be completed __)

(Is not necessary xx)

The undersigned does solemnly swear that he has knowledge of the facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this _____ day of _____, 19__.

Notary Public, _____

Residing at _____

My commission expires _____

(Seal)

Supporting Signature

Street Address, City, State

1. PLACE OF DEATH

County of Ada
City of Boise

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
AUG 2 1922
BUREAU OF VITAL STATISTICSRegistration District No. 2Primary Registration District No. 7004St. W. Hays

2. FULL NAME

Charles S. McCormellState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 38712Registered No. 38712

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH

Aug 20 1857
(Month) (Day) (Year)

7. AGE

64 Yrs 10 Mos 27 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Probation Officer

9. BIRTHPLACE

(State or Country)

Wayne Co., Iowa.

10. NAME OF FATHER

Wm. McCormell

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Nancy Graham

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Earl McCormell

(Address)

Wiser, Idaho.

15.

Filed

7-191922R. H. Pratt

Local Registrar

CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 17 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from July 11 1922, to July 17 1922
that I last saw him alive on July 17 1922
and that death occurred on the date stated above, at 1230 AM

The CAUSE OF DEATH* was as follows:

Rocky Mountain Spotted Fever(Duration) Yrs..... mos. 9 ds.Contributory Acute Dilatation of Stomach
(Secondary) Pulmonary edema(Duration) yrs..... mos. 2 ds.(Signed) J. N. Brastan M. D.July 19 1922 (Address) Boise Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

Boise, Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Harris Hill Cemetery 7/22 1922

20. UNDERTAKER

ADDRESS

Schreiber & Siderfaden Boise, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1.

PLACE OF DEATH

County of Gadara Registration District No. 2
 City of Basin Primary Registration District No. 1004
8th & Front St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Mygard

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 38713
 Registered No. 177

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married

6. DATE OF BIRTH

1857
 (Month) (Day) (Year)

7. AGE

65
 Yrs. Mos. ds. IF LESS than 1 day
 how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

Laborer

9. BIRTHPLACE

(State or Country)

Unknown

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Chas. E. Summers
Basin, Idaho

15.

Filed

July 19 1922 R. H. Pratt
 Local Registrar

16. DATE OF DEATH

July 16 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I saw attended deceased from July 16 1922 to 19
 that I last saw him alive on 19

and that death occurred on the date stated above, at 70 M.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease
Dropped dead
 (Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed)

(Address)

Chas. E. Summers
Basin, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Summers & Sons July 19 1922

20. UNDERTAKER

ADDRESS

Summers & Sons Basin, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH

Adair 1922
 County of Adair Registration District No. 2
 City of Boise, Idaho
 If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

George S. Pitzer

CERTIFICATE OF DEATH

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 38714

Registered No. 176

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OF RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
 (Write the word.)

6. DATE OF BIRTH

About 1858
 (Month) (Day) (Year)

7. AGE

About 64 Yrs. Mos. ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer).

Farmer

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

Jared Pitzer

11. BIRTHPLACE OF FATHER

(State or Country)

U.S.A.

12. MAIDEN NAME OF MOTHER

Olie Bates

13. BIRTHPLACE OF MOTHER

(State or Country)

U.S. & Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

7-18-22

19

22

R. H. Pratt
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 16 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 10 1922, to July 16 1922, that I last saw him alive on July 15 1922, and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(Duration) Yrs. mos. 20 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

D. P. Hipp

M. D.

7-18-1922

(Address) Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

Brunneman, Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. John's Cemetery

7-18-1922

20. UNDERTAKER

ADDRESS

Schuchman & Schuchman, Boise

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH *Adrian, Idaho*
 County of *Adrian*
 City of *Boise*
 Registration District No. *2*
 Primary Registration District No. *1004*
 (No. *110* State *Idaho*)

File No. *38715*
 Registered No. *175*

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of address and number.

2. FULL NAME

Frank Albert Ridenour

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *M* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*
 (Write the word.)

6. DATE OF BIRTH

April 5th 1922
 (Month) (Day) (Year)

7. AGE

3 Yrs. *12* Mos. *ds.*

IF LESS than 1 day
 how many..... hrs.
 or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

none

9. BIRTHPLACE

(State or Country)

Ada Co Idaho

10. NAME OF FATHER

Virgil Ridenour

11. BIRTHPLACE OF FATHER

(State or Country)

Iowa

12. MAIDEN NAME OF MOTHER

Ira Cecil

13. BIRTHPLACE OF MOTHER

(State or Country)

Neb.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Virgil Ridenour

(Address)

15.

Filed

July 18, 1922 A. H. Pratt

Local Registrar

16. DATE OF DEATH

July 17th 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *July 17, 1922* to *July 17, 1922*
 that I last saw him alive on *July 17, 1922*
 and that death occurred on the date stated above, at *5:30* A.M.

The CAUSE OF DEATH* was as follows:

Fractured

(Duration) Yrs. *3* mos. *ds.*

Contributory
 (Secondary)

(Duration) yrs. *3* mos. *ds.*

(Signed)

M. H. Tallman M. D.

(Address)

Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

Ada County

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Japhie Cemetery

7/19/22

20. UNDERTAKER

ADDRESS

Schmidt Ridenour *Boise*

Dr. Tallman

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

RECEIVED

Registration District No.

County of

Primary Registration District No.

City of

(No.)

State

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15. Filed

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Signed)

19

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 38715
Registered No. 1004

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

Registration District No. 2
County of Ada
City of Boise
Primary Registration District No. 15-10 Jefferson
Bureau of Vital Statistics

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Bernie Lee Krough

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single

6. DATE OF BIRTH

Aug 5th 1896
(Month) (Day) (Year)

7. AGE

26

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Teacher

9. BIRTHPLACE

(State or Country)

Danvers Ill

10. NAME OF FATHER

Peter Krough

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Johanna Dunworth

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

R. H. Pratt
Boise

15.

Filed

7-13

1922

R. H. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 13th 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1 1922, to July 13 1922 that I last saw her alive on July 12 1922, and that death occurred on the date stated above, at 9:40 A.M.

The CAUSE OF DEATH* was as follows:

Cardiac Arthma

(Duration) Yrs. mos. ds. 10
Contributory Pulmonary Tuberculosis
(Secondary)

(Duration) 5 yrs. mos. ds.
(Signed) D. P. Hays M. D.

7-13 1922 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Bath Ills.

DATE OF BURIAL

7/13 1922

20. UNDERTAKER

Schreiber & Videnfaden Boise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
 MAKING RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No.

Primary Registration District No.

(No.)

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

Contributory
 (Secondary)

(Signed)

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

7-13

1922

Local Registrar

CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

and that death occurred on the date stated above, at... 2 A.M.

The CAUSE OF DEATH* was as follows:

Contributory (Secondary)

(Signed)

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **38720**
Registered No. **169**1. PLACE OF DEATH **Boise, Idaho**
County of **Ada** Registration District No. **2**
City of **Boise** Primary Registration District No. **1004**
State of **Idaho** No. **710** (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lin Laurie

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **Yellow** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Married**
(Write the word.)

6. DATE OF BIRTH

1856
(Month) (Day) (Year)

7. AGE

66 Yrs. Mos. ds. IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)**Gardner**

9. BIRTHPLACE

(State or Country)

China

10. NAME OF FATHER

Dont Know

11. BIRTHPLACE OF FATHER

(State or Country)

China

12. MAIDEN NAME OF MOTHER

Dont Know

13. BIRTHPLACE OF MOTHER

(State or Country)

China

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wang Wo.

(Address)

Boise, Idaho.

15.

Filed

7-8**1922****R. H. Pratt**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

28

16. DATE OF DEATH

July 7
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 7 19**22**, to **July 7** 19**22**
that I last saw him alive on **July 7** 19**22**
and that death occurred on the date stated above, at **M.**

The CAUSE OF DEATH* was as follows:

Tuberculosis(Duration) Yrs. mos. ds.
Contributory **Exhaustion**
(Secondary)(Duration) yrs. mos. ds.
(Signed) **C. S. Allen** M. D.**7/8** 19**22** (Address) **318-19 McCarty Bldg**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **Chinese Cemetery** DATE OF BURIAL **7/9** 19**22**20. UNDERTAKER **Schreiber & Sidenfaden** ADDRESS **Boise, Ida****Dr. Allen**

1. PLACE OF DEATH

Registration District No. 2
 County of Ada AUG 2 1922
 City of Boise BUREAU OF VITAL STATISTICS
 St. Boise

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ambrase S. Butcher

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 38721Registered No. 167

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Widower
 (Write the word.)

6. DATE OF BIRTH 1841
 (Month) (Day) (Year)

7. AGE 81 — — IF LESS than 1 day
 how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

Veteran Civil War

9. BIRTHPLACE

(State or Country)

Indiana

10. NAME OF FATHER

Don't Know

11. BIRTHPLACE OF FATHER

(State or Country)

1

12. MAIDEN NAME OF MOTHER

2

13. BIRTHPLACE OF MOTHER

(State or Country)

7

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. McBratney

(Address)

Boise Idaho

15.

Filed

July 6 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 5, 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 1 1922 to July 5 1922
 that I last saw him alive on July 2 1922
 and that death occurred on the date stated above, at 5:30 AM

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

(Duration) 1 Yrs. 0 mos. 0 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

Reverend C. Ward M. D.

7/5 1922 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Morris Hill Cemetery

DATE OF BURIAL

7/6 1922

20. UNDERTAKER

W. McBratney

ADDRESS

Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

Stewart

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 38722
Registered No. 38722

1. PLACE OF DEATH
County of Ada Registration District No. 2
City of Bureau of Vital Statistics Primary Registration District No. 1004
(No. 410 W. State St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Sterling

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH June 2, 1862
(Month) (Day) (Year)

7. AGE 60 yrs. 1 Mos. 3 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Accountant
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE Scotland
(State or Country)

10. NAME OF FATHER George Sterling

11. BIRTHPLACE OF FATHER Scotland
(State or Country)

12. MAIDEN NAME OF MOTHER Janet Finlayson

13. BIRTHPLACE OF MOTHER Scotland
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Janet Sterling Peterson
(Address) 645 Grand ave

15. Filed 7-6 1922
A. L. Smith
Local Registrar

16. DATE OF DEATH July 5, 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 18 1922 to July 5 1922
that I last saw him alive on July 5 1922
and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:
Septic infection of the right hip joint

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) James H. Stewart M. D.

(Address) Bonanza

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence Bonanza Burns, Ore.

19. PLACE OF BURIAL OR REMOVAL Portland, Oregon DATE OF BURIAL July 6, 1922

20. UNDERTAKER Summers & Tuck ADDRESS Bonanza

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Ada Registration District No. 11
 City of Meridian Registration District No. 11 (St.)
 If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

George Henry Rogers

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-OWED OR DIVORCED

Male white married
 (Write the word.)

6. DATE OF BIRTH

August 30 1845
 (Month) (Day) (Year)

7. AGE

76 Yrs. 7 Mos. 10 ds.

IF LESS than 1 day
 how many..... hrs.
 or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

farmer

9. BIRTHPLACE

(State or Country) Wisconsin

10. NAME OF FATHER

Francis Rogers

11. BIRTHPLACE OF FATHER

(State or Country) Vermont

12. MAIDEN NAME OF MOTHER

Esther George

13. BIRTHPLACE OF MOTHER

(State or Country) Vermont

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Mary G. Rogers
 (Address) Meridian, Idaho

15.

Filed 6-10 19 22 H. F. Neal
 Local Registrar

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 38723

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

10

16. DATE OF DEATH

June 9 19 22
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 21 19 22 to June 9 19 22
 that I last saw him alive on June 9 19 22
 and that death occurred on the date stated above, at 1:45 P.M.

THE CAUSE OF DEATH* was as follows:

Influenza(Duration) Yrs. 5 mos. 10 ds.Contributory.
(Secondary)

(Duration) Yrs. _____ mos. _____ ds.

(Signed)

H. F. Neal M. D.

6/10 19 22 (Address) Meridian, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Meridian Cemetery June 10, 19 22

20. UNDERTAKER

ADDRESS

W. D. Mator Meridian, Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 38724

Registered No.

1. PLACE OF DEATH

County of Ada Registration District No. _____
City of Meridian Primary Registration District No. _____
(No. _____) (St.) _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

BUREAU OF
STATISTICSNaron Graham Scott

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDMale White Married
(Write in words.)

6. DATE OF BIRTH

July 18 1850
(Month) (Day) (Year)

7. AGE

71 Yrs. 10 Mos. 23 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country) Jefferson Co Ind.

10. NAME OF FATHER

Moses Scott

11. BIRTHPLACE OF FATHER

(State or Country) Ohio

12. MAIDEN NAME OF MOTHER

Mary A Graham

13. BIRTHPLACE OF MOTHER

(State or Country) Bardston Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. Scott(Address) Boise Idaho

15.

Filed 6-12-1922Local Registrar H F Neal

MEDICAL CERTIFICATE OF DEATH

80

16. DATE OF DEATH

June 11 1922
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from June 11 1922 to June 11 1922that I last saw him alive on June 11 1922
and that death occurred on the date stated above, at 10:30 A.M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris(Duration) Yrs. mos. 1 1/2 ds.

Contributory (Secondary)

(Duration) Yrs. mos. 20 ds.(Signed) H F Neal M. D.6-13-1922 (Address) Meridian Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Boise Idaho

DATE OF BURIAL

19

20. UNDERTAKER

H F Neal

ADDRESS

RECEIVED CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of AdaCity of Meridian

Registration District No.

Primary Registration District No.

File No.

38726

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

George F Jackson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married

6. DATE OF BIRTH

March31907

(Month)

(Day)

(Year)

7. AGE

65

Yrs.

3

Mos.

19

ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Indiana

10. NAME OF FATHER

Geo Jackson

11. BIRTHPLACE OF FATHER

(State or Country)

Indiana

12. MAIDEN NAME OF MOTHER

Mary Laffoon

13. BIRTHPLACE OF MOTHER

(State or Country)

Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

George F Jackson
Meridian, Idaho

15.

Filed

6-231922H. F. Neal

Local Registrar

MEDICAL CERTIFICATE OF DEATH

40

16. DATE OF DEATH

June221922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Apr 291922to June 221922that I last saw him alive on June 211922and that death occurred on the date stated above, at 9:30 A.M.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach(Duration) 1-3 Yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. B. Vumbers Jr

M. D.

6/22/1922(Address) Meridian Ada

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Meridian CemeteryJune 23, 1922

20. UNDERTAKER

ADDRESS

W. D. Mather Meridian

RECEIVED

JUL 1 1922

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 38727

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Ada

City of Meridian

Registration District No.

Registration District No.

(No.)

(St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Allen Elliott

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male White

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Aug 12 1910
(Month) (Day) (Year)

7. AGE

11 Yrs 10 Mos 13 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

School boy

9. BIRTHPLACE

(State or Country)

Meridian

10. NAME OF FATHER

James M. Elliott

11. BIRTHPLACE OF FATHER

(State or Country)

Illinois

12. MAIDEN NAME OF MOTHER

Pearl Miller

13. BIRTHPLACE OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ernest Elliott
(Address) Meridian Idaho

15.

Filed 6-26 1922

JF West
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 25 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19

that I last saw him alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

drowned

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) H. F. West M. D.

626 1922 (Address) Meridian

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Meridian Idaho

June 27 1922

20. UNDERTAKER

ADDRESS

W. B. Matney Meridian

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Adams Reception District No. _____
City of Council Primary Registration District No. _____
St.)

File No. 38728

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Helmarth

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
x Widowed (Write the word.)

6. DATE OF BIRTH

Jan 8 1868
(Month) (Day) (Year)

7. AGE

53 Yrs. 11 Mos. 28 ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

Barber by Trade

9. BIRTHPLACE

(State or Country)

Edgar Co, Ills.

10. NAME OF FATHER

George Helmarth

11. BIRTHPLACE OF FATHER

(State or Country)

Don't know

12. MAIDEN NAME OF MOTHER

Mary Elizabeth Holden

13. BIRTHPLACE OF MOTHER

(State or Country)

Don't know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Chas F. Helmarth
Clarkston Wash

15.

Filed Mar 21 1922John F. Fisher

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 6 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY; That I attended deceased from Dec 24 1921 to Jan 6 1922, that I last saw him alive on Jan 5 1922 and that death occurred on the date stated above, at 5 A M.

The CAUSE OF DEATH* was as follows:

Renal Dropsy

(Duration) 2 Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) E. Vadney M. D.

Jan 7, 1922 (Address) Council Bluffs

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

I.O.O.F.Jan 7 1922

20. UNDERTAKER

ADDRESS

E. W. FisherCouncil

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **38729**

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH **Adams**
County of **Adams** Registration District No. _____
City of **Leamington** Primary Registration District No. _____
(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Stephen McClair**

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Single**
(Write the word.)6. DATE OF BIRTH. **Unknown**
(Month) (Day) (Year)7. AGE **82**
Yrs. Mos. ds.IF LESS than 1 day
how many hrs. or
min.?8. OCCUPATION **Miner**(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....9. BIRTHPLACE **✓**

(State or Country)

10. NAME OF FATHER **✓**11. BIRTHPLACE OF FATHER **✓**

(State or Country)

12. MAIDEN NAME OF MOTHER **✓**13. BIRTHPLACE OF MOTHER **✓**

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) _____

(Address) _____

15. _____

Filed **June 30 1922**

Local Registrar

16. DATE OF DEATH **June 16 1922**
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from **June 5 1922** to **June 16 1922**, that I last saw him alive on **June 16 1922** and that death occurred on the date stated above, at **3 P.** M.

The CAUSE OF DEATH* was as follows:

senile dementia due to age(Duration) **2** Yrs. mos. ds.

Contributory (Secondary) _____

(Duration) Yrs. mos. ds.

(Signed) **M. M. J. Brown** M. D.**June 16 1922** (Address) **Leamington**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **Soat**DATE OF BURIAL **June 17 1922**20. UNDERTAKER **Fisher**

ADDRESS _____

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. _____
County of Adams Primary Registration District No. _____
City of Jamarack (No. _____ St.) _____File No. 38730

Registered No. _____

If death occurs away from
usual residence, give facts
called for under special
information.

2. FULL NAME

Lewis FilleyIf death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Male

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.Widowed

(Write the word.)

6. DATE OF BIRTH.

January 5

(Month)

(Day)

1833
(Year)

7. AGE

89

Yrs.

4

Mos.

9

ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min. 2)

8. OCCUPATION

(a) Trade, profession or
particular kind of work...
(b) General nature of in-
dustry, business, or estab-
lishment in which employ-
ed (or employer).....Farmer. Retired.

9. BIRTHPLACE

(State or Country)

Michigan10. NAME OF
FATHERWilliam Filley11. BIRTHPLACE
OF FATHER

(State or Country)

Missouri12. MAIDEN NAME
OF MOTHERAby June Benson13. BIRTHPLACE
OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Pa. Filley

(Address)

Jamarack Idh

15.

Filed

July 211922WMB

Local Registrar

16. DATE OF DEATH

May
(Month)14
(Day)1922
(Year)17. I HEREBY CERTIFY, That I attended deceased from
March 191 to May 13 1922that I last saw him alive on May 13 1922
and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Indigestion due to infirmity
of age

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)W. M. Brown

(Duration)

Yrs.

mos.

ds.

(Signed)

W. M. Brown

M. D.

July 2, 1922 (Address)Council*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place

of death.....

yrs.....

mos.....

days

In the

State.....

yrs.....

mos.....

days

Where was disease contracted
if not at place of death?.....

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

Scott, Council

DATE OF BURIAL

May 15 1922

20. UNDERTAKER

Fisher

ADDRESS

Council

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED

JUL 1 1922

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bear Lake District No. 32
 City of Montpelier (No. _____ St.)
 If death occurs away from usual residence, give facts called for under special information.

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 38731

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Linnae Peterson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED single
 (Write the word.)

6. DATE OF BIRTH

6 (Month) 14 (Day) 1920 (Year)

7. AGE

3 Yrs. — Mos. 26 ds.

IF LESS than 1 day
 how many _____ hrs.
 or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

None

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Oliver L. Peterson

11. BIRTHPLACE OF FATHER

(State or Country) Idaho

12. MAIDEN NAME OF MOTHER

Hazel Lindsay

13. BIRTHPLACE OF MOTHER

(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Oliver L. Peterson(Address) Overl Idaho

15.

Filed 6-28-1922 E. H. Peterson

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June (Month) 9 (Day) 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 5-1922, to June 9-1922
 that I last saw her alive on June 9-1922
 and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Burns caused from falling in hot water.(Duration) _____ Yrs. _____ mos. 5 ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Geo. F. Ashley M. D.6-10-1922 (Address) Montpelier

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. 6 days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? Overl Idaho.

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Overl Idaho

DATE OF BURIAL

6-11-1922

20. UNDERTAKER

Wm. H. Peterson

ADDRESS

Overl Idaho

CERTIFICATE OF DEATH

1. PLACE OF DEATH *Blair Lake* Registration District No. *52*
 County of *Blair* Primary Registration District No. *2136*
 City of *Montpelier* (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lois Virginia Shrope

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. *38732*
 Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*
 (Write the word.)

6. DATE OF BIRTH

April *29* *1922*
 (Month) (Day) (Year)

7. AGE

Yrs. Mos. *20* ds.

IF LESS than 1 day
 how many _____ hrs.
 or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) *Montpelier Idaho Blair Lake*

10. NAME OF FATHER

Alpheus A. Shrope

11. BIRTHPLACE OF FATHER

(State or Country) *Paullina O'Brien, Iowa*

12. MAIDEN NAME OF MOTHER

Mary Sommer

13. BIRTHPLACE OF MOTHER

(State or Country) *Montpelier Ida Blair Lake*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Alpheus A. Shrope
Montpelier Ida

(Address)

15.

Filed *6-25-22* *N H King*

Local Registrar

16. DATE OF DEATH

May *19* *1922*
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *May 16* *1922* to *May 19* *1922*
 that I last saw him alive on *May 18* *1922*
 and that death occurred on the date stated above, at *59* M.
 The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
 (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) *Erst C. Bailey* M. D.

19 *1922* (Address) *Montpelier*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Montpelier, Idaho *5-20* *1922*

20. UNDERTAKER

ADDRESS

Alfred Flores *Montpelier*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bear Lake
City of Montpelier

JUL 1 1922

Registration District No. 52

Registration District No. 2106

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Leona Staley Lundstrom

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 38733
Registered No. 38733
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH.

Sept
(Month)

27
(Day)

1901
(Year)

7. AGE

20 Yrs. 6 Mos. 24 ds.

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Housework

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

W. G. Staley

11. BIRTHPLACE OF FATHER

(State or Country)

Nebraska

12. MAIDEN NAME OF MOTHER

Hannah Burey

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. G. Staley

(Address)

Montpelier, Idaho

15.

Filed 6-25-22 1922

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 20 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 10 1922 to April 20 1922
that I last saw her alive on April 20 1922

and that death occurred on the date stated above, at 6 M.

The CAUSE OF DEATH* was as follows:

Puerperal Sepsis

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

A. S. Needles M. D.

Apr 17 1922 (Address) Montpelier

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Montpelier, Idaho

DATE OF BURIAL

Apr. 23 1922

20. UNDERTAKEN

Wm. Williams
Montpelier, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Burbon*

City of *Highway*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Wm B Pendry

RECEIVED

JUL 1 1922

BURBON

STATE

Registration District No.

Registration District No.

2136

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. *38734*
Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

10

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH.

June 19 1889

(Month) (Day) (Year)

7. AGE

32 Yrs. *7* Mos. *17* ds.

IF LESS than 1 day
how many . . . hrs. or
. . . min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of in-
dustry, business, or estab-
lishment in which em-
ployed (or employer)

Plumber

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF
FATHER

D Wm Pendry

11. BIRTHPLACE
OF FATHER

(State or Country)

England

12. MAIDEN NAME
OF MOTHER

Elizabeth Budge

13. BIRTHPLACE
OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Wm B Pendry
Highway

15.

6-25-

1922

H H King

Filed

Local Registrar.

16. DATE OF DEATH

April 6 1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 2 1922 to *April 6 1922*

that I last saw him alive on *April 6 1922*

and that death occurred on the date stated above, at *2:30 A.M.*

The CAUSE OF DEATH* was as follows:

"Flu"

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

G. W. West

M. D.

4/6/1922 (Address) *Highway*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death . . . yrs. . . mos. . . days, State . . . yrs. . . mos. . . days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Mountain View

DATE OF BURIAL

April 9 1922

20. UNDERTAKER

H H King

ADDRESS

Highway

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bear Lake
City of MontpelierJUL 1 1922
BUREAU OF
STATISTICSRegistration District No. 57Primary Registration District No. 2136File No. 38735Registered No. 38735

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Gordon LaGrande Bartschi.

If death occurred in hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male

White

Infant
(Write the word.)

6. DATE OF BIRTH

April 7 1921
(Month) (Day) (Year)

7. AGE

Yrs. 11 Mos. 20 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Infant

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho.

10. NAME OF FATHER

Lagrand H. Bartschi.

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Julia Lindsay.

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Legrand H. Bartschi
(Address) Nounan, Idaho

15.

Filed 6-25-221922H. H. King

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 20 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from March 8 1922, to March 20 1922, that I last saw him alive on March 20 1922, and that death occurred on the date stated above, at 8 A.M. The CAUSE OF DEATH* was as follows:"Flu"(Duration) Yrs. mos. 14 ds.Contributory
(Secondary)(Duration) Yrs. mos. ds.(Signed) Elmer E. Stingley M. D.3/21/1922 (Address) Montpelier, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Nounan, Idaho

DATE OF BURIAL

Mar. 22 1922

20. UNDERTAKER

F. M. Wilham

ADDRESS

Montpelier, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

1. PLACE OF DEATH

County of Bear Lake Registration District No. 52
City of Montpelier Registration District No. 2136
If death occurs away from usual residence, give facts called for under special information.

FULL NAME Chas. A. Buck

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 38736
Registered No.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH. Nov. 22 1887
(Month) (Day) (Year)

7. AGE 34 Yrs. 3 Mos. 16 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Night Watchman
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Maryland

10. NAME OF FATHER Franklin O. Buck

11. BIRTHPLACE OF FATHER

(State or Country) Maryland

12. MAIDEN NAME OF MOTHER Sarah Burr

13. BIRTHPLACE OF MOTHER

(State or Country) Maryland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H. W. Buck
(Address) Corbeville Wyoming

15. 6-25-22 H. A. King
Filed 1922 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar. 10 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 4 1915 to Mar. 10 1922
that I last saw him alive on Mar. 10 1922
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Apoplexy
(Duration) Yrs. mos. ds.
Contributory (Secondary) Peritonitis
(Duration) Yrs. mos. ds.
(Signed) W. F. Riddle M. D.
3-10-22 (Address) Montpelier

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Montpelier Idaho DATE OF Mar. 12 1922

20. UNDERTAKER F. M. Wilham ADDRESS Montpelier Idaho

CERTIFICATE OF DEATH

1. PLACE OF DEATH.....
 County of Bennett Registration District No. 31
 City of Desmet Primary Registration District No.
 (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ignace Loginhead

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 38737
 Registered No. 14

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE Indian 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
 (Write the word.)

6. DATE OF BIRTH 1852
 (Month) (Day) (Year)

7. AGE 66 Yrs. Mos. ds. IF LESS than 1 day
 how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

none

9. BIRTHPLACE

(State or Country)

Washington

10. NAME OF FATHER

not known

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank Barbeau
 (Address) Desmet, Idaho

15. 7/12 1922 Y. E. Bilson
 Filed Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 11 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 19 to 19
 that I last saw h..... alive on 19
 and that death occurred on the date stated above, at M.
 The CAUSE OF DEATH* was as follows:

Tuberculosis - Hip joint disease

(Duration) 4 Yrs. mos. ds.

Contributory
 (Secondary)

(Duration) 4 yrs. mos. ds.

(Signed) Frank Barbeau M. D.

7/11/1922 (Address) Desmet, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Desmet DATE OF BURIAL 7/14 1922

20. UNDERTAKER J. F. Folsom ADDRESS Desmet

1. PLACE OF DEATH

County of Benedict City of Desmet State of Idaho District No. 31 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Regina Garrick

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE Indian 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH

April 29 1922
(Month) (Day) (Year)

7. AGE

1 Yrs. 2 Mos. 3 ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

David Garrick

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Rose Wildshoe

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Joe Garrick

(Address)

Idaho

15.

Filled July 3 1922

Y. L. Bhan
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 2 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 26 1922, to July 2 1922, that I last saw h.e. alive on July 2 1922, and that death occurred on the date stated above, at 1 P. M. The CAUSE OF DEATH* was as follows:
Cholera infantum

(Duration) Yrs. mos. 7 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Fred Barten M. D.

7/3 1922 (Address) Desmet, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Desmet, Idaho 7/3 1922

20. UNDERTAKER

ADDRESS

J. Falen Desmet

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 2 38738

Registered No. 19

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH

County of BonnerCity of Sandpoint

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William Henry Edward Burden

RECENT CERTIFICATE OF DEATH

Registration District No. 78Primary Registration District No. 2155City of Sandpoint St.)State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 38739

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

Feb. 6 1867
(Month) (Day) (Year)

7. AGE

55 Yrs. 4 Mos. 17 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Canada

10. NAME OF FATHER

Edward Burden

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Mary Hanna

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Burr Burden

(Address)

Careywood, Ida.

15.

Filed July 2 1922Viola Allen
Deputy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 23 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 10 1922, to June 23 1922that I last saw him alive on June 22 1922and that death occurred on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:

Cholecystitis(Duration) Yrs. 2 mos. _____ ds.Contributory
(Secondary)

(Duration) yrs. _____ mos. _____ ds.

(Signed)

J. T. Jones M.D.6/24 1922 (Address) Sandpoint, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lakeview CemeteryJune 27 1922

20. UNDERTAKER

ADDRESS

MOON & DALESandpoint, IdahoL. Moore

RECEIVED

JUL 12 1922

BUREAU OF DISTRICT No. 76

Registration District No. 2150

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 38740

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Bonner
City of Samuels (rural)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant Parks

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

June 19 1922
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or 30 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Samuels, Ida.

10. NAME OF FATHER

Wm. H. Parks

11. BIRTHPLACE OF FATHER

(State or Country) Little Rock, Ark.

12. MAIDEN NAME OF MOTHER

Weslie Lee

13. BIRTHPLACE OF MOTHER

(State or Country) Fairfield, Wash.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm. H. Parks(Address) Samuels, Ida. (rural)

15.

Filed July 2 1922 Viola AllenDeputy Local Registrar

MEDICAL CERTIFICATE OF DEATH

151a

16. DATE OF DEATH

June 19 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

.....19....., to19.....

that I last saw her alive on June 19 1922
and that death occurred on the date stated above, at 1:30 A.M.

The CAUSE OF DEATH* was as follows:

Unknown

(Duration) Yrs. mos. ds.

Contributory Maternal (7 mo)
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Alfred E. S. S. S. M. D.July 2 1922 (Address) Samuels, Ida.

State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Samuels, Ida. (rural)

DATE OF BURIAL

June 19 1922

20. UNDERTAKER

Father

ADDRESS

Samuels, Ida.

FORM V. S. No. 5-25 M. 1-19.

Coroner's Office

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bonner
City of SandpointRegistration District No. 78
Primary Registration District No. 2155
(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Amanda SawyerState of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 38741
Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-OWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH

September 11 1902
(Month) (Day) (Year)

7. AGE

20 Yrs. 7 Mos. 24 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Dressmaker

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Michigan

10. NAME OF FATHER

Chas. H. Sawyer

11. BIRTHPLACE OF FATHER

(State or Country)

Michigan

12. MAIDEN NAME OF MOTHER

Marcella LaPoint

13. BIRTHPLACE OF MOTHER

(State or Country)

Michigan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Chas. H. Sawyer

(Address)

Sandpoint, Idaho.

15.

Filed July 2 1922Viola Allen
Deputy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 5, 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____ 19____, to _____ 19____,
that I last saw h_____ alive on _____ 19____,
and that death occurred on the date stated above, at _____ M.
The CAUSE OF DEATH* was as follows:Natural

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

E. M. Moore Coroner M. D.6/8 1922 (Address) _____

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL
Lakeview CemeteryDATE OF BURIAL
6/8 1922

20. UNDERTAKER

MOON & DALE

ADDRESS

Sandpoint, Ida.

FORM V. S. No. 5-25 M. 1-19.

Coroner Moore

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of BonnerCity of ClarksforkIf death occurs away from
usual residence, give facts
called for under special in-
formation.Registration District No. 78Primary Registration District No. 2155

(No. _____ St.)

File No. 38742

Registered No. _____

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.2. FULL NAME James R. Pittman.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDDivorced
(Write the word.)

6. DATE OF BIRTH

Unknown

(Month)

(Day)

1 (Year)

7. AGE

About 60 yrs. Mos. ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.Farm Labor(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country)

Unknown10. NAME OF
FATHERUnknown11. BIRTHPLACE
OF FATHER

(State or Country)

Unknown12. MAIDEN NAME
OF MOTHERUnknown13. BIRTHPLACE
OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed July 2 1922Viola Allen
Deputy Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 5, 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19that I last saw him alive on 19and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) S. M. Moore Coroner5/5 1922 (Address)*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted,
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Lakeview Cemetery

DATE OF BURIAL

5/12 1922

20. UNDERTAKER

MOON & DALE

ADDRESS

Sandpoint, Ida.L. Moon

FORM V. S. No. 5-25 M. 1-19.

Coroner Moore

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **38743**

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of **Bonner**
City of **Sandpoint**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Henry Kohler Nichols**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Married**
(Write the word.)

6. DATE OF BIRTH

March 17 1883
(Month) (Day) (Year)

7. AGE

39 Yrs. **2** Mos. **17** ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work **U.S. Forest Service**
(b) General nature of industry, business or establishment in which employed (or employer) **Clerk**

9. BIRTHPLACE

(State or Country) **Minn.**

10. NAME OF FATHER

----- **Kohler**

11. BIRTHPLACE OF FATHER

(State or Country) **Switzerland**

12. MAIDEN NAME OF MOTHER

Louise -----

13. BIRTHPLACE OF MOTHER

(State or Country) **Switzerland**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Henry Kohler Nichols**(Address) **Sandpoint, Idaho.**

15.

Filed **July 2** 19**22****Viola Allen**
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 4 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

..... 19....., to 19.....

that I last saw him alive on 19.....

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

accidental drowning

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) **S. M. Nichols**(Address) **63 19th**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Lakeview Cemetery

DATE OF BURIAL

June 8 1922

20. UNDERTAKER

MOON & DALE

ADDRESS

Sandpoint, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH
in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Dr. Stackhouse

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of **Bonner**
City of **Sandpoint**
Registration District No. **78**
Primary Registration District No. **2155**
(No. **STATISTICS**) St.)

File No. **38744**
Registered No. _____

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME **Nels Olaf Modig**

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED **Married**
(Write the word.)

6. DATE OF BIRTH
February 16, 1875
(Month) (Day) (Year)

7. AGE **47** Yrs. **3** Mos. **17** ds.
IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION
(a) Trade, profession or
particular kind of work. **Day Laborer**
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer).

9. BIRTHPLACE **Sweden**
(State or Country)

10. NAME OF FATHER **Nels Modig**

11. BIRTHPLACE OF FATHER **Sweden**
(State or Country)

12. MAIDEN NAME OF MOTHER **Martha Olson**

13. BIRTHPLACE OF MOTHER **Sweden**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) **Mrs Nels Modig**
(Address) **Sandpoint, Idaho.**

15. Filed **July 2, 1922**
Viola Allen
Deputy Local Registrar

16. DATE OF DEATH
June 3, 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Apr 21, 1922 to **June 3, 1922**
that I last saw h. **in** alive on **June 2, 1922**
and that death occurred on the date stated above, at **10:15 A.**

The CAUSE OF DEATH* was as follows:
Pulmonary tuberculosis

(Duration) **2** Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) **C. P. Stackhouse** M. D.
6/5, 1922 (Address) **Sandpoint**

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **Lakeview Cemetery** DATE OF BURIAL **6/6, 1922**

20. UNDERTAKER **MOON & DALE** ADDRESS **Sandpoint, Ida**
L. Moon

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bonner.City of Glenzary.

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 78Primary Registration District No. 2155

(No. _____, _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 38746

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Howard Franklin Evans.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White.5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDSingle
(Write the word.)

6. DATE OF BIRTH

Nov.
(Month)

(Day)

1920
(Year)

7. AGE

20 Yrs. 20 Mos. 20 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

None

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho.

10. NAME OF FATHER

F. D. Evans.

11. BIRTHPLACE OF FATHER

(State or Country)

North Dakota

12. MAIDEN NAME OF MOTHER

Nora Reynolds.

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

F. D. Evans

(Address)

Glenzary, Idaho.

15.

Filed July 2 1922Viola Allen
Deputy Local Registrar

MEDICAL CERTIFICATE OF DEATH

169

16. DATE OF DEATH

June 23 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____ 19____, to _____ 19____.

that I last saw him _____ alive on _____ 19____.

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed)

Emmerson ChouesApr 19 22

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Newman Cemetery.June 24 1922

20. UNDERTAKER

MOON & DALE

ADDRESS

Sanpoint Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

1. PLACE OF DEATH.

County of *Bonner* Registration District No. *58*
City of *Hope* Primary Registration District No. *2107*
STATISTICAL St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Moise Corbeille

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

*White*5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.*Single*
(Write the word.)

6. DATE OF BIRTH.

Unknown
(Month) (Day) (Year)

7. AGE

About 67 - Yrs. - Mos. - ds.

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Canada

10. NAME OF FATHER

Louis Corbeille

11. BIRTHPLACE OF FATHER

(State or Country)

Canada

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

"

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

W. E. Corbeille

(Address)

15.

Filed

July 1922

19

John Larson
Local Registrar

CERTIFICATE OF DEATH.

38749 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. *1*Registered No. *27*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

169

16. DATE OF DEATH

About June 29 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to 191

that I last saw him alive on 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Accidental drowning

(Duration) Yrs. mos. ds.

Contributory (Secondary)

no

(Duration) yrs. mos. ds.

(Signed)

E. M. Moon

7/5/22 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days In the State. yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Sanford Idaho**7/5 1922*

20. UNDERTAKER

MOON & DALE

ADDRESS

Sanford Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 38750

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Butte
City of Arco

Registration District No. 59

Primary Registration District No.

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lily A. Kroeger

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

Nov 30 1871
(Month) (Day) (Year)

7. AGE

50 Yrs. Mos. ds.

IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife

9. BIRTHPLACE

(State or Country)

Elizabeth Colo

10. NAME OF FATHER

Anton Kaempfer

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

L. A. Kroeger
Arco, Idaho

15. Filed

7/5 1922

19122

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 4 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY That I attended deceased from 7/1 1922 to 7-4 1922 that I last saw her alive on 7-4 1922 and that death occurred on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:

Permeious Anemia

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

7/5 (Signed) E. L. Egle M. D.
1922 (Address) Arco, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

Denver, Colo

19. PLACE OF DEATH OR REMOVAL

Castle Rock, Colo

DATE OF BURIAL

191

20. UNDERTAKER

E. L. Egle

ADDRESS

Arco, Idaho

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **38751**
Registered No. _____1. PLACE OF DEATH **Butte** Registration District No. **59**
County of **Butte** Primary Registration District No. _____
City of **Butte** (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Alvin Brown Henderson**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Married**
(Write the word.)6. DATE OF BIRTH. **Dec 21** 18**62**
(Month) (Day) (Year)7. AGE **60** Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?8. OCCUPATION **Farmer**
(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...9. BIRTHPLACE **Richmond Utah**
(State or Country)10. NAME OF FATHER **Martin Henderson**11. BIRTHPLACE OF FATHER **Mo**
(State or Country)12. MAIDEN NAME OF MOTHER **Sarah Wheeler**13. BIRTHPLACE OF MOTHER _____
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) **Mrs A Henderson**
(Address) **Moore, Idaho**15. **4/13** 191**2**
Filed _____ Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **6/13** 191**22**
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from **6/10** 191**22** to **6/13** 191**22**,
that I last saw him alive on **6/13** 191**22**
and that death occurred on the date stated above, at **3 P.M.**

The CAUSE OF DEATH* was as follows:

Chronic Bronchymatous nephritis
(Duration) **1** Yrs. mos. ds.

Contributory (Secondary)

(Duration) **6/13** yrs. mos. ds.
(Signed) **E. L. F.** M. D.
(Address) **Moore, Idaho**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death... yrs... mos... days In the State... yrs... mos... days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL **Moore, Idaho** DATE OF BURIAL **6/15** 191**22**20. UNDERTAKER **Alvin B. Beverland** ADDRESS **Moore, Idaho**

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 38752

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Butte

City of Arco

RECEIVED District No. 39

July 13, 1922 Primary Registration District No.

BUREAU

STATE

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mrs. Dora W. Island

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female

white

married

(Write the word.)

6. DATE OF BIRTH

Feb 7

(Day)

1859 (Year)

7. AGE

63

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).

House wife

9. BIRTHPLACE

(State or Country)

Ross, Kent Co. Mich.

10. NAME OF FATHER

Prentiss Weaver

11. BIRTHPLACE OF FATHER

(State or Country)

Conn

12. MARRIEN NAME OF MOTHER

Mary Vickrey

13. BIRTHPLACE OF MOTHER

(State or Country)

N. Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Arco, Idaho

15. Filed

7-13

1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 12

(Month)

(Day)

1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1922 to 7-12

1922

that I last saw him alive on 7-12 1922

and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

apoplexy

(Duration)

Yrs.

mos.

ds.

Contributory (Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

1922 (Address)

Arco, Idaho

M. D.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Arco, Idaho

7-13 1922

20. UNDERTAKER

ADDRESS

E. H. Huddick Arco, Idaho

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

JUL 12 1922

Registration District No. 7

County of

BUREAU OF VITAL STATISTICS

Primary Registration District No. 1006

File No.

38753

City of

Nampa

(No. 1)

Nampa Hospital St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Oarl W Barnard

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male

white

Single (see word.)

6. DATE OF BIRTH

Aug 25 1897
(Month) (Day) (Year)

7. AGE

75 Yrs. 10 Mos. 2 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Farmer

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

J. O. Barnard

11. BIRTHPLACE OF FATHER

(State or Country)

Iowa

12. MAIDEN NAME OF MOTHER

Evelyn Gibson

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. O. Barnard
Parma #3 Sta

15.

Filed June 25 1922

Pearie J. J. J.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June - 27 - 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 24 1922, to 6 - 27 1922

that I last saw him alive on 6 - 27 - 1922

and that death occurred on the date stated above, at 99 M.

The CAUSE OF DEATH* was as follows:

Traumatic injury of large foot

(Duration) Yrs. mos. ds.

Contributory (Secondary)

General peritonitis.

(Duration) yrs. mos. ds.

(Signed)

Thos. E. Mangum, M. D.

6-27-1922 (Address) Nampa, Idaho.

*State the Disease Causing Death; or in Deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Big Bend Oregon

6/28 1922

20. UNDERTAKER

ADDRESS

H. K. Robinson

Nampa

Ida

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Canyon
City of MelbaRegistration District No. 7Primary Registration District No. 2552(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary Elinor MurphyState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 38754Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

single
(Write the word.)

6. DATE OF BIRTH

July 3 1922
(Month) (Day) (Year)

7. AGE

✓ Yrs. ✓ Mos. ✓ ds.IF LESS than 1 day
how many 12 hrs.
or 2 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

None

(b) General nature of industry, business or establishment in which employed (or employer).

None

9. BIRTHPLACE

(State or Country)

Canyon Co. Idaho

10. NAME OF FATHER

Edwin Lorenzo Murphy

11. BIRTHPLACE OF FATHER

(State or Country)

Tennessee

12. MAIDEN NAME OF MOTHER

Josephine Elinora Whipple

13. BIRTHPLACE OF MOTHER

(State or Country)

Colorado

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Edwin T. Murphy
Melba, Ida

15.

Filed July 5 1922 Charles Deane
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 3 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 2 1922 to July 3 1922
that I last saw her alive on July 2 1922,
and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Patent foramen ovale(Duration) ✓ Yrs. ✓ mos. ✓ ds.Contributory
(Secondary)(Duration) ✓ yrs. ✓ mos. ✓ ds.

(Signed)

Samuel A. Swaine M. D.7-3-1922 (Address) Melba, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Melba, Ida. Cemetery July 3 1922

20. UNDERTAKER

ADDRESS

None

1. PLACE OF DEATH

County of CanyonCity of Nampa

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Barbara Marie Slerret

CERTIFICATE OF DEATH

RECEIVED

JUL 1 1922

BUREAU OF VITAL STATISTICS

Registration District No. 7Primary Registration District No. 1006(No. 1006)

(St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 38756Registered No. 79

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX
Female4. COLOR OR RACE
White5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Widow

(Write the word.)

6. DATE OF BIRTH

May14833

(Month)

(Day)

(Year)

7. AGE

891

Yrs.

Mos.

ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Housewife

(b) General nature of industry, business or establishment in which employed (or employer).

(retired)

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

John Bumgarner

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Anna Marie Brand

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Idleman

(Address)

Nampa Ida.

15.

Filed June 25 1922Pearle D. Dadds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June

(Month)

(Day)

1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 15 1922, to June 15 1922that I last saw her alive on June 15 1922and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH, was/as follows:

Acute dilatation of heart.(Duration) Yrs. 1 mos. 1 ds.Contributory (Secondary) Myocarditis organic valvediarrhea (Duration) 1 yrs. 1 mos. 1 ds.(Signed) Harry P. Belknap M. D.4/15/22 (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Portland Oregon

DATE OF BURIAL

6/15/ 1922

20. UNDERTAKER

Fred K. Robinson

ADDRESS

Nampa Ida.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of AdaRegistration District No. 7City of NampaPrimary Registration District No. 1006File No. 38757

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Sophia Rachael Bull

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widowed
(Write the word.)

6. DATE OF BIRTH

Aug 24 1887
(Month) (Day) (Year)

7. AGE

82 Yrs. 9 Mos. 12 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)none

9. BIRTHPLACE

(State or Country)

Conn

10. NAME OF FATHER

(?) Swannell

11. BIRTHPLACE OF FATHER

(State or Country)

(?)

12. MAIDEN NAME OF MOTHER

(?) Bryant

13. BIRTHPLACE OF MOTHER

(State or Country)

Mass

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Francis Kroeger
Mission Idaho

15.

Filed

June 28 1922 Charles Doide

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 15 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar. 10 1922 to Mar 10 1922that I last saw her alive on Mar 10 1922and that death occurred on the date stated above, at 10:13 A.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast.(Duration) 5 Yrs. _____ mos. _____ ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

H. F. Neal M. D.6-16-19-22 (Address) Mission Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Kohlman Cem6-16 1922

20. UNDERTAKER

ADDRESS

FR RobinsonNampa

CERTIFICATE OF DEATH.

38758

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Caribou Registration District No. 82
City of Soda Springs Bureau of Vital Statistics Registration District No. 2159

File No. 116

Registered No. 157

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mike Bejovich

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single

(Write the word.)

6. DATE OF BIRTH.

Feb. 10, 1878

(Month)

(Day)

(Year)

7. AGE

44

Yrs.

5

Mos.

5

ds.

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Miner
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country) Austra

10. NAME OF FATHER

Joseph Bejovich

11. BIRTHPLACE OF FATHER

(State or Country) Austra

12. MAIDEN NAME OF MOTHER

Jocie Naglan

13. BIRTHPLACE OF MOTHER

(State or Country) Austra

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ellis Karsley
(Address) Soda Springs, Idaho

15.

Filed July 16, 1922 191

Local Registrar

16. DATE OF DEATH

July 15, 1922

(Month)

(Day)

191

(Year)

17. I HEREBY CERTIFY, That I attended deceased from July 14, 1922 to July 15, 1922

that I last saw him alive on July 15, 1922

and that death occurred on the date stated above, at 8:00 M.

The CAUSE OF DEATH* was as follows:

Operation for Ulcer of Stomach

(Duration) Yrs. 1 mos. 1 ds.

Contributory Chronic ulcer of Stomach (Secondary)

(Duration) 14 yrs. mos. ds.

(Signed) Ellis Karsley M. D.

7/16/22 (Address) Soda Springs, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rock Springs, Wyo

7/18/22 191

20. UNDERTAKER

ADDRESS

Shumaker & Hall

Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully classified. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 38759
Registered No. 29

1. PLACE OF DEATH AUG 4 1922
County of Cassia
City of Puffert
Registration District No. 19
County Registration District No. 2016
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fred Carlson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED
(Write the word.)
6. DATE OF BIRTH May 7 1871
(Month) (Day) (Year)
7. AGE 45 Yrs. Mos. ds.
LESS than 1 day
How many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Farming
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Finland

10. NAME OF FATHER Care Carlson

11. BIRTHPLACE OF FATHER
(State or Country) Finland

12. MAIDEN NAME OF MOTHER dont know

13. BIRTHPLACE OF MOTHER
(State or Country) Finland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Rika Carlson
(Address)

15. Filed 7-28-22
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
July 25 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7-10 1922 to 7-25 1922 that I last saw him alive on July 25 1922 and that death occurred on the date stated above, at 6:40 A.M.

The CAUSE OF DEATH* was as follows:
Tubercular pneumonia

(Duration) Yrs. 3 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Faye Kenagy M. D.

19.22 (Address) Rupert Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

20. UNDERTAKER Rupert Cemetery
Address

1. PLACE OF DEATH

County of Minidoka Registration District No. 19
 City of Rupert Primary Registration District No. 2013
 (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Alva Charles Little

CERTIFICATE OF DEATH

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 38760

Registered No. 30

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Child
 (write the word.)

6. DATE OF BIRTH

Feb 11 1922
 (Month) (Day) (Year)

7. AGE

5 Yrs. 19 Mos. 19 ds.
 IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

Child

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Alva Jared Little

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Agnes Hymie Chapier

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Alva Jared Little
Salt Lake City, Utah

15.

Filled

8-1

1922

E. E. Elmore
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 30 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 26 1922 to July 30 1922
 that I last saw him alive on July 30 1922
 and that death occurred on the date stated above, at 9 A. M.
 The CAUSE OF DEATH* was as follows:
Cholera

(Duration) Yrs. mos. ds.

Contributory
 (Secondary)

(Duration) Yrs. mos. ds.

(Signed)

1922 (Address) Rupert Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

W. G. Goodman Aug 2 1922

20. UNDERTAKER

ADDRESS

Salt Lake City Rupert Ida

1. PLACE OF DEATH

County of MinidokaCity of Rupert

If death occurs away from usual residence, give facts called for under special information.

CERTIFICATE OF DEATH

RECEIVED
AUG 4 1922
BUREAU OF VITAL STATISTICSRegistration District No. 19Registration District No. 2015

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 38761Registered No. 231

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sarah E Root

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Fem

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widow

(Write the word.)

6. DATE OF BIRTH

Aug 28th 1843
(Month) (Day) (Year)

7. AGE

78 Yrs. 9 Mos. 13 ds.IF LESS than 1 day
how many.....hrs.
or.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

House wife

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

dont know

11. BIRTHPLACE OF FATHER

(State or Country)

" "

12. MAIDEN NAME OF MOTHER

" "

13. BIRTHPLACE OF MOTHER

(State or Country)

" "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harrett E Clark(Address) Rupert Idaho

15.

Filed June 19 1922E. H. Elmore
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June II 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 10 1922 to June 11 1922that I last saw her alive on June 11 1922and that death occurred on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) Yrs. mos. ds.

Contributory
(Secondary)Chronic nephritis

(Duration) yrs. mos. ds.

(Signed)

E. H. Elmore M. D.6-19-1922 (Address) Rupert Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Rupert, Cemetry

DATE OF BURIAL

June 13 1922

20. UNDERTAKER

W. G. Goodman

ADDRESS

Rupert Idaho

CERTIFICATE OF DEATH

38767 State of Idaho
BOARD OF HEALTH

Bureau of Vital Statistics

File No.

Registered No. 594
If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

1. PLACE OF DEATH **RECEIVED**
County of Cass Registration District No. 117
City of Bureau of Vital Statistics Primary Registration District No. 2196
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Annie Elmira Richardson

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED. Single (Write the word.)

16. DATE OF DEATH

6. DATE OF BIRTH

Unknown
(Month) (Day) (Year)

7. AGE

38 Yrs. Mos. ds.IF LESS than 1 day
how many hrs. or
min. ?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of in-
dustry, business, or estab-
lishment in which em-
ployed (or employer)None

9. BIRTHPLACE

(State or Country) Plain City Utah10. NAME OF
FATHERWarren Richardson11. BIRTHPLACE
OF FATHER(State or Country) Salt Lake City12. MAIDEN NAME
OF MOTHEREliza Singlet13. BIRTHPLACE
OF MOTHER(State or Country) Plain City Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thos. Richardson(Address) Durley Ida.15. Filed June 13 1922 D. J. Patterman
Local Registrar.

16. DATE OF DEATH

May 10 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
Mar 10 1922 to May 10 1922
that I last saw him alive on May 6 1922
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Malignant Growth of Blv.(Duration) 1 Yrs. mos. ds.Contributory
(Secondary)(Duration) 1 Yrs. mos. ds.(Signed) F. H. Cutler M. D.19. (Address) Durley*State the Disease Causing Death; or in deaths from Violent
Causes, state (1) Means of Injury; and (2) whether Accidental,
Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)At place In the
of death yrs. mos. days, State yrs. mos. daysWhere was disease contracted
if not at place of death?Former or
usual residence19. PLACE OF BURIAL OR REMOVAL Almo Idaho DATE OF BURIAL 5/12/192220. UNDERTAKER L. B. Gallagher ADDRESS Durley Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

38768

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 130
County of *Idaho* Primary Registration District No. 2199
City of *Oakley* St.File No. *XV 111*
Registered No. *25*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Correll Sutton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *Male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *single*
(Write the word.)

6. DATE OF BIRTH *June 19* 19*22*
(Month) (Day) (Year)

7. AGE *4* IF LESS than 1 day how many... hrs. or... min.?
Yrs. Mos. ds.

16. DATE OF DEATH

June 23 19*22*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *June 19* 19*22* to *June 23* 19*22*
that I last saw him alive on *June 23* 19*22*
and that death occurred on the date stated above, at *5* P. M.
The CAUSE OF DEATH* was as follows:

Premature child

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) *W. H. Nelson* M. D.1922 (Address) *Oakley, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death... yrs... mos... days. In the State... yrs... mos... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Oakley, Idaho *June 23*

20. UNDERTAKER

Bob John A. Adams Oakley, Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *J. H. Sutton*(Address) *Oakley, Idaho*15. Filed *June 30* 19*22* *W. H. Nelson*

Local Registrar

CERTIFICATE OF DEATH

38770

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Cassia
City of BurleyRegistration District No. 117Primary Registration District No. 2196

(No. _____ St.)

File No. 596Registered No. 596

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Orena Francis Barr

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
-
- OWED OR DIVORCED

Male White Single
(Write the word.)

6. DATE OF BIRTH

August 10 1921
(Month) (Day) (Year)

7. AGE

6 Yrs. 24 Mos. 24 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work.
-
- (b) General nature of industry, business or establishment in which employed (or employer).

None

9. BIRTHPLACE

(State or Country) Burley Ida.

10. NAME OF FATHER

Charles Isaac Barr

11. BIRTHPLACE OF FATHER

(State or Country) Salina Utah

12. MAIDEN NAME OF MOTHER

Pearl Kelley

13. BIRTHPLACE OF MOTHER

(State or Country) American Fork Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

C. J. Barr

(Address)

Burley Ida

15.

Filed July 1st 1922 D. J. C. Vetter
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 4 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb. 27 1922 to March 4 1922that I last saw him alive on March 4 1922and that death occurred on the date stated above, at 8:45 A.M.

The CAUSE OF DEATH* was as follows:

Influenza-Pneumonia(Duration) _____ Yrs. _____ mos. 6 ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

C. A. Rich M. D.3-4-1922 (Address) Burley Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Burley Ida

DATE OF BURIAL

3-4 1922

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

38771
State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 117

County of Cassia

Primary Registration District No. 2196

City of Burley

No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Phyllis Carmen Cook

File No.

Registered No. 597

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WID-OWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

June 1 1922
(Month) (Day) (Year)

7. AGE

Yrs. Mos. 11 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

None

9. BIRTHPLACE

(State or Country)

Burley
Cassia Co Id.

10. NAME OF FATHER

Samuel Dewey Cook

11. BIRTHPLACE OF FATHER

(State or Country)

Albion Ida.

12. MAIDEN NAME OF MOTHER

Mildred May Gardner

13. BIRTHPLACE OF MOTHER

(State or Country)

Ketchey Michigan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs Dewey Cook

(Address)

Burley Idaho

15.

Filed July 1st 1922 L. J. Pattison
Local Registrar

MEDICAL CERTIFICATE OF DEATH

37

16. DATE OF DEATH

June 11 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 1 1922, to June 11 1922,
that I last saw her alive on June 11, 1922,
and that death occurred on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:

Congenital Syphilis.

(Duration) Yrs. mos. 11 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) C. A. Rich M. D.

June 11, 1922 (Address) Burley Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Burley, Ida

June 12-19-22

20. UNDERTAKER

ADDRESS

None

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH

Bureau of Vital Statistics

File No. 38772

Registered No. 620

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Cassia

Registration District No. 117

Primary Registration District No. 2196

(No. 38)

St.)

City of Burley

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Bernt Matheson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married (Write the word.)

6. DATE OF BIRTH.

Nov. 22, 1874
(Month) (Day) (Year)

7. AGE

47 Yrs. 6 Mos. 13 ds.

IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Norway

10. NAME OF FATHER

Mathias Goode

11. BIRTHPLACE OF FATHER

(State or Country)

Norway

12. MAIDEN NAME OF MOTHER

Ida Jensen

13. BIRTHPLACE OF MOTHER

(State or Country)

Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John Matheson

(Address) R. F. D. # 2, Burley, Ida.

15.

Filed July 13, 1912

H. J. Patten
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

172

16. DATE OF DEATH

June 4, 1912
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to 191

that I last saw him alive on 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Fracture of Spine in Fall
from Electric Pole

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) L. B. Tallopy, Coroner

June 11, 1912, (Address) Burley, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days, State yrs. mos. daysWhere was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Burley Idaho

DATE OF BURIAL

June 7, 1912

20. UNDERTAKER

L. B. Tallopy

ADDRESS

Burley, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH

Bureau of Vital Statistics

File No. 38274

Registered No. 2196

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Cassia

Registration District No. 117

City of Burley

Primary Registration District No. 2196

If death occurs away from usual residence, give facts called for under special information.

(No. 117, St.)

2. FULL NAME Cora Adeline Edwards

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widowed
(Write the word.)

6. DATE OF BIRTH.

July 20, 1875
(Month) (Day) (Year)

7. AGE

46 Yrs. 10 Mos. 13 ds.

IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

Clifford Freeman

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Sarah Jane McMullen

13. BIRTHPLACE OF MOTHER

(State or Country)

Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mable F. Bayles

(Address) Burley, Ida.

15.

Filed June 3, 1922

Dr. J. C. Patterson
By S. C. Local Registrar

MEDICAL CERTIFICATE OF DEATH 45

16. DATE OF DEATH

June 2, 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 2, 1922 to June 2, 1922

that I last saw him alive on June 2, 1922

and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Internal Cancer
Cancer of rectum

(Duration) 1 Yrs. 3 mos. ds.

Contributory

(Secondary)

(Duration) Yrs. mos. ds.

(Signed) L. B. Gallagher, Surgeon M. D.

19. (Address) L. B. Gallagher

*State the Disease Causing Death, or death from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days, State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Ashland Oregon

DATE OF BURIAL

6/6/1922

20. UNDERTAKER

L. B. Gallagher

ADDRESS

Burley, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **38775**
Registered No. _____

1. PLACE OF DEATH

County of **Clark** Registration District No. **125**
City of **Argona** Primary Registration District No. **2203**
(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Kenneth Rud Grunt

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Married**
(Write the word.)

6. DATE OF BIRTH

June 12 1922
(Month) (Day) (Year)

7. AGE

Yrs. Mos. **14** ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) **Idaho**

10. NAME OF FATHER

Elmer Grunt

11. BIRTHPLACE OF FATHER

(State or Country) **Utah**

12. MAIDEN NAME OF MOTHER

Lena M Palezick

13. BIRTHPLACE OF MOTHER

(State or Country) **Idaho**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Elmer Grunt**
(Address) **Argona ID**

15.

Filed **June 27 1922** **CE Jones MD**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 26 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

10 to **10**
that I last saw him alive on **June 26 1922**
and that death occurred on the date stated above, at **10:30 AM**.
The CAUSE OF DEATH* was as follows:

Auto infection

(Duration) _____ Yrs. _____ mos. **7** ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) **CE Jones** M. D.

627 1922 (Address) **Butte Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Small Idaho **6-27 1922**

20. UNDERTAKER

ADDRESS

None

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 125
County of Clark Primary Registration District No. 2203
City of Subow (State) _____ St.)File No. 38776
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Warren G. Leonardson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Infant
(Write the word.)6. DATE OF BIRTH Feb 19 1922
(Month) (Day) (Year)7. AGE _____ IF LESS than 1 day
how many _____ hrs.
Yrs. 11 Mos. 11 ds. or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Carl F. Leonardson

11. BIRTHPLACE OF FATHER

(State or Country) Idaho

12. MAIDEN NAME OF MOTHER

Leah Thomas

13. BIRTHPLACE OF MOTHER

(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Carl F. Leonardson
(Address) Subow Idaho15. July 1 1922 W. Jones M.D.
Filed _____ Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 30 1922
(Month) (Day) (Year)17. ~~I HEREBY CERTIFY~~ That I attended deceased from _____ to _____

that I last saw him _____ alive on _____ 19____

and that death occurred on the date stated above, at 3:00 M.
The CAUSE OF DEATH* was as follows:Acute Gastritis
8 hours

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W. Jones M. D.7-1 1922 (Address) Subow Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Subow

DATE OF BURIAL

July 1 1922

20. UNDERTAKER

None

ADDRESS

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Franklin
City of Clifton

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ole S. HowellRECEIVED
AUG 5 1922
BUREAU OF VITAL STATISTICS
STATE OF IDAHO

MEDICAL CERTIFICATE OF DEATH

Registration No. 27
Prima District No. 2119
() St.)State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 38777
Registered No. 46

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED single
(Write the word.)

6. DATE OF BIRTH

July 29 1922
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day
how many hrs.
Yrs. Mos. ds. or 5 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Marion Howell

11. BIRTHPLACE OF FATHER

(State or Country) Idaho

12. MAIDEN NAME OF MOTHER

Elsie Lunt

13. BIRTHPLACE OF MOTHER

(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed Aug 2 1922 Mrs Ida Lippert
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 29 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from July 29 1922 to July 29 1922
that I last saw him alive on July 29 1922
and that death occurred on the date stated above, at 6:40 P.M.

The CAUSE OF DEATH* was as follows:

Asphyxia
(Duration) Yrs. mos. ds.Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

U. R. Cullup M. D.
7/29. 1922 (Address) Preston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Clifton Idaho July 30, 1922

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

RECEIVED
AUG 5 1922
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1. PLACE OF DEATH.
County of Franklin Registration District No. 2119
City of Weston (No. _____, St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 38778
Registered No. 43

If death occurs away from usual residence, give facts called for under special instruction.

2. FULL NAME

James Peter Mickelsen

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH April - 18 - 1847
(Month) (Day) (Year)

7. AGE 75 yrs. 8 mos. 13 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Bornholm Denmark

10. NAME OF FATHER

Jens Mickelsen

11. BIRTHPLACE OF FATHER

(State or Country)

Denmark

12. MAIDEN NAME OF MOTHER

Bertha Jensen

13. BIRTHPLACE OF MOTHER

(State or Country)

Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

John A. Mickelsen
Weston Idaho

15.

Filed

Aug 2 1922 Mrs Ida Lyngset
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July 31 - 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June - 1 - 1922, to July 31 - 1922
that I last saw him alive on July 22 - 1922
and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(Duration) 2 yrs. - mos. - ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) For J. B. Wood M. D.

Aug 1 - 1922 (Address) Weston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death? _____
Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Weston Idaho Aug 2 1922

20. UNDERTAKER

ADDRESS

1. PLACE OF DEATH

County of Franklin
City of Preston

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Wackie Lewis Roe

CERTIFICATE OF DEATH

District No. 2119Registration District No. 27

St. _____

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 38779Registered No. 576 44

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white5. SINGLE, MARRIED, WID-
OWED OR DIVORCED
married
(Write the word.)

6. DATE OF BIRTH

Aug 1 1866
(Month) (Day) (Year)

7. AGE

55 Yrs. 10 Mos. 20 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Editor and Publisher
"Fairplay to Women"
Printing Co.

9. BIRTHPLACE

(State or Country)

Derby - Shire England

10. NAME OF FATHER

John Roe

11. BIRTHPLACE OF FATHER

(State or Country)

Derby - Shire England

12. MAIDEN NAME OF MOTHER

Katherine Byatt

13. BIRTHPLACE OF MOTHER

(State or Country)

Derby - Shire England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Louise B. Roe
Preston Ida

(Address)

Filed July 1 19 22Mrs. H. H. Huppert

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 19 19 22
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from March 16 1922 to June 19 1922
that I last saw h.f.m. alive on June 17 1922
and that death occurred on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach(Duration) _____ Yrs. 9 mos. _____ ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Curtis Bland M. D.(Address) Preston, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Salt Lake City Ut June 22 1922

20. UNDERTAKER

ADDRESS

W. A. Skidmore Preston Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

RECEIVED CERTIFICATE OF DEATH

38781

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 103
County of Idaho
City of Cottonwood
State of Idaho
Registration District No. 2183

File No. 14

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William George Hemhoff

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Aug 27 1916
(Month) (Day) (Year)

7. AGE

3 yrs. 9 mos. 4 ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Ne Perce Idaho

10. NAME OF FATHER

John Hemhoff

11. BIRTHPLACE OF FATHER

(State or Country) Humphrey Neb

12. MAIDEN NAME OF MOTHER

Mary Brockhaus

13. BIRTHPLACE OF MOTHER

(State or Country) Humphrey Neb

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John Hemhoff

(Address) Cottonwood Idaho

15.

Filed July 7 1922 W. F. Orr
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 1 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb. 1922 to June 1 1922

that I last saw him alive on May 30 1922

and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Endocarditis with
coronary dilatation

(Duration) yrs. 3 mos. ds.

Contributory Influenza Pneumonia
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Wesley F. Orr, M. D.
6/1 1922 (Address) Cottonwood Id.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Cottonwood Id. 6-3 1922

20. UNDERTAKER

ADDRESS

W. F. Orr Cottonwood Id.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Latah
City of Grangeville

If death occurs away from usual residence, give facts called for under special information.

RECEIVED

JUL 14 1922

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. _____

Registration District No. _____

City of _____

2. FULL NAME

Johanna WinterfeldtState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 38782

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

FM

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

widowed

(Write the word.)

6. DATE OF BIRTH

aug 28 1894
(Month) (Day) (Year)

7. AGE

92 Yrs. 9 Mos. 16 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

House wife

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

Don't know

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Johanna Mueller

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. F. Wolff

(Address)

Grangeville, Idaho

15. Filed

June 15 1922 W. F. Ehn

Local Registrar

MEDICAL CERTIFICATE OF DEATH

29

16. DATE OF DEATH

June 14 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 12 1922 to June 13 1922
that I last saw h. h alive on June 13 1922
and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Miliary Tuberculosis(Duration) 2 Yrs. _____ mos. _____ ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

A. F. Wolff M. D.June 15 1922 (Address) Grangeville, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

H. C. Lambert Grangeville

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
JUL 13 1922

CERTIFICATE OF DEATH

38783

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No.

Primary Registration District No.

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19..... to 19.....

that I last saw him..... alive on..... 19.....

and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Unknown
Probably from tumor

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

M. D.

19.....

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

yrs.

mos.

days.

In the

State

yrs.

mos.

days

Where was disease contracted if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

FORM V. S. No. 5-A-25 M. 1-19:

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of JeromeCity of Salmon

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 41Primary Registration District No. 2116(No. SD)File No. 38785

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

John Engle

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

widowed
(Write the word.)

6. DATE OF BIRTH

December 15 1887
(Month) (Day) (Year)

7. AGE

71 Yrs. _____ Mos. _____ ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).stone mason

9. BIRTHPLACE

(State or Country) Canada

10. NAME OF FATHER

John Engle

11. BIRTHPLACE OF FATHER

(State or Country) _____

12. MAIDEN NAME OF MOTHER

Minnie Penskie

13. BIRTHPLACE OF MOTHER

(State or Country) _____

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ruby Brough

(Address) _____

15.

Filed July - 10 - 1922Oliver Bellamy
abp Local Registrar

MEDICAL CERTIFICATE OF DEATH

81

16. DATE OF DEATH

June 22 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar 10 1922 to June 20 1922
that I last saw him alive on June 20 1922
and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Acute SclerosisContributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Chas F Hamme M. D.1922 (Address) Salmon

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Salmon Cemetery

DATE OF BURIAL

6-23 1922

20. UNDERTAKER

H. C. Jacobs

ADDRESS

Salmon Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Lemhi
City of Salmon

Registration District No. 41
Primary Registration District No. 2116
(No. _____ St.)

File No. 38786
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Iver Marcussen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH

April 2nd 1874
(Month) (Day) (Year)

7. AGE

48 Yrs. 2 Mos. 25 ds. IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Rancher

9. BIRTHPLACE

(State or Country) Germany

10. NAME OF FATHER

Hans Marcussen

11. BIRTHPLACE OF FATHER

(State or Country) Germany

12. MAIDEN NAME OF MOTHER

Catherine Evenson

13. BIRTHPLACE OF MOTHER

(State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Peter Marcussen
(Address) Salmon, Idaho.

15. Filed July 10 - 1922

Chris Bellamy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

159

16. DATE OF DEATH

June 27th 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 2 1922 to June 27 1922 that I last saw him alive on June 26 1922 and that death occurred on the date stated above, at 7 A. M.

The CAUSE OF DEATH* was as follows:

Gun shot injury to skull - self inflicted with suicidal intent

(Duration) _____ Yrs. _____ mos. 24 ds.
Contributory (Secondary) _____

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) Chas F Hammer M. D.

7/27 1922 (Address) Salmon

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Salmon Cemetery

6-28 1922

20. UNDERTAKER

ADDRESS

W.C. Jacob

Salmon Idaho

FORM V. S. No. 5-25 M 1-19.

1. PLACE OF DEATH

County of *Lewis*City of *Craig*

If death occurs away from usual residence, give facts called for under special information.

RECEIVED

AUG 4 1922

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. *60*City Registration District No. *2129*

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

38787

Registered No. *11*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME *Lizzie Bronchean*

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *F*4. COLOR OR RACE *Indian*5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*
(Write the word.)6. DATE OF BIRTH *Apr 29 1921*
(Month) (Day) (Year)7. AGE *1* Yrs. *2* Mos. *4* ds.IF LESS than 1 day
how many yrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE *Idaho*
(State or Country)10. NAME OF FATHER *Alex Bronchean*11. BIRTHPLACE OF FATHER *Idaho*
(State or Country)12. MAIDEN NAME OF MOTHER *Susie Lawyer*13. BIRTHPLACE OF MOTHER *Idaho*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Alex Bronchean*(Address) *Lapwai Id*15. *7/3*Filed *7/3*

1922

R. O. Deuch

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *July 3 1922*
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *July 2 1922* to *July 3 1922*that I last saw him alive on *July 2 1922*and that death occurred on the date stated above, at *6 P.* M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia(Duration) Yrs. mos. *14* ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) *R. O. Deuch* M. D.(Address) *Craig*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence *Spaulding Id*19. PLACE OF BURIAL OR REMOVAL *Lapwai Id*DATE OF BURIAL *7/4 1922*20. UNDERTAKER *Alex Bronchean*ADDRESS *Spaulding*

RECEIVED CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **38788**
Registered No. **10**

1. PLACE OF DEATH

Leura

AUG 4 1922

District No.

Primary Registration District No.

City of

BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Leatha Dora Young

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

F

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single (Write the word.)

6. DATE OF BIRTH

March 11 1904

7. AGE

18 Yrs. 3 Mos. 15 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

Housewife

9. BIRTHPLACE

(State or Country)

Garfield Co. Wash

10. NAME OF FATHER

W. D. Young

11. BIRTHPLACE OF FATHER

(State or Country)

Oregon

12. MAIDEN NAME OF MOTHER

Rettie O'Keefe

13. BIRTHPLACE OF MOTHER

(State or Country)

Colorado

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. J. O'Keefe

(Address)

Craigmont

15.

Filed

6/27 1922

P. E. Duval

Local Registrar

16. DATE OF DEATH

June 26 1922

17. I HEREBY CERTIFY, That I attended deceased from

June 25 1922 to June 26 1922

that I last saw him alive on June 26 1922

and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Burn accidental
(over)
(Duration) 27 hrs. 27 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) P. E. Duval M. D.

6/27 1922 (Address) Craigmont

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

F. H. O'Keefe

DATE OF BURIAL

6/27 1922

20. UNDERTAKER

S. W. O'Keefe

ADDRESS

Craigmont

1. PLACE OF DEATH

County of Lincoln
City of Lincoln

If death occurs away from usual residence, give facts called for under special information.

RECEIVED

AUG 4 1922

CERTIFICATE OF DEATH

Registration District No. 50County Registration District No. 2129State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 38789Registered No. 12

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Harvey M. Bride Hosley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

June 6 1922
(Month) (Day) (Year)

7. AGE

7 Yrs. 7 Mos. 7 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

Infant

9. BIRTHPLACE

(State or Country)

Winchester, Ida

10. NAME OF FATHER

Harvey M. Hosley

11. BIRTHPLACE OF FATHER

(State or Country)

Illinois

12. MAIDEN NAME OF MOTHER

Viola M. Brooks

13. BIRTHPLACE OF MOTHER

(State or Country)

Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Harvey M. Hosley
Winchester, Ida

15.

Filed

7/6 1922R. D. Duell

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 13 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 6 1922 to June 13 1922
that I last saw him alive on June 13 1922
and that death occurred on the date stated above, at 2:30 AM.

The CAUSE OF DEATH* was as follows:

Meningitis, Septic?(Duration) Yrs. 1 mos. 1 ds.

Contributory (Secondary)

(Duration) yrs. 9 mos. 9 ds.

(Signed)

R. H. Lane, M. D.June 13 1922 (Address) Winchester, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. 7 mos. 7 days. In the State yrs. 7 mos. 7 days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Forest, Ida June 13 1922

20. UNDERTAKER

ADDRESS

Julius Truckee Forest, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH.

County of Lewis

City of Craigmont,

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED
AUG 4 1922
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

Registration District No. 50

Primary Registration District No. 2129

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 38790

Registered No. 13

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

single

(Write the word.)

6. DATE OF BIRTH.

July 13,

1922.

(Month)

(Day)

(Year)

7. AGE

Yrs. Mos. 2/5 ds.

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work...

infant

(b) General nature of in-
dustry, business, or estab-
lishment in which employ-
ed (or employer).....

9. BIRTHPLACE

(State or Country)

Craigmont, Idaho.

10. NAME OF
FATHER

Robert J. McClaren

11. BIRTHPLACE
OF FATHER

(State or Country)

Colorado

12. MAIDEN NAME
OF MOTHER

Gertrude Bean

13. BIRTHPLACE
OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15.

Filed

7/14

1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 14

(Month)

(Day)

1922.

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 15

1922.

to July 14

1922.

that I last saw him alive on July 13

1922.

and that death occurred on the date stated above, at 12.04

The CAUSE OF DEATH* was as follows:

Prematurity. (7 months uterine
development)

(Duration)

Yrs.

mos.

2/3 ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

P. E. Dwyer M. D.

7/14

(Address)

Craigmont, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death.....yrs.....mos.....days

In the

State.....yrs.....mos.....days

Where was disease contracted
if not at place of death?.....

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

I. O. O. F. Cemetery

DATE OF BURIAL

7/14 1922

20. UNDERTAKER

Robt. McClaren

ADDRESS

Craigmont

RECEIVED

AUG 4 1922

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 38791

Registered No. 14

1. PLACE OF DEATH

County of Lewis

City of Caldwell

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Frederick Schubert

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male White

Married
(Write the word.)

6. DATE OF BIRTH

Feb 27 1862
(Month) (Day) (Year)

7. AGE

60 Yrs. 4 Mos. 27 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Farmer

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

John F. Schubert
Caldwell, Idaho

15.

Filed

7/25 1922

19

F. D. Jewell

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 24 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 12 1922 to July 15 1922

that I last saw him alive on July 15 1922

and that death occurred on the date stated above, at 7:40 PM.

The CAUSE OF DEATH* was as follows:

Diabetic Melitis
about

(Duration) 3 Yrs. 3 mos. ds.

Contributory
(Secondary)

Bronchitis

(Duration) 3 yrs. 3 mos. ds.

(Signed)

J. C. Langley, M. D.

7/25 1922

(Address) Winchester, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Lafayette Cemetery

DATE OF BURIAL

7/26 1922

20. UNDERTAKER

Chas. Miller

ADDRESS

Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of *Madison*
City of *Crystal-Butte*
Registration District No. *110*
St. *2178*

File No. *38792*
Registered No. *46*

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME *Loid Mickesell*

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *M.* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. *Boy*
(Write the word.)

16. DATE OF DEATH
July *2* *1922*
(Month) (Day) (Year)

6. DATE OF BIRTH
July *14* *1915*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *191* to *191*, that I last saw him alive on *191*, and that death occurred on the date stated above, at *6 P. M.*

7. AGE *6* Yrs. *11* Mos. *15* ds.
IF LESS than 1 day how many hrs. or min.?

The CAUSE OF DEATH* was as follows:
Accidental, fell from a tree and fractured his skull.
(Duration) Yrs. mos. ds.

8. OCCUPATION
(a) Trade, profession or particular kind of work... *Student*
(b) General nature of industry, business, or establishment in which employed (or employer).....

Contributory (Secondary) _____
(Duration) yrs. mos. ds.
(Signed) *J. R. Young* *Donna*
19. (Address) *Reynolds Idaho*

9. BIRTHPLACE
(State or Country) *Reynolds Idaho*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

10. NAME OF FATHER *William W. Mickesell*

11. BIRTHPLACE OF FATHER
(State or Country) *Utah*

12. MAIDEN NAME OF MOTHER *Elma Hughes*

13. BIRTHPLACE OF MOTHER
(State or Country) *Idaho*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *William W. Mickesell*
(Address) *Reynolds*

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

15. Filed *7/4* *1922* *J. R. Young*
Local Registrar

19. PLACE OF BURIAL OR REMOVAL *Idaho* DATE OF BURIAL *7/5* *1922*

20. UNDERTAKER *J. R. Young* ADDRESS *Reynolds*

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Madison
City of Sugar

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
JUL 3 1922
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 100Registration District No. 2178

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 38793Registered No. 47

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sarah Elizabeth Twitchell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

FemaleWhiteWidowed

(Write the word.)

6. DATE OF BIRTH

Sept.
(Month)30th
(Day)1876
(Year)

7. AGE

45 Yrs.7 Mos.3 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Housewife

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Robert P. Allen

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Elizabeth Mitchell

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. Twitchell

(Address)

Sugar City, Idaho

15.

Filed 7/519 22W. Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July
(Month)3rd
(Day)1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 1, 1922, to June 1, 1922that I last saw her alive on June 1, 1922and that death occurred on the date stated above, at 3:30 P.

The CAUSE OF DEATH* was as follows:

Carcinoma of right kidney.(Duration) few Yrs. mos. ds.Contributory
(Secondary)hematuria(Duration) 5 yrs. mos. ds.

(Signed)

7/6Lorin F. Rich M. D.(Address) Rexburg, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

David Young, Rexburg

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED

CERTIFICATE OF DEATH.

1. PLACE OF DEATH Madison District No. 100
 County of Madison Registration District No. 2178
 City of Boyle (No.) 38794 (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baley Harris

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 38794
 Registered No. 48

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Bachelor
 (Write the word.)

6. DATE OF BIRTH. July 7 1922
 (Month) (Day) (Year)

7. AGE IF LESS than 1 day how many hrs. or min.
 Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work...
 (b) General nature of industry, business, or establishment in which employed (or employer).....

Bachelor

9. BIRTHPLACE Boyle Idaho
 (State or Country)

10. NAME OF FATHER Charlton Harris

11. BIRTHPLACE OF FATHER Boyle Idaho
 (State or Country)

12. MAIDEN NAME OF MOTHER Ewa Cooper

13. BIRTHPLACE OF MOTHER Boyle Idaho
 (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. H. Cooper
 (Address) Boyle

15. Filed July 8 1922 J. R. Gorman
 Local Registrar

MEDICAL CERTIFICATE OF DEATH 1896

16. DATE OF DEATH July 7 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 7 1922 to July 7 1922,
 that I last saw her alive on 1922,
 and that death occurred on the date stated above, at 5 a M.

The CAUSE OF DEATH* was as follows:

Still Born

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Signed) J. H. Cooper M. D.
 7/7 1922 (Address) Boyle Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Boyle DATE OF BURIAL 7/8 1922

20. UNDERTAKER J. R. Gorman ADDRESS Boyle

1. PLACE OF DEATH

County of Madison
City of Rexburg

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Joseph Robert Wylie

CERTIFICATE OF DEATH

Registration District No. 100Primary Registration District No. 2175

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 38795Registered No. 47

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Male White

Single

(Write the word.)

6. DATE OF BIRTH

September 24th 1909
(Month) (Day) (Year)

7. AGE

12 Yrs. 9 Mos. '28 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Robert Wylie

11. BIRTHPLACE OF FATHER

(State or Country) Utah

12. MAIDEN NAME OF MOTHER

Rebecca Weeks

13. BIRTHPLACE OF MOTHER

(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

19 22

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

19 22 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

7/17 - 1922, to 7-21 - 1922

that I last saw h.l.m. alive on 7-21 - 1922

and that death occurred on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(Duration) Yrs. mos. 15 ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

7/22 1922

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sunnydell, Ida

7/25 1922

20. UNDERTAKER

ADDRESS

David Young

Rexburg

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
JUL 14 1922

CERTIFICATE OF DEATH

(Gunnar)
State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
58797
File No. 58797
Registered No.

1. PLACE OF DEATH

County of MyerCity of Leviaton

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 96Primary Registration District No. 1079

(No. St.)

2. FULL NAME

Katie M. Richards

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

May 23rd 1853
(Month) (Day) (Year)

7. AGE

69 Yrs. 14 Mos. ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Housewife

(b) General nature of industry, business or establishment in which employed (or employer).

At Home

9. BIRTHPLACE

(State or Country)

Wis

10. NAME OF FATHER

unknown

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Katherine Johnson

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Geo W. Richards
Leviaton Idaho

15.

Filed

7/6/1922 F.T. Harris, M.D.

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 7th 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from May 24 1922 to June 7 1922 that I last saw her alive on June 7 1922 and that death occurred on the date stated above, at 6am.

The CAUSE OF DEATH was as follows:

cardiac crisis(Duration) Yrs. 3 mos. ds.Contributory
(Secondary)(Duration) yrs. mos. ds.(Signed) E. H. Gunnar M. D.19..... (Address) Leviaton Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Leviaton Idaho 6-8-1922

20. UNDERTAKER

ADDRESS

Leviaton Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH **RECEIVED**
 County of Hyatt Registration District No. 96
 City of Lewiston Primary Registration District No. 1009
 (No. 1009 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Alice White Cherrier

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 38798
 Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED married
 (Write the word.)

6. DATE OF BIRTH

July 17 1869
 (Month) (Day) (Year)

7. AGE

52 Yrs. 11 Mos. 9 ds.

IF LESS than 1 day
 how many _____ hrs.
 or _____ min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

At home

9. BIRTHPLACE

(State or Country) Ont. Canada

10. NAME OF FATHER

Wm. White

11. BIRTHPLACE OF FATHER

(State or Country) Scotland

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country) Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) L. Cherrier

(Address) _____

15.

Filed 7/6/ 19 22 F. T. Harris, M.D.
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 26 19 22
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 25 19 22, to June 26 19 22
 that I last saw her alive on June 25 19 22,
 and that death occurred on the date stated above, at 12:42 AM.

The CAUSE OF DEATH* was as follows:

Other pneumonia
following operation for gall
stones

(Duration) 1 Yrs. _____ mos. _____ ds.

Contributory Poor health
 (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) A. D. Harris M. D.

_____ 19 _____ (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Lewiston, Idaho June 28 19 22

20. UNDERTAKER

ADDRESS Lewiston Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Carson
State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **38799**
Registered No.

1. PLACE OF DEATH

Registration District No. **96**
County of **Myer** Primary Registration District No. **1009**
City of **Leicester** (St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
JUL 14 1922
BUREAU OF VITAL STATISTICS

2. FULL NAME

John Schmitt

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Single**
(Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

about 75

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Farmer

9. BIRTHPLACE

(State or Country)

Wis.

10. NAME OF FATHER

Christopher Schmitt

11. BIRTHPLACE OF FATHER

(State or Country)

France

12. MAIDEN NAME OF MOTHER

Annie Haukauer

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Christopher Schmitt
Leicester, Idaho

(Address)

15.

Filed **7/6/** 19 **22** **F.T. Harris, M.D.**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 4 19 **22**
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from **June 1st** 19**22** to **June 4th** 19**22**
that I last saw him alive on **June 4th** 19**22**
and that death occurred on the date stated above, at **3:30 P.M.**
The CAUSE OF DEATH* was as follows:

Acute Pneumonia

(Duration) Yrs. mos. **3** ds.

Contributory (Secondary) **Gastric catarrh**

(Duration) yrs. mos. **3** ds.

(Signed) **O. C. Carson** M. D.

19 (Address) **Leicester, Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Pomeroy, Idaho 19.....

20. UNDERTAKER

ADDRESS

Passar and Co. Leicester

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 38800

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Nez Perce
City of Lapwai
BUREAU OF VITAL STATISTICS

Registration District No. 96

Primary Registration District No. 1009

No.

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

James

Jaurceit

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

m

4. COLOR OR RACE

Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH.

(Month)

(Day)

(Year)

7. AGE

18

Yrs.

Mos.

ds.

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country)

Alaska

10. NAME OF FATHER

Peter Jaurceit

11. BIRTHPLACE OF FATHER

(State or Country)

Alaska

12. MAIDEN NAME OF MOTHER

Anna

13. BIRTHPLACE OF MOTHER

(State or Country)

Alaska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Geo O'Keefe

Lapwai Idaho

15.

Filed

7/6/

1922

F.T. Harris, M.D.

Local Registrar

16. DATE OF DEATH

May 7

(Month)

(Day)

1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from May 10 1922, to June 7 1922, that I last saw him alive on June 7 1922 and that death occurred on the date stated above, at 10:30 AM.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

(Address)

Geo O'Keefe, M.D.
Lapwai Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death.....

yrs.

mos.

days

In the

State.....

yrs.

mos.

days

Where was disease contracted if not at place of death?

Oregon

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Fort Lapwai Cavalorum

DATE OF BURIAL

6/8 1922

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 38801

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No.

Primary Registration District No.

St.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

Yrs. 8 Mos. 22 ds.

IF LESS than 1 day
how many.....hrs.
or.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

7/6/ 19 22

F. T. Harris, M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

May 20 1922 to June 7 1922
that I last saw him alive on June 7 1922
and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis.

(Duration) Of not known yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. 4 ds.

(Signed)

6/8/1922 (Address) Leavitt, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 38802

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Hey Per Registration District No. 96
City of Camden Primary Registration District No. 1009
St. Idaho

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ebbe M Collier

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED single
(Write the word.)

6. DATE OF BIRTH

July 23 1894
(Month) (Day) (Year)

7. AGE

77 Yrs. 10 Mos. 21 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Farmer

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

Lloyd Collier

11. BIRTHPLACE OF FATHER

(State or Country)

Indiana

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

H. C. Dingley
Spencer

15.

Filed 7/6/ 1922 F. T. Harris, M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 13 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from June 13 1922
to June 13 1922that I last saw him alive on June 13 1922and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis(Duration) 7 Yrs. 0 mos. 0 ds.Contributory
(Secondary)(Duration) 0 yrs. 0 mos. 0 ds.

(Signed)

O. C. Lemason

M. D.

19

(Address)

Lewiston Id.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cottonwood

19

20. UNDERTAKER

ADDRESS

Mrs. J. MassarLewiston

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **38803**
Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

Registration District No. **96**
County of **Pay Perce** Primary Registration District No. **1009**
City of **Lapwai** (No. _____) St. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Pearceovia Pesnicoff

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **Indian** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. **Single**
(Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year) **1908**

7. AGE

14 Yrs. _____ Mos. _____ ds.IF LESS than 1 day
how many _____ hrs. or
_____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country) **Alaska**

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country) **Alaska**

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country) **Alaska**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) **Mrs. E. Johnson**
(Address) **Lapwai, Idaho**

15.

Filed **7/6/** **1922** **F.T. Harris, M.D.**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 15 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from **May 10 1922** to **June 15 1922**, that I last saw her alive on **June 14 1922** and that death occurred on the date stated above, at **6 A.M.**

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(Duration) **2** Yrs. _____ mos. _____ ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) **Geo. Keck** M. D.
6/5 1922 (Address) **Lapwai, Idaho**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death **1** yrs. **9** mos. _____ days In the State _____ yrs. _____ mos. _____ daysWhere was disease contracted if not at place of death? **Oregon**

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lapwai, Idaho **6/6 1922**

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Casson
State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **38804**

1. PLACE OF DEATH

County of *Boise*Registration District No. *96*City of *Lewiston*Primary Registration District No. *1001*

St.)

Registered No. *940*

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female White

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

July 26 1850
(Month) (Day) (Year)

7. AGE

*71 Yrs. 11 Mos. 24 ds.*IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

At Home

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Scotland

10. NAME OF FATHER

Ronald McDonald

11. BIRTHPLACE OF FATHER

(State or Country)

Scotland

12. MAIDEN NAME OF MOTHER

Murray

13. BIRTHPLACE OF MOTHER

(State or Country)

Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mary H. Lyon(Address) *727 6th Ave. City*

15.

Filed *7/6/1922**F.T. Harris, M.D.*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 20 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

*May 9, 1922, to June 20, 1922*that I last saw h.e.r. alive on *June 20, 1922*and that death occurred on the date stated above, at *M.*

The CAUSE OF DEATH* was as follows:

Pulmonary Edema(Duration) *1* yrs. *1* mos. *ds.*Contributory
(Secondary)*Chronic Nephritis*(Duration) *1* yrs. *1* mos. *ds.*

(Signed)

O. G. Casson

M. D.

19 (Address) *Lewiston, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death *1* yrs. *1* mos. *ds.* In the State *1* yrs. *1* mos. *ds.*

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Lewiston Ida

DATE OF BURIAL

6/23/1922

20. UNDERTAKER

Bassar Inc Co -

ADDRESS

Lewiston Ida

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **38805**

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

Registration District No. _____

County of JeffersonPrimary Registration District No. 7009City of Liberal

No. _____

St. _____

If death occurs away from usual residence, give facts called for under special information.

JUL 14 1922
SUE FULL NAMECharles Emery Whitcomb

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White5. SINGLE, MARRIED, WIDOWED OR DIVORCED
married
(Write the word.)

6. DATE OF BIRTH

Feb 10 1862
(Month) (Day) (Year)

7. AGE

60 Yrs. 4 Mos. 14 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Contractor

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Ill

10. NAME OF FATHER

Emery Stratton Whitcomb

11. BIRTHPLACE OF FATHER

(State or Country)

Ill

12. MAIDEN NAME OF MOTHER

Rodak Ross

13. BIRTHPLACE OF MOTHER

(State or Country)

Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

C. E. Whitcomb(Address) 1623 - 9th Ave.

15.

Filed

7/6/ 1922F. T. Harris, M. D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

195-c

16. DATE OF DEATH

June 24 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____ 19____ to _____ 19____

that I last saw h. _____ alive on _____ 19____

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Gun pole falling striking on Head Accidental

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

N. B. Williamson CoronerJune 19 1922 (Address) Lawson Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Lawson Idaho

DATE OF BURIAL

June 27 1922

20. UNDERTAKER

ADDRESS

Lawson Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

Registration District No.

Primary Registration District No.

(No.)

St.)

File No.

38806

Registered No.

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF
FATHER11. BIRTHPLACE
OF FATHER

(State or Country)

12. MAIDEN NAME
OF MOTHER13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

7/6/ 1922

F.T. Harris, M.D.

Local Registrar

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw h. alive on

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

(Duration) 2 Yrs. mos. ds.

Contributory
(Secondary)

(Duration) 3 yrs. mos. ds.

(Signed) John W. Kelley M. D.

19. (Address) Livonia

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH
in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME. If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

Form No. 8, Nov. 1916		RECEIVED		STATE OF IDAHO		BOARD OF HEALTH		Bureau of Vital Statistics	
PLACE OF DEATH		COUNTY OF		CITY OF		STATE OF		REGISTERED NO.	
Idaho		Oneida		Malad		Idaho		38811	
If death occurs away from usual residence, give facts called for under special information.		2. FULL NAME		Francis Burks		If death occurred in a hospital, institution or camp, give its NAME instead of street and number.			
PERSONAL AND STATISTICAL PARTICULARS					MEDICAL CERTIFICATE OF DEATH				
3. SEX		4. COLOR OR RACE		5. SINGLE, MARRIED, WIDOWED OR DIVORCED.		16. DATE OF DEATH			
male		white		-married- (Write the word.)		July 17 1922 (Month) (Day) (Year)			
6. DATE OF BIRTH					17. I HEREBY CERTIFY, That I attended deceased from				
March 10 1879 (Month) (Day) (Year)					July 8 1922 to July 17 1922				
7. AGE					that I last saw him alive on July 17 1922				
43 yrs. 4 mos. 7 ds.					and that death occurred on the date stated above, at 11 ³⁰ P. M.				
8. OCCUPATION					The CAUSE OF DEATH* was as follows:				
(a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)					Rocky Mountain Spotted fever				
9. BIRTHPLACE					(Duration) yrs. mos. ds.				
(State or Country) Iowa					Contributory (Secondary)				
10. NAME OF FATHER					(Duration) yrs. mos. ds.				
E. W. Burks					(Signed) J. F. Alton M. D.				
11. BIRTHPLACE OF FATHER					July 18 1922 (Address) Malad, Idaho				
(State or Country) Ind.					*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.				
12. MAIDEN NAME OF MOTHER					18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)				
Mary Gingley					At place of death. yrs. mos. days. In the State. yrs. mos. days.				
13. BIRTHPLACE OF MOTHER					Where was disease contracted if not at place of death?				
(State or Country) Ohio					Former or usual residence.				
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE					19. PLACE OF BURIAL OR REMOVAL				
(Informant) M. W. Burks					Washington				
(Address) Malad					DATE OF BURIAL July 18 1922				
15. Filed July 18 1922 J. F. Alton					20. UNDERTAKER				
Local Registrar					Woodland and Co.				
					ADDRESS Malad				

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH
in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19. RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH AUG 4 1922
County of Oneida
City of Malad
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 26
Primary Registration District No. 2069
(No.) St.)

File No. 38812
Registered No. 29

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME David Harris Thomas

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
6. DATE OF BIRTH June 7 1841
(Month) (Day) (Year)
7. AGE 81 Yrs 15 Mos. 15 ds.
IF LESS than 1 day how many hrs. or min.?
8. OCCUPATION Farmer
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).
9. BIRTHPLACE Wales.
(State or Country)
10. NAME OF FATHER Daniel Thomas
11. BIRTHPLACE OF FATHER Wales
(State or Country)
12. MAIDEN NAME OF MOTHER Margaret Harris
13. BIRTHPLACE OF MOTHER Wales
(State or Country)
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edward J Thomas
(Address) _____
15. Aug 4 1922
Filed _____
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 22 1922
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from July 16 1922 to July 22 1922
that I last saw him alive on July 22 1922
and that death occurred on the date stated above, at 11 P. M.
The CAUSE OF DEATH* was as follows:
Apoplexy.
(Duration) Yrs. 1 mos. ds.
Contributory (Secondary) Unknown.
(Duration) yrs. mos. ds.
(Signed) J. M. Kerns, M. D.
7/25/1922 (Address) Malad Idn.
*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.
18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days.
Where was disease contracted if not at place of death?
Former or usual residence _____
19. PLACE OF BURIAL OR REMOVAL Malad, Ida. DATE OF BURIAL 7-26-1922
20. Undertaker H. E. Johnson ADDRESS Malad

SYMS-YORK CO., PRINTERS & BINDERS, MOISE 51087

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of OneidaCity of Malaga

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

JANE B. MORSE

CERTIFICATE OF DEATH

Registration District No. 26Registration District No. 2069No. 2069St. IdahoState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 38813Registered No. 23

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widowed
(Write the word.)

6. DATE OF BIRTH

June 18 1846
(Month) (Day) (Year)

7. AGE

76 Yrs. 1 Mos. 5 ds. 5 min. ?
IF LESS than 1 day how many hrs.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed
(c) for employment

9. BIRTHPLACE

(State or Country) Kalis

10. NAME OF FATHER

Edward Morgan

11. BIRTHPLACE OF FATHER

(State or Country) Wales

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Morse

(Address)

15. Filed

July 28 1922Local Registrar R. W. Mauer M.D.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

7 (Month) 23 (Day) 1922 (Year)I HEREBY CERTIFY, That I attended deceased from June 26 1922 to July 23 1922 that I last saw him alive on June 26 1922 and that death occurred on the date stated above, at 11:20 A.M.
The CAUSE OF DEATH* was as follows:Cerebral Hemorrhage

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) J. F. Nelson7-26-1922 (Address) Malaga M. D.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Samaria

DATE OF BURIAL

July 28 1922

20. UNDERTAKER

J. G. Benson

ADDRESS

Malaga

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **38814**
Registered No. **6**

1. PLACE OF DEATH

Registration District No. **74**
County of **Elm** Precinct **102** Registration District No. _____
City of **MacBride Creek** (Township _____) (County _____) (State _____)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Harvey Ingle

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male **White** **Single** (Write the word.)

6. DATE OF BIRTH

Dec. **25** **1884**
(Month) (Day) (Year)

7. AGE

37 Yrs. **6** Mos. **15** ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Shughead

9. BIRTHPLACE

(State or Country) **Elk C. Kansas.**

10. NAME OF FATHER

Harvey S. Ingle.

11. BIRTHPLACE OF FATHER

(State or Country) **Indiana**

12. MAIDEN NAME OF MOTHER

Minerva Cooper

13. BIRTHPLACE OF MOTHER

(State or Country) **South Carolina**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Jess Ingle.
Howard Kansas.

15.

Filed

July 12 **1922** **Wf Eckenbush**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

157

16. DATE OF DEATH

July **10** **1922**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

..... 19....., to 19.....
that I last saw him alive on 19.....
and that death occurred on the date stated above, at **9:30 AM.**

The CAUSE OF DEATH* was as follows:

Gunshot wound self inflicted
(suicidal)

..... (Duration) Yrs. mos. ds.

Contributory
(Secondary)

..... (Duration) yrs. mos. ds.

(Signed)

Wf Eckenbush

M. D.

July 11 1922**Grand View Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Caldwell Idaho.

DATE OF BURIAL

July 13 1922

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH *Over Sea*
County of *Idaho*
City of *Idaho*

Registration District No. *43*
Primary Registration District No. *212*
(No. _____, _____ St.)

File No. *38815*
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Fredrick Harris*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED. *married*
(Write the word.)

6. DATE OF BIRTH *July 20 1858*
(Month) (Day) (Year)

7. AGE *63 yrs. 11 mos. 20 ds.* IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work *miner*
(b) General nature of industry business, or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country) *London*

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country) *Unknown*

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country) *Unknown*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mr. Fred Harris*
(Address) *Idaho City*

15. Filed *July 13th 1921* *Chas. A. Gatchell*
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July 12 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
_____ 191____, to _____ 191____,
that I last saw h_____ alive on _____ 191____,
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Had a stroke.

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

19. (Address) _____

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

R. O. Cemetery Idaho City July 17 1922
20. UNDERTAKER *John. White* ADDRESS *Idaho City*

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 38816

Registered No. 34
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Residence District No.

Primary Registration District No.

BUREAU OF VITAL STATISTICS

St.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at 4 p.m.

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Signed)

7/31 1922 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs mos days In the State yrs mos days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

OREGON STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

1 PLACE OF DEATH

County

Payette

State

Idaho

State Registered No.

38817

Local Registered No.

33

Township

on road between Payette & Oiler

Village

City

No.

St.

Ward

(If death occurred in a hospital or institution, give its name instead of street and number)

2 FULL NAME

Beatrice Charlotte Patheal

(a) Residence. No.

St.

(Usual place of abode)

(If nonresident, give city or town and state)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female	4 COLOR OR RACE White	5 Single, Married, Widowed, or Divorced (write the word) Single
-----------------	--------------------------	--

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If less than 1 day, hrs. or min.
	9	9		

OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9 BIRTHPLACE (city or town)
(State or country)

St. Maries
Idaho Benwahco

10 NAME OF FATHER

Ben Patheal

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Salem S. Dakota

12 MAIDEN NAME OF MOTHER

Alice Riffle

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Salem
Idaho Henry Co.

14 Informant
(Address)

Blair Wayne
Tussockland Idaho

15 Filed

July 17, 1922 J. C. Woodward
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4 1922

17 I HEREBY CERTIFY, That I attended deceased from 7/4
1922 to 7/4, 1922 that I last saw her alive on 7/4, 1922, and that death occurred on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Auto Accident
fracture of skull
instant death
(duration) yrs. mos. days.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. days.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. C. Woodward M. D.
7/5, 1922 (Address) Oiler, Idaho

* State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Payette Idaho 7/4

20 UNDERTAKER

ADDRESS

J. C. Woodward

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. *Payette*
County of *Payette*
City of *Payette*
(No. _____ St.)

File No. *38818*
Registered No. *33*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Infant Farber*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH.

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. *Single*
(Write the word.)

16. DATE OF DEATH *July 26 1922*
(Month) (Day) (Year)

6. DATE OF BIRTH *July 25 1922*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *July 25 1922*, to *July 26 1922*, that I last saw him alive on *July 26 1922*, and that death occurred on the date stated above, at *11 A.M.*

7. AGE _____ yrs. _____ mos. _____ ds.
IF LESS than 1 day how many _____ hrs. or _____ mins.?

The CAUSE OF DEATH* was as follows:

8. OCCUPATION
(a) Trade, profession or particular kind of work *Infant*
(b) General nature of industry business, or establishment in which employed (or employer)

Atelectasis

9. BIRTHPLACE *Payette*
(State or Country)

(Duration) _____ yrs. _____ mos. _____ ds.

10. NAME OF FATHER *Ralph Farber*

Contributory (Secondary)
(Duration) _____ yrs. _____ mos. _____ ds.

11. BIRTHPLACE OF FATHER *Neb.*
(State or Country)

(Signed) *O. H. Avery* M. D.
7/29/1922 (Address) *Payette, Ida*

12. MAIDEN NAME OF MOTHER *Mabel Kinzey*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

13. BIRTHPLACE OF MOTHER *Ida*
(State or Country)

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

(Informant) *Ralph Farber*
(Address) *Payette Ida*

Where was disease contracted if not at place of death?

15. *July 30 1922*

Former or usual residence _____

Filed *July 30 1922*
Local Registrar

19. PLACE OF BURIAL OR REMOVAL *Payette Ida* DATE OF BURIAL *July 27 1922*
UNDERTAKER *J. H. Adams* ADDRESS *Payette Ida*

FORM

1.

County

City of

(No.

St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or nursing home, give its NAME, street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

male white

married
(Write the word.)

6. DATE OF BIRTH

February 17 1877
(Month) (Day) (Year)

7. AGE

45 Yrs. 4 Mos. 23 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Farmer

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

S. D. Allen

11. BIRTHPLACE OF FATHER

(State or Country)

Michigan

12. MAIDEN NAME OF MOTHER

Mary P. Cook

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Clara M. Silbert

(Address)

Brutland Idaho

15.

Filed July 10 - 1922

L. E. Caxton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 10
(Month) (Day)

17. I HEREBY CERTIFY, That I attended deceased

July 1, 1922, to July 10, 1922,
that I last saw him alive on July 10, 1922,

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) Yrs. mos. 10 ds.

Contributory
(Secondary)

Meningitis

(Duration) Yrs. mos. 4 ds.

(Signed)

L. E. Caxton

M. D.

7/10/1922 (Address) Brutland Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Payette Idaho

July 11, 1922

20. UNDERTAKER

ADDRESS

W. H. Payette

Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

1. PLACE OF DEATH.

County of *Panette*
City of *New Plymouth*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Charles Wesley Detrick

RECEIVED CERTIFICATE OF DEATH.

Register District No. *5*

Primary Registration District No. *7001*

BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. *38820*

Registered No. *3*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH.

April 15 1850
(Month) (Day) (Year)

7. AGE

72 Yrs. *2* Mos. *5* ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... *Rancher*
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country) *Des Moines Iowa.*

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Willard Detrick*
(Address) *New Plymouth, Ida.*

15.

Filed *July 31 1922* *W. J. Dysdale*
Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 25 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 12 1922 to *June 23 1922*,
that I last saw him *alive* on *June 23 1922*,
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Acute Rheumatism

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) *J. H. Smith* M. D.

19 (Address) *New Plymouth, Ida.*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? *new Plymouth, Ida.*

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

New Plymouth

DATE OF BURIAL

June 25 1922

20. UNDERTAKER

A. Meyer

ADDRESS

New Plymouth

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-19

RECEIVED

CERTIFICATE OF DEATH.

1. PLACE OF DEATH.

AUG 5 1922

Registration District No.

5

County of

Payette

BUREAU OF VITAL STATISTICS

Primary Registration District No.

1009

City of

New Plymouth

(No.)

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Joe Satch

Slane

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

38821

Registered No.

4

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male

White

Married

(Write the word.)

6. DATE OF BIRTH.

June

12

1847

(Month)

(Day)

(Year)

7. AGE

15 Yrs. 30 ds.

IF LESS than 1 day
how many hrs. or
min. 2

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

X

11. BIRTHPLACE OF FATHER

(State or Country)

X

12. MAIDEN NAME OF MOTHER

X

13. BIRTHPLACE OF MOTHER

(State or Country)

X

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. Jennie Anderson

(Address)

Pondelton

15.

Filed

8/1

1922

Wm J Drysdale

Local Registrar

16. DATE OF DEATH

July

23

1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 1

1921

to July 22

1922

that I last saw him alive on

July 22

1922

and that death occurred on the date stated above, at 2:30 M.

The CAUSE OF DEATH* was as follows:

Diphtheria

(Duration)

Indefinite

yrs.

mos.

ds.

Contributory (Secondary)

Myocarditis

(Duration)

Indefinite

yrs.

mos.

ds.

(Signed)

O. H. Avery

M. D.

7/29/1922 (Address)

Payette, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death.....yrs.....mos.....days State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

New Plymouth

July 25 1922

20. UNDERTAKER

ADDRESS

J. H. Hedger Payette Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

RECEIVED
JUL 10 1922

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

BUREAU Registration District No. 4
County of Lemhi Registration District No. 1008
City of Payette (No. St.)

File No. 38822

Registered No. 31

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Edgar Wilson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male White Single (Write the word.)

6. DATE OF BIRTH

July 18 1905
(Month) (Day) (Year)

7. AGE

16 yrs. 11 mos. 12 ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Student

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Albert Wilson

11. BIRTHPLACE OF FATHER

(State or Country)

Penn

12. MAIDEN NAME OF MOTHER

Mary Appligate

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Albert Wilson

(Address)

Payette Idaho

15.

Filed

July 31 191

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June 30 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar 14 1922 to June 30 1922

that I last saw him alive on June 29 1922

and that death occurred on the date stated above, at 11:30 M.

The CAUSE OF DEATH* was as follows:

Infection of ear

(Duration) yrs. 5 mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. P. Wilson M. D.

1922 (Address) Payette Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Payette Idaho 7-4 1922

20. UNDERTAKER

ADDRESS

H. A. Anderson Payette Idaho

FORM V. S. No. 1-13.

1. PLACE OF DEATH

County: *Shoshone*
City of: *Mullan*

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
JUL 31 1922

CERTIFICATE OF DEATH

Registration District No.

20

Registration District No.

101

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

38823

Registered No.

58

2. FULL NAME

Clyde North Fitzgerald

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

married
(Write the word)

6. DATE OF BIRTH

Sept
(Month)*24*
(Day)*1886*
(Year)

7. AGE

35 Yrs.*9* Mos.*4* ds.

IF LESS than 1 day

how many _____ hrs.

or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

mines

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Isaac Fitzgerald

11. BIRTHPLACE OF FATHER

(State or Country)

Maryland

12. MAIDEN NAME OF MOTHER

Annie Garlitz

13. BIRTHPLACE OF MOTHER

(State or Country)

Maryland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Isaac Fitzgerald*(Address) *Mountain Home Idaho**June 24* 19*22**F.L. Jung*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 21
(Month)*21*
(Day)*1922*
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19____ to 19____

that I last saw him alive on _____

and that death occurred on the date stated above, at *27* M.

The CAUSE OF DEATH was as follows:

*Organic with
myocardial
infarction
Mullan*
(Duration) _____ Yrs. _____ mos. _____ ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

W. H. Moulton
19*22* (Address) *Walla Walla*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence *Mullan Idaho*

19. PLACE OF BURIAL OR REMOVAL

*Mountain Home Idaho*DATE OF BURIAL
June 24 19*22*

20. UNDERTAKER

Ward and Co

ADDRESS

*Wallace**Idaho*

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Shoshone Registration District No. 31City of Wallace Registration District No. 31

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Johnson

File No. 38825Registered No. 2

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED single

(Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

62 Yrs. — Mos. — ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

merchant

9. BIRTHPLACE

(State or Country)

Denmark

10. NAME OF FATHER

not known

11. BIRTHPLACE OF FATHER

(State or Country)

" "

12. MAIDEN NAME OF MOTHER

" "

13. BIRTHPLACE OF MOTHER

(State or Country)

" "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) County Suprman(Address) Wallace15. June 19 22

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 3 22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 27 19 19 to June 3 19 22

that I last saw him alive on June 2 19 22and that death occurred on the date stated above, at 4:30 A.M.

The CAUSE OF DEATH* was as follows:

Uremia(Duration) Yrs. 5 mos. ds.Contributory (Secondary) Chr Nephritis(Duration) Yrs. years mos. ds.(Signed) James R. Brann M. D.(Address) Wallace

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Wallace IdaDATE OF BURIAL 6-7 19 2220. UNDERTAKER W. E. NorstethADDRESS Wallace

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 38826
Registered No. 53

1. PLACE OF DEATH
County of Shoshone OF Idaho Registration District No. 70
City of Haight (No. 1011) (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Charles Hasse

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

male white (Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

Lumberjack

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

June 20 1922 F. L. Lindsey
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 17 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19
that I last saw him alive on 19
and that death occurred on the date stated above, at 11:30 A.M.
The CAUSE OF DEATH was as follows:

Heart failure while crossing the Snake River
(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

6/20 1922 (Address) Wallopsburg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Wallopsburg, Ida 6/20 1922
20. UNDERTAKER Bruce Norvell ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH *Shoshone* Registration District No. *70*
County of *Shoshone* Registration District No. *1011*
City of *Wallace* *Wallace Hospital* St.)

File No. *38827*
Registered No. *56*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mr. Dorothy M. Courmire

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *married*
(Write the word.)

6. DATE OF BIRTH *May 1 1895*
(Month) (Day) (Year)

7. AGE *27* Yrs. *1* Mos. *15* ds. IF LESS than 1 day how many hrs. or min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Colorado

10. NAME OF FATHER

Ezra E Lollar

11. BIRTHPLACE OF FATHER

(State or Country)

Indiana

12. MAIDEN NAME OF MOTHER

Flora S Spur

13. BIRTHPLACE OF MOTHER

(State or Country)

Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mrs. B. L. Murray*
(Address) *Mullan, Idaho*

15. *June 23 1922* F. L. Zund
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 16 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *June 16 1922* to *June 16 1922*
that I last saw her alive on *June 16 1922*
and that death occurred on the date stated above, at *1:30 P.*

The CAUSE OF DEATH* was as follows:

myocarditis

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *Wm. T. Smith* M. D.

6/7/22 19 (Address) *Wallace Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Mullan Idaho 6/23/1922
20. UNDERTAKER *Bruce S. Norstrom* ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Shoshone Registration District No. 70
City of Wallace Primary Registration District No. 1011
BUREAU OF VITAL STATISTICS Brundage Hospital

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Louise YhrigFile No. 38828
Registered No. 57

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH

Sept 8 1851
(Month) (Day) (Year)

7. AGE

70 Yrs. 9 Mos. 12 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Germiller
(b) General nature of industry, business or establishment in which employed (or employer) Paleman

9. BIRTHPLACE

(State or Country) German

10. NAME OF FATHER

Henry P Yhrig

11. BIRTHPLACE OF FATHER

(State or Country) Germany

12. MAIDEN NAME OF MOTHER

No Information

13. BIRTHPLACE OF MOTHER

(State or Country) France

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. E. Yhrig(Address) U. S. Army

15. FILED

June 23 1922F. L. Indig

Local Registrar

MEDICAL CERTIFICATE OF DEATH

30

16. DATE OF DEATH

June 20 22
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from June 15 1922, to June 20 1922
that I last saw him alive on June 20 1922
and that death occurred on the date stated above, at 6:25 P.M.

The CAUSE OF DEATH* was as follows:

Meningitis, Tubercular(Duration) _____ Yrs. several mos. _____ ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Dr. M. W. E. M. D.6/22/22 (Address) Wallace, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence St Louis Missouri

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wallace Ida June 23 1922

20. UNDERTAKER

ADDRESS

Ward Und Co Wallace
Ida

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15. June 26 1922

Local Registrar

RECEIVED CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

4/26/1922 (Address) Wallace Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH Shoshone JUL 31 1922
 County of Shoshone Registration District No. 76
 City of Wallace Primary Registration District No. 1061
County Infirmary St.)

File No. 38830
 Registered No. 66

If death occurs away from
usual residence, give facts
called for under special in-
formation.

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

2. FULL NAME Louis Hultman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED Not known
 (Write the word.)

6. DATE OF BIRTH Not known 1853
 (Month) (Day) (Year)

7. AGE 69 Yrs. — Mos. — ds.
 IF LESS than 1 day
 how many — hrs.
 or — min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
 (b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE Sweden
 (State or Country)

10. NAME OF FATHER Not known

11. BIRTHPLACE OF FATHER Not known
 (State or Country)

12. MAIDEN NAME OF MOTHER Not known

13. BIRTHPLACE OF MOTHER Not known
 (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Record at County Infirmary
 (Address) of Shoshone County

June 28 1922 F. L. Jenden
 Filed Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 25 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
March 17 1922 to June 26 1922
 that I last saw him alive on June 1925
 and that death occurred on the date stated above, at 1 P. M.
 The CAUSE OF DEATH* was as follows:

Uremia

(Duration) 1 Yrs. — mos. — ds.
 Contributory (Secondary) Chr. Nephritis

(Duration) 4 yrs. — mos. — ds.

(Signed) James R. Deane M. D.
6/26/22 (Address) Wallace

*State the Disease Causing Death; or in deaths from Violent Causes, state
 (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 1 yrs. 8 mos. — days. In the State — yrs. — mos. — days

Where was disease contracted
 if not at place of death?

Former or usual residence Enaville Idaho

19. PLACE OF BURIAL OR REMOVAL Wallace Idaho DATE OF BURIAL 6-28 1922
 UNDERTAKER Wm. S. Nowell ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH
 in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH

County of *Shoshone*City of *Wallace*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Charles Tilden

CERTIFICATE OF DEATH

Registration District No. *70*Registration District No. *1011*

County Infirmary St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *38831*Registered No. *61*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

*white*5. SINGLE, MARRIED, WID-
OWED OR DIVORCED*not known*
(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

(Year)

7. AGE

75

Yrs.

Mos.

ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Kentucky

10. NAME OF FATHER

not known

11. BIRTHPLACE OF FATHER

(State or Country)

not known

12. MAIDEN NAME OF MOTHER

not known

13. BIRTHPLACE OF MOTHER

(State or Country)

not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

County Record

(Address)

15. FILER

June 29 1922 J. L. Tilden

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June

(Month)

28

(Day)

22

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

*Jan**1919**June 28**1922*that I last saw him alive on *June 27* *1922*and that death occurred on the date stated above, at *6:00* M.

The CAUSE OF DEATH* was as follows:

Chr. Nephritis

(Duration)

3

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

6/28 22

(Address)

*James R. Brant
Wallace*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death *general*

yrs.

mos.

In the

days.

State

yrs.

mos.

days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Wallace, Idaho

DATE OF BURIAL

6-29-1922

20. UNDERTAKER

B. G. Worstell

ADDRESS

Wallace

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No.

Registration District No.

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

July 30 - 1922

Martha Marker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 8 1922 to July 22 1922

that I last saw h. w. alive on July 22 1922

and that death occurred on the date stated above, at 11:45 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Intestinal Infection

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

Chas. M. M. D.

1922

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

Martha Marker
1000 My Street

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of *Seton*City of *Chicago*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

married

(Write the word.)

6. DATE OF BIRTH

September 9 1861

(Month)

(Day)

(Year)

7. AGE

68

Yrs.

10

Mos.

8

ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed *July 30 - 1922**Martha Marker*
Local Registrar

CERTIFICATE OF DEATH

Registration District No. *77*Primary Registration District No. *2176*

St.)

RECEIVED
AUG 7 1922
BUREAU OF VITAL STATISTICSState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *38833*Registered No. *13*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 17 - 1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 17 1922 to *July 17 1922*that I last saw him alive on *July 17 1922*and that death occurred on the date stated above, at *4:15 P.M.*

The CAUSE OF DEATH* was as follows:

Cerebral Palsy

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

*Chas. W. ... M. D.**July 1922* (Address) *Chicago Ill*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Martha Marker *July 1922*

20. UNDERTAKER

ADDRESS

Chicago

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Teton
City of Victor

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elwood LeppelRegistration District No. 77Primary Registration District No. 2176(No. TAL)

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 38834
Registered No. 12

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)6. DATE OF BIRTH
June 1st. 1922
(Month) (Day) (Year)7. AGE
Yrs. One Mos. Six ds.
IF LESS than 1 day
how many hrs.
or min. 8. OCCUPATION
(a) Trade, profession or particular kind of work Infant
(b) General nature of industry, business or establishment in which employed (or employer) Infant9. BIRTHPLACE
(State or Country) Idaho.10. NAME OF FATHER J.C. Leppel11. BIRTHPLACE OF FATHER
(State or Country) Washington12. MAIDEN NAME OF MOTHER Burger A. Weeks13. BIRTHPLACE OF MOTHER
(State or Country) Iowa14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. L. Leppel
(Address) Victor, Idaho.15. Filed July 30 1922 Martha Marker
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 7, 1922.
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
.....19..... to19.....
that I last saw h..... alive on.....19.....
and that death occurred on the date stated above, at 7A:M.
The CAUSE OF DEATH* was as follows:Gastro Enteritis

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. A. Bresler, M.D.7/7/1922 (Address) Victor, Idaho. J.P.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Victor, Idaho. DATE OF BURIAL 7-8-1922.20. UNDERTAKER Co. D. M. G. ADDRESS Driggs, Ida.

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of

City of

Registration District No.

Bureau of Vital Statistics
Registration District No.

(No.)

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 38835

Registered No.

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF
FATHER11. BIRTHPLACE
OF FATHER

(State or Country)

12. MAIDEN NAME
OF MOTHER13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

19... to 19...
that I last saw h... alive on 19...
and that death occurred on the date stated above, at... M.

The CAUSE OF DEATH* was as follows:

Accidental drowning

(Duration) Yrs. mos. ds.
Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) E. E. Sanders M. D.

19 (Address) Carons

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bonners Ferry Ida 7/5 1922

20. UNDERTAKER

ADDRESS

Dr. Storky Bonners Ferry

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 38836
Registered No. _____

1. PLACE OF DEATH

County of Idaho Falls
City of Buhl

Registration District No. 39
Primary Registration District No. 2087
(No. _____) (St. _____)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Luther Gay Hill

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED
Married
(Write the word.)

6. DATE OF BIRTH

Mar 11 1882
(Month) (Day) (Year)

7. AGE

40 Yrs. 3 Mos. 15 ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Farmer

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Tennessee

10. NAME OF FATHER

Geo. Hill

11. BIRTHPLACE OF FATHER

(State or Country)

Tennessee

12. MAIDEN NAME OF MOTHER

Don't Know

13. BIRTHPLACE OF MOTHER

(State or Country)

Tennessee

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. A. J. Hill

(Address)

Buhl, Ida.

15.

Filed 6-27 1922

J. H. Murphy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 26 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-20-1922 to 6-26-1922 that I last saw him alive on 6-26-1922 and that death occurred on the date stated above, at 8 A. M. The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration) Yrs. 3 mos. 6 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Geo. Jennings M. D.

6-26-1922 (Address) Buhl, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Buhl Cemetery

DATE OF BURIAL

6-27-1922

20. UNDERTAKER

L. Johnson

ADDRESS

Buhl, Ida.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Twin Falls*
 City of *Twin Falls*

Registration District No. *39*Primary Registration District No. *2087*(No. *1*) St.

If death occurs away from
 residence, give facts
 caused for under special in-
 formation.

2. FULL NAME

Louise H. Schroeder

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. *38837*

Registered No. _____

If death occurred in a hos-
 pital, institution or camp,
 give its NAME instead of
 street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WID-

married
 (Write the word.)

6. DATE OF BIRTH

April 24 1886
 (Month) (Day) (Year)

7. AGE

36 Yrs. *1* Mos. *7* ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or
 particular kind of work.
 (b) General nature of in-
 dustry, business or estab-
 lishment in which employ-
 ed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Nebraska

10. NAME OF FATHER

J. H. Kimsoth

11. BIRTHPLACE OF FATHER

(State or Country)

Missouri

12. MAIDEN NAME OF MOTHER

Mary Beckler

13. BIRTHPLACE OF MOTHER

(State or Country)

Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

H. O. Schroeder

(Address)

Buhl

15.

Filed *6-8* 19*22*

J. H. Murphy
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 5 19*22*
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
6-1- 19*22* to *6-5-* 19*22*

that I last saw h*er* alive on *6-5-* 19*22*

and that death occurred on the date stated above, at *7 P.* M.

The CAUSE OF DEATH* was as follows:

Surgical shock
following gastric operation
 (Duration) Yrs. mos. *5* hrs. ds.

Contributory *Functional heart dis.*
 (Secondary)

(Duration) yrs. mos. ds.

(Signed) *Geo. Jennings* M. D.

6-6-1922 (Address) *Buhl Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state
 (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
 if not at place of death?

Former or
 usual residence

19. PLACE OF BURIAL OR REMOVAL

Idaho

DATE OF BURIAL

6/9 19*22*

20. UNDERTAKER

Johnson

ADDRESS

Buhl

(Always write with black ink)

TRANSPORTATION OF CORPSE

1. PLACE OF DEATH

CERTIFICATE OF DEATH.

County of

Twin Falls

Registration District No.

38

City of

Gile

Primary Registration District No.

2086

(No.)

St.)

File No.

38839

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jacob Cronenwett

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. Single, Married, Widowed or Divorced.

Male

White

Single

(Write the Word)

6. DATE OF BIRTH.

(Month) (Day) (Year)

7. AGE.

68

Yrs. Mos. ds.

IF LESS than 1 day, how many hrs. or min.?

8. OCCUPATION.

(a) Trade, profession or particular kind of work.

Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

Farm

9. BIRTHPLACE.

(State or Country)

Crawford Ohio

10. NAME OF FATHER

John Cronenwett

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Hettinger

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

H. J. Weaver

(Address)

Twin Falls Ida.

15. Filed

July 15 1912

G. A. Newberry

Local Registrar.

Place Where Remains are to be Sent.

Date of Shipment

1912

SHIPPING UNDERTAKER

ADDRESS

Firm Name

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 14 1912

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 14 1912 to July 14 1912

that last saw him alive on July 10 1912

and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH was as follows:

Apoplexy

(Duration)

Immediate

Contributory

(Secondary)

Heat Exhaustion

Primary

(Duration)

Years mos. hrs.

(Signed)

H. A. Dwight

M. D.

July 15 1912 (Address)

Twin Falls Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transient or Recent Residents.)

At place

In the

of death yrs. mos. days State yrs. mos. days

Where was disease contracted if not at place of death.

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Date of Burial

20. UNDERTAKER

Add

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED CERTIFICATE OF DEATH.

38840

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

Registering District No.

Bureau of Vital Statistics

STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

6. DATE OF BIRTH.

7. AGE

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15.

Filed

Aug 7 1922

E. E. Watts

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 2 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 17, 1921, to Jan 25, 1922, that I last saw him alive on Jan 25, 1922, and that death occurred on the date stated above, at 5:35 A.M. The CAUSE OF DEATH* was as follows:

Subphrenic Abscess

(Duration) Yrs. 29 mos. 20 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

19. (Address) Sedgewick Alta

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death... yrs. 3 mos. 5 days In the State... yrs. 3 mos. 5 days

Where was disease contracted if not at place of death? Sedgewick Alta

Former or usual residence Sedgewick Alta

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Agatha, P.O. Sedgewick Alta Mar 4 1922

20. UNDERTAKER

ADDRESS

C. Smith, Island Id.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH

County of Bonneville
City of Ucon

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No. 73Primary Registration District No. 2150(No. Ucon St.)

38841

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 38841Registered No. 27

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Married

(Write the word.)

6. DATE OF BIRTH

Jan 27 1850
(Month) (Day) (Year)

7. AGE

72 Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Rancher

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

New York

10. NAME OF FATHER

Baxter Pledge

11. BIRTHPLACE OF FATHER

(State or Country)

N. H.

12. MAIDEN NAME OF MOTHER

Mary Strong

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

G. G. A. Hodge

(Address)

Ucon

15.

Filed

July 17 1922 Wm. J. Hodge
Local Registrar

SYNOPSIS CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 2, 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 1920 to March 3, 1922

that I last saw him alive on March 2, 1922

and that death occurred on the date stated above, at 8:45 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Bright's Disease

(Duration) 1 Yrs. mos. ds.

Contributory (Secondary)

Cancer of Sigmoid G. Int.

(Duration) 3 Yrs. mos. ds.

(Signed)

W. J. Hodge M. D.
Idaho Falls Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Ucon Idaho. Feb 6, 1922

20. UNDERTAKER

ADDRESS

W. J. Hodge Idaho Falls

Wm. J. Hodge

CERTIFICATE OF DEATH

38842

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Bonneville*
City of *Idaho Falls*Registration District No. *73*Primary Registration District No. *210-0*(No. *4 miles S Idaho Falls* St.)File No. *38842*Registered No. *26*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Florence Elizabeth Jesson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

March *26* *1897*
(Month) (Day) (Year)

7. AGE

28 Yrs. *10* Mos. *18* ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

House wife

9. BIRTHPLACE

(State or Country)

Kansas

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

Pennsylvania

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. L. Armour
Idaho Falls Ida

15.

Filed *July 17* 19 *22* *Idaho Falls*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb *14* *1922*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19....., to 19.....

that I last saw him alive on 19.....

and that death occurred on the date stated above, at.....M.

The CAUSE OF DEATH* was as follows:

a Congestive Peritonitis

.....(Duration) Yrs.....mos.....ds.

Contributory
(Secondary)

.....(Duration) yrs.....mos.....ds.

(Signed)

19..... (Address) *Idaho Falls, Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs.....mos.....days. In the State yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Rose Hill

DATE OF BURIAL

7/17 19 *22*

20. UNDERTAKER

Chaffey

ADDRESS

*Idaho Falls Ida**W. Ernest*

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

38843

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Bannock*City of *Idaho Falls*

If death occurs away from usual residence, give facts called for under special information.

Registration District No. *73*Primary Registration District No. *21 V-0*(No. *Idaho*)

St.)

File No. *38843*Registered No. *A 3*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME *Edward Skar*

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male*4. COLOR OR RACE *White*5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*

(Write the word.)

6. DATE OF BIRTH

Dec 30 1917
(Month) (Day) (Year)

7. AGE

23 25
Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work *Iron*

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) *Idaho Falls*10. NAME OF FATHER *Ed Skar*

11. BIRTHPLACE OF FATHER

(State or Country) *Germany*12. MAIDEN NAME OF MOTHER *?*13. BIRTHPLACE OF MOTHER *?*

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE *Ed Skar*

(Informant)

(Address) *Idaho Falls Ida*

15.

Filed *July 14 1922**W. J. Finn*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 26 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

*March 20 1922 to March 26 1922*that I last saw him alive on *March 26 1922*and that death occurred on the date stated above, at *10 P.M.*

The CAUSE OF DEATH* was as follows:

Influenza(Duration) Yrs. mos. *6* ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) *P. R. Soderquist*

M. D.

3/26 1922(Address) *Idaho Falls Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

*Rose Hill Id. March 28 1922*20. UNDERTAKER *Idaho Falls*ADDRESS *Idaho Falls*

CERTIFICATE OF DEATH

38844

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 38844

Registered No. 72

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of *Bonner*
City of *Idaho Falls*Registration District No. *73*Primary Registration District No. *2140*
(No. *Free St.*)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant Lambert

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

*Female White**Single*
(Write the word.)

6. DATE OF BIRTH

Feb 18 1922
(Month) (Day) (Year)

7. AGE

Born dead.
Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)*None*

9. BIRTHPLACE

(State or Country)

Idaho Falls Ida

10. NAME OF FATHER

Lawrence Lambert

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Bessie Hill

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Lawrence Lambert

(Address)

Idaho Falls Ida

15.

Filed *July 14 1922**W. R. Pendleton*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 18 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

*Feb 18 1922 to Feb 18 1922*that I last saw her alive on *Feb 18 1922*

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows

Still born
Faulty development

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. R. Pendleton M. D.

1922

(Address) *Idaho Falls, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Idaho Falls**Feb 18 1922*

20. UNDERTAKER

ADDRESS

*W. R. Pendleton**Idaho Falls*

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

38845

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bonner
City of Idaho FallsRegistration District No. 73Primary Registration District No. 2186(No. Specimen Hosp. St.)File No. 38845Registered No. 21

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mervyn B. Becker

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH

Feb 12 1921
(Month) (Day) (Year)

7. AGE

1 Yrs. 1 Mos. 0 ds.IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work no.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho Falls

10. NAME OF FATHER

Henry Becker

11. BIRTHPLACE OF FATHER

(State or Country) Iowa

12. MAIDEN NAME OF MOTHER

Helen, Ellis

13. BIRTHPLACE OF MOTHER

(State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henry Becker(Address) Idaho Falls Ida

15.

Filed July 14 1922 W. K. Kinnard
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 6 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Feb 26 1922 to March 1922
that I last saw him alive on March 1922
and that death occurred on the date stated above, at 11 P.M.
The CAUSE OF DEATH* was as follows:Branch pneumonia following influenza
(Duration) 1 Yrs. 0 mos. 0 ds.

Contributory (Secondary)

(Duration) 1 yrs. 0 mos. 0 ds.(Signed) W. K. Kinnard

M. D.

19

(Address) Idaho Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 0 yrs. 0 mos. 0 days. In the State 0 yrs. 0 mos. 0 days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

River View IdahoMarch 1922

20. UNDERTAKER

ADDRESS

W. K. KinnardIdaho FallsDr. Kinnard

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

38846

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Bonneville*Registration District No. *73*City of *Idaho Falls*Primary Registration District No. *21470*(No. *Idaho Falls*)

(St.)

File No. *38846*Registered No. *90*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Harold G. Miller

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Feb 22 1922
(Month) (Day) (Year)

7. AGE

Yrs. *3*Mos. *03*

ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) *Idaho Falls Ida*

10. NAME OF FATHER

Harold Miller

11. BIRTHPLACE OF FATHER

(State or Country) *mont*

12. MAIDEN NAME OF MOTHER

Hallie Braden

13. BIRTHPLACE OF MOTHER

(State or Country) *mont*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Harold Miller*(Address) *Idaho Falls*

15.

Filed *July 17 1922*

1922

Local Registrar *W. Wilson*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 22 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 22 1922 to *Feb 25 1922*that I last saw him alive on *Feb 25 1922*and that death occurred on the date stated above, at *M.*

The CAUSE OF DEATH* was as follows:

*Some circulatory difficulty
probably failure of action of
heart. Autopsy not permitted*(Duration) Yrs. *3* mos. *3* ds.Contributory
(Secondary)(Duration) yrs. *3* mos. *3* ds.(Signed) *Harry L. Willson**3/19/22* (Address) *Idaho Falls, Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. *3* mos. *3* days. In the State yrs. *3* mos. *3* days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Rose Hill Cemetery

DATE OF BURIAL

Feb 22 1922

20. UNDERTAKER

Chas. H. Hays

ADDRESS

Idaho Falls Ida

CERTIFICATE OF DEATH

38847

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Burse*
City of *Bozeman*

RECEIVED

Registration District No. *12*Primary Registration District No. *12*(No. *12* St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Mary Ann Eckroth*File No. *38847*

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

*Feb**28*

(Month)

(Day)

(Year)

7. AGE

*2 days*IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

Frank Eckroth

11. BIRTHPLACE OF FATHER

(State or Country)

Nebraska

12. MAIDEN NAME OF MOTHER

Bell Eckroth

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(Address) _____

15.

Filed

*July 10**1922**Mrs E. L. Robinson*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 2

(Month)

(Day)

1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____ 19____, to _____ 19____

that I last saw him _____ alive on _____ 19____

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

unknown

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

No doctor

M. D.

_____ 19____ (Address) _____

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Gardena

DATE OF BURIAL

March 1922

20. UNDERTAKER

ADDRESS

RECEIVED

CERTIFICATE OF DEATH

38848

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No.

BUREAU OF PUBLIC HEALTH SERVICE HOSPITAL

File No. 38848
Registered No. 17

Boone Barracks in hospital, institution or camp, street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male White Married (Write the word.)

6. DATE OF BIRTH

Feb. 15 1874
(Month) (Day) (Year)

7. AGE

48 Yrs. 5 Mos. 11 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

Merchant
Cigar Dealer

9. BIRTHPLACE

(State or Country)

Boone Co. Iowa

10. NAME OF FATHER

Harry Lake
Pa.

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Maggie James

13. BIRTHPLACE OF MOTHER

(State or Country)

Boone Co. Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Harry W. Lake Jr.
Boone Idaho

15.

Filed

Aug. 12 1922

R. H. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

August 8 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I ~~submitted~~ saw deceased ~~from~~about 10 Am. 8-8-1922
that last saw him on ~~at~~ that
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Lung shot wound. Entrance
just below right border of anterior axillary
line, left. Wound in upper part of
left lung, through diaphragm.
No exit.

(Duration) yrs. mos. ds.

(Signed) W. W. Brodie M. D.

8-9 1922 (Address) Boone Barracks
Boone, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Morris Hill Cemetery 8/12 1922

20. UNDERTAKER

ADDRESS

Schreiber & Sidenfaden Boone

CERTIFICATE OF DEATH

38850

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada
City of EagleRegistration District No. 9710Primary Registration District No. 9710(No. St.)File No. 21Registered No. 21

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lillian Louise Pyns

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

Aug 20 1922
(Month) (Day) (Year)

7. AGE

Yrs. 9 Mos. 9 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Ada, Idaho

10. NAME OF FATHER

Wm L Pyns

11. BIRTHPLACE OF FATHER

(State or Country)

Kansas

12. MAIDEN NAME OF MOTHER

Lillian Worthington

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wm L Pyns
R R Pyns

(Address)

15.

Filed Aug 30 1922Gene J. Pyns
Eagle, Idaho

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 29 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 20 1922, to Aug 28 1922
that I last saw him alive on Aug 28 1922and that death occurred on the date stated above, at 2 A.M.

The CAUSE OF DEATH* was as follows:

Thrombosis of Femoral Vein(Duration) Yrs. 4 mos. 4 ds.Contributory
(Secondary)(Duration) yrs. 4 mos. 4 ds.

(Signed)

Geo M. Hall M. D.

19

(Address)

Eagle, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Long Creek Cemetery Aug 30 1922

20. UNDERTAKER

none

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

RECEIVED

CERTIFICATE OF DEATH

38851

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH Ada Registration District No. 124
County of Ada Registration District No. 2202
City of Ada (No. St.)

File No. 1
Registered No. 45

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Bessie Myrtle Tolwell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH Sep 10 1888
(Month) (Day) (Year)

7. AGE 32 yrs. mos. ds.
IF LESS than 1 day how many hrs. or mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE Idaho
(State or Country)

10. NAME OF FATHER J. B. Rothwell

11. BIRTHPLACE OF FATHER Mo
(State or Country)

12. MAIDEN NAME OF MOTHER Minerva Stockton

13. BIRTHPLACE OF MOTHER Mo.
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harry N. Tolwell
(Address)

15. Filed 9 - 4, 1912 W. H. Stevens
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 1 1912
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 15 1912, to Aug 1 1912 that I last saw her alive on July 18 1912 and that death occurred on the date stated above, at 29 M.

The CAUSE OF DEATH was as follows:
Lympho sarcoma of liver.
(Duration) 3 yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) M. H. Sullivan M. D.
8/1 1912 (Address) Boise, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Kenna Ida DATE OF BURIAL 8-2 1912

20. UNDERTAKER W. H. Robinson ADDRESS Nampa Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

38852

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 124
County of Ada Primary Registration District No. 2202
City of Kuna (St.)

File No. 46
Registered No. 46

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Eldon E. Book

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED single
(Write the word.)

6. DATE OF BIRTH Nov 26 1921
(Month) (Day) (Year)

7. AGE 8 Yrs. 12 Mos. ds. IF LESS than 1 day how many... hrs. or... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work ✓
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Ada Co - Idaho

10. NAME OF FATHER

John Book

11. BIRTHPLACE OF FATHER

(State or Country) Id

12. MAIDEN NAME OF MOTHER

Bernie Botner

13. BIRTHPLACE OF MOTHER

(State or Country) Id

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John Book

(Address)

Kuna Idaho

15.

Filed

9-4-22 W. B. Stevens

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 7 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 24 1922 to Aug 7 1922 that I last saw him alive on Aug 7 1922 and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Cholera Infantum with dysentery

(Duration) Yrs. mos. 19 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. H. Murray M. D.

8/8/1922 (Address) Kuna Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Kuna Cem.

DATE OF BURIAL

8-8-22

20. UNDERTAKER

Parents

ADDRESS

Kuna

1. PLACE OF DEATH

County of *Ada*
City of *Boise*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No. *8*Primary Registration District No. *2004*State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *38853*Registered No. *78*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*
(Write the word.)

6. DATE OF BIRTH

July 15th 1918
(Month) (Day) (Year)

7. AGE

4 Yrs *11* Mos *18* dsIF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)*none*

9. BIRTHPLACE

(State or Country)

Baker Oregon

10. NAME OF FATHER

Balantin Bidabolo

11. BIRTHPLACE OF FATHER

(State or Country)

Spain

12. MAIDEN NAME OF MOTHER

Beatris Astasolo

13. BIRTHPLACE OF MOTHER

(State or Country)

Spain

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. Letenardie

(Address)

Boise, Idaho

15.

Filed

*Aug 28 1922**R. H. Pratt*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 26th 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 25 1922 to Aug 26 1922
that I last saw him alive on *Aug 25 1922*
and that death occurred on the date stated above, at *9:30 A.M.*

The CAUSE OF DEATH* was as follows:

Convulsions, cause undetermined

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

R. L. McCalla

M. D.

19.

(Address)

Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*St. Joseph**8/28 1922*

20. UNDERTAKER

ADDRESS

Schreiber & Siderfaden, Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-18

Back.
CERTIFICATE OF DEATH.

1. PLACE OF DEATH Ada Registration District No. 8
County of Ada Primary Registration District No. 2008
City of No. 1 mile S.W. of Boise St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
SEP 7 1922
BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 38854
Registered No. 77
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alice Wade

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married (the Spouse)
6. DATE OF BIRTH. Sep 18 1 864
(Month) (Day) (Year)
7. AGE 57 Yrs. 11 Mos. 8 ds. IF LESS than 1 day how many.....hrs. or.....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work..... At Home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Illinois

10. NAME OF FATHER Horace B. Whitney

11. BIRTHPLACE OF FATHER
(State or Country) Illinois

12. MAIDEN NAME OF MOTHER Virginia Woodworth

13. BIRTHPLACE OF MOTHER
(State or Country) Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. E. Wade
(Address)

15. Filed Aug 26 1922 R. H. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 26 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4/29 1912 to Aug 26 1922 that I last saw her alive on Aug 24 1922 and that death occurred on the date stated above, at 4:45 A.M.

The CAUSE OF DEATH* was as follows:
Myocarditis

(Duration) 2 Yrs. mos. ds.
Contributory Chronic nephritis
(Secondary)
(Duration) 2 yrs. mos. ds.
(Signed) Ralph Taylor M. D.
8/26/1922 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Morris Hill Cemetery DATE OF BURIAL Aug 27 1922

20. UNDERTAKER Summers & Co. ADDRESS Boise Idaho

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
SEP 7 1922
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada Registration District No. 2008
City of Boise Primary Registration District No. near Franklin School
(No. 76 St.)File No. 38855
Registered No. 76

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Sarah Jane Eby.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX F 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widow
(Write the word.)6. DATE OF BIRTH Nov. 27 - 1832
(Month) (Day) (Year)7. AGE 89 Yrs. 8 Mos. 26 ds. (IF LESS than 1 day how many hrs. or min.?)

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Housewife

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

Martin Albright

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Mary Brandon

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W McBratney

(Address)

Boise Idaho

15.

Filed 8-24 1922 A. L. Pratt
Local Registrar

16. DATE OF DEATH

Aug 23 - 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from March 1922 to Aug 22 1922that I last saw her alive on Aug 22 1922
and that death occurred on the date stated above, at Boise M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia(Duration) Yrs. 3 mos. 3 ds.

Contributory (Secondary)

Old age(Duration) yrs. 0 mos. 0 ds.

(Signed)

Harold W Stone M. D.8/24 1922 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. 0 mos. 0 days. In the State yrs. 0 mos. 0 days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Toledo - Iowa

DATE OF BURIAL

19

20. UNDERTAKER

W McBratney

ADDRESS

Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-19

CERTIFICATE OF DEATH

Idaho
State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 38856
Registered No. 72

1. PLACE OF DEATH
County of Ada
City of Boss
Registration District No. 6
Primary Registration District No. 2004
(No. 5 1/2 W. of Boss St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles Marshall Brown

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH. Oct 28 1853
(Month) (Day) (Year)

7. AGE 68 Yrs. 9 Mos. 10 ds. IF LESS than 1 day how many hrs. or min. 2

8. OCCUPATION Farmer
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE New York
(State or Country)

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER Unknown
(State or Country)

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER Unknown
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. F. Anderson

(Address) Yampa Idaho R. 2

15. 8-9 1912 R. H. (Dr.)

Filed 8-9 1912 R. H. (Dr.)
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 8 1912
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-11 1912, to Aug 8 1912, that I last saw him alive on July 8 1912, and that death occurred on the date stated above, at 12 P.M.

The CAUSE OF DEATH* was as follows:
Pulmonary hemorrhage
(Duration) 2 Yrs. — mos. — ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. H. (Dr.) M. D.

1912 Address Boswell 49

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Morris Hill Cemetery Aug 10 1912

20. UNDERTAKER ADDRESS

Sumner & Krebs Boswell

1. PLACE OF DEATH

County of Ada Registration District No. 8
 City of Boise Primary Registration District No. 7008
 (No. Ada County Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Miss Anna Wagner

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 38857Registered No. 79

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
 (Write the word.)
 6. DATE OF BIRTH June, 4, 1857
 (Month) (Day) (Year)
 7. AGE 65, 27 Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Illinois

10. NAME OF FATHER

Emanuel Wagner

11. BIRTHPLACE OF FATHER

(State or Country)

Md.

12. MAIDEN NAME OF MOTHER

Elisabeth Tridley

13. BIRTHPLACE OF MOTHER

(State or Country)

Md.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W McBratney

(Address)

Boise, Idaho

15.

Filed

9-1

1922

R. H. Rath
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug - 31 - 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1, 1922 to Aug 31, 1922
 that I last saw her alive on Aug 30, 1922
 and that death occurred on the date stated above, at 1 P. M.
 The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) Yrs. mos. 3 ds.
 Contributory (Secondary) Respiratory Paralysis

(Duration) yrs. mos. 1 hour ds.
 (Signed) T. N. Brantow M. D.
8/31 1922 (Address) Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery 9-1 1922

20. UNDERTAKER

ADDRESS

W McBratney Boise Idaho

MARGIN REQUIRED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH **RECEIVED**
Registration District No. 2
County of Ada SEP 7 1922
City of Boise Primary Registration District No. 11004
BUREAU OF VITAL STATISTICS
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME Donald Krahm

File No. 38858
Registered No. 157
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)
6. DATE OF BIRTH July 14, 1922
(Month) (Day) (Year)
7. AGE 21 ds. IF LESS than 1 day
Yrs. Mos. ds. how many hrs. or min.?

16. DATE OF DEATH Aug 4, 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 14, 1922 to Aug 4, 1922
that I last saw him alive on Aug 3, 1922
and that death occurred on the date stated above, at 11:30 P.
The CAUSE OF DEATH* was as follows:

Premature,

(Duration) Yrs. mos. 20 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) R. P. French M. D.

7/5 1922 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence Boise Idaho

19. PLACE OF BURIAL OR REMOVAL Morris Hill Cem DATE OF BURIAL 8/5 1922

20. UNDERTAKER Schreiber & Hidenfaden ADDRESS Boise

8. OCCUPATION
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business or establishment in which employed (or employer)
9. BIRTHPLACE Boise Idaho
(State or Country)
10. NAME OF FATHER Robert Krahm
11. BIRTHPLACE OF FATHER Wis.
(State or Country)
12. MAIDEN NAME OF MOTHER Edith Carter
13. BIRTHPLACE OF MOTHER Idaho.
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Robert Krahm
(Address) 419 00120 13 Boise Idaho

15. Filed Aug 5 1922 R. H. Pratt
Local Registrar

Dr. French

1. PLACE OF DEATH

County of AdaCity of Boise

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
SEP 7 1922
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 2City Registration District No. 1094(No. 404)

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 38859Registered No. 204

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Josephine McCarroll

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F4. COLOR OR RACE W.5. SINGLE, MARRIED, WID-
OWED OR DIVORCED(Write the word.) Single

6. DATE OF BIRTH

Aug - 9 - 1922

(Month)

(Day)

(Year)

7. AGE

19 Yrs. 1 Mos. 19 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

None

9. BIRTHPLACE

(State or Country)

Boise - Idaho.

10. NAME OF FATHER

Joseph McCarroll

11. BIRTHPLACE OF FATHER

(State or Country)

Minn.

12. MAIDEN NAME OF MOTHER

Lorene Johnson

13. BIRTHPLACE OF MOTHER

(State or Country)

Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W McBratney(Address) Boise Idaho15. Filed Aug. 29, 1922A. H. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug. 28 - 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Aug 28, 1922 to Aug 28, 1922
that I last saw her alive on Aug 28, 1922
and that death occurred on the date stated above, at 1 a. M.

The CAUSE OF DEATH* was as follows:

Convulsion(Duration) after winter Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) John Smith M. D.8/28/22 (Address) Boise Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Morris Hill Cemetery

DATE OF BURIAL

8/29, 1922

20. UNDERTAKER

W McBratney

ADDRESS

Boise Idaho.

1. PLACE OF DEATH

County of Ada Registration District No. 2
 City of Boise Registration District No. 1004
Idaho Soldiers Homes

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
 SEP 7 1922
 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 38860Registered No. 203

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

George H. Richardson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED
Widower
 (Write the word.)

6. DATE OF BIRTH 1846
 (Month) (Day) (Year)

7. AGE 76 Yrs. — Mos. — ds. IF LESS than 1 day
 how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

Civil War.
Veteran

9. BIRTHPLACE

(State or Country)

Ill.

10. NAME OF FATHER

Don't Know

11. BIRTHPLACE OF FATHER

(State or Country)

9

12. MAIDEN NAME OF MOTHER

9

13. BIRTHPLACE OF MOTHER

(State or Country)

9

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

D. McBratney
Boise, Ida

15.

Filed

Aug 29 1922

R. H. Rath
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

40

16. DATE OF DEATH

Aug - 28 - 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 20 1922 to Aug 28 1922
 that I last saw h. in alive on Aug 27 1922
 and that death occurred on the date stated above, at 7:00 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

(Duration) 9 Yrs. 6 mos. 0 ds.

Contributory (Secondary)

None(Duration) — yrs. — mos. — ds.

(Signed)

Roscoe B. Ward
Aug 29 1922 (Address) Boise, Ida.

M. D.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death — yrs. — mos. — days In the State — yrs. — mos. — days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery

8/29 1922

20. UNDERTAKER

ADDRESS

D. McBratney

Boise, Ida.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **38861**Registered No. **158**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH **RECEIVED**County of **Ada** Registration District No. **7004**
City of **Boise** Primary Registration District No. **132** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Elizabeth Woods**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Widow**
(Write the word.)

6. DATE OF BIRTH

Sept 24 1840
(Month) (Day) (Year)

7. AGE

81 Yrs. **10** Mos. **11** ds. **11**
IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)**House Wife**

9. BIRTHPLACE

(State or Country)

Dollar Scotland

10. NAME OF FATHER

Peter Riddell

11. BIRTHPLACE OF FATHER

(State or Country)

Scotland

12. MAIDEN NAME OF MOTHER

Janet Lindsay

13. BIRTHPLACE OF MOTHER

(State or Country)

Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

M. L. Throgood

(Address)

1117 N 10

15.

Filed **8-4****1922****R. H. Pratt**
Local RegistrarMEDICAL CERTIFICATE OF DEATH **64**

16. DATE OF DEATH

Aug 4 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 12 1922 to Aug 4 1922that I last saw him alive on **Aug 3 1922**and that death occurred on the date stated above, at **M.**

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) **Edmund** M. D.

19. (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence **Boise, Idaho**

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Morris Hill Cemetery 8/4 1922

20. UNDERTAKER

ADDRESS

Schreiber & Sidenhede Boise**Ballister**

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **38862**
Registered No. **187**

1. PLACE OF DEATH **RECEIVED**
Registration District No. **2**
County of **Ada** SEP 7 1922
City of **Boise** BUREAU OF VITAL STATISTICS
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME **Myra E. Thomas**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Married**
(Write the word.)

6. DATE OF BIRTH **April 7th 1875**
(Month) (Day) (Year)

7. AGE **47** Yrs. **3** Mos. **26** ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work **housewife**
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE **Nodaway Co., Mo.**
(State or Country)

10. NAME OF FATHER **John W. Williams**

11. BIRTHPLACE OF FATHER **Mo.**
(State or Country)

12. MAIDEN NAME OF MOTHER **Amanda Perry.**

13. BIRTHPLACE OF MOTHER **Mo.**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Frank J. Thomas**
(Address)

15. Filed **8-4** 19 **22** **R. H. Pratt**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **Aug 3rd 1922**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **July 31 1922** to **Aug 3 1922**
that I last saw **her** alive on **Aug 2 1922**
and that death occurred on the date stated above, at **4 A.M.**
The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) **10** Yrs. mos. ds.

Contributory (Secondary) **Exophthalmic goiter**

(Duration) **15** yrs. mos. ds.

(Signed) **Ralph Falk** M. D.

8/4 1922 (Address) **Boise**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death **St Lukes Hospital** In the **Boise** State **3** yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence **Eagle, Idaho**

19. PLACE OF BURIAL OR REMOVAL **Harris Hill Cemetery** DATE OF BURIAL **8/5 1922**

20. UNDERTAKER **Schreiber & Sidenfaden** ADDRESS **Boise**

Dr. Falk

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

1. PLACE OF DEATH. **RECEIVED** Registration District No. 2
 County of Ada Primary Registration District No. 1004
 City of Boise **SEP 7 1922** 408 Ressegue St.)
BUREAU OF VITAL STATISTICS
 If death occurs away from usual residence, give facts called for under special information.

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 38863

Registered No. 192

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John C Williams

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widower
 (Write the word.)

6. DATE OF BIRTH. May 5 1857
 (Month) (Day) (Year)

7. AGE 65 Yrs. 3 Mos. 3 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Retired Merchant.
 (b) General nature of industry, business, or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) New York

10. NAME OF FATHER

N. B. Williams

11. BIRTHPLACE OF FATHER

(State or Country) Rhode Island

12. MAIDEN NAME OF MOTHER

Mercy C. Bartoo

13. BIRTHPLACE OF MOTHER

(State or Country) New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Williams

(Address) 408 Ressegue St

15.

Filed 8-9 1922

R. H. Pratt
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

8 (Month) 8 (Day) 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

6/1 1922 to 8/8 1922
 that I last saw him alive on 6/1 1922
 and that death occurred on the date stated above, at 10 P.M.
 The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(Duration) Yrs. mos. ds.

Contributory
 (Secondary)

(Duration) Yrs. mos. ds.

(Signed) Thos. A. [Signature] M. D.

8/9 1922 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Ins Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Denver Colorado Aug 12 1922

20. UNDERTAKER

ADDRESS

Williams & Sons Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD.
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH **RECEIVED**
 County of Ada SEP 7 1922
 City of Bureau of Vital Statistics 410
 Registration District No. 1004
 State Idaho (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Thomas John Ryan

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 38864
 Registered No. 123

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widower
 (Write the word.)

6. DATE OF BIRTH September 12 - 1853
 (Month) (Day) (Year)

7. AGE 69 Yrs. 10 Mos. 28 ds.
 IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

Retired -

9. BIRTHPLACE

(State or Country)

Urbington - Illinois

10. NAME OF FATHER

Thomas Ryan

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Katherine Duvoey

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Katherine R. Simpson
 (Address)

15. Filed 8-10 1922 R. H. Pratt
 Local Registrar

16. DATE OF DEATH

Aug 9 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 9 1922, to 19
 that I last saw him alive on August 9 1922,
 and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Concussion of the brain following a fall

(Duration) Yrs. mos. 1 1/2 hrs.

Contributory
 (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. M. Spelsch M. D.

8/10 1922 (Address) Bosse Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence 816 North 10th City

19. PLACE OF BURIAL OR REMOVAL St. Johns Cemetery DATE OF BURIAL 8/11/1922

20. UNDERTAKER Schubert & Hildebrand ADDRESS Rosse Id.

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of

Ada

City of

Boise

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mr. Karl Marguis

BUREAU OF VITAL STATISTICS

Registration District No.

2

Statistical District No.

1004

(No.)

(St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

38865

Registered No.

116

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

widower

6. DATE OF BIRTH

March 16 -

(Month)

(Day)

1866 (Year)

7. AGE

56 Yrs. 4 Mos. 29 ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Farming

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

Charles Wesley Marguis

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Laura Workman

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Viola Marguis

(Address)

Boise

15.

Filed Aug 16 1922

R. H. Pratt

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 14 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug. 14 1922 to

that I last saw him alive on

and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Fractured skull, struck by automobile.

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Clyde E. Summers, Coroner M. D.

8/16/22

Address Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

Near Callister

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery 8/17/1922

20. UNDERTAKER

ADDRESS

Schubert & Widengrad Boise

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

SEP 7 1922

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of AdaCity of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. U.S.V. Hospital #52 St.)State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Willard O. Roges

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Single

(Write the word.)

6. DATE OF BIRTH

Aug.

(Month)

10

(Day)

1898

(Year)

7. AGE

24

Yrs.

0

Mos.

4

ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

In A.G.R.S.

(b) General nature of industry, business or establishment in which employed (or employer)

Returned soldier

9. BIRTHPLACE

(State or Country)

Illinois

10. NAME OF FATHER

C.L. Roges

11. BIRTHPLACE OF FATHER

(State or Country)

N.Y.

12. MAIDEN NAME OF MOTHER

Alida Ormsby

13. BIRTHPLACE OF MOTHER

(State or Country)

Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wm. McBratney

(Address)

Boise, Idaho

15.

Filed

Aug. 14 1922

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug.

(Month)

14, 1922

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 91922

to

Aug. 14, 192219that I last saw him alive on Aug. 14, 19223:30 A.M.

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

Tuberculosis, pulmonary, chronicUnknown

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)NoneXX

(Duration)

yrs.

mos.

ds.

(Signed) W.H. Allen, Surgeon in Charge D.8-151922

(Address)

Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

yrs.

mos.

66

In the

days.

State

yrs.

mos.

days

Where was disease contracted if not at place of death?

Unknown

Former or

usual residence

Caldwell, Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Caldwell, Idaho8-16-2219

20. UNDERTAKER

WM. McBRATNEY

ADDRESS

BOISE, IDAHO

1. PLACE OF DEATH

Registration District No. South Boise — 1094
 County of Ada
 City of Boise
 BUREAU OF VITAL STATISTICS
So Boise Ave. (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William Henry Ridenbaugh

CERTIFICATE OF DEATH

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 38867

Registered No. 118

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
 (Write the word.)

6. DATE OF BIRTH April 17 — 1854
 (Month) (Day) (Year)

7. AGE 68 Yrs 4 Mos. ds.
 IF LESS than 1 day
 how many..... hrs.
 or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Lumber business
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE St Joseph — Missouri
 (State or Country)

10. NAME OF FATHER William Henry Ridenbaugh

11. BIRTHPLACE OF FATHER Penn
 (State or Country)

12. MAIDEN NAME OF MOTHER Hannah Creal

13. BIRTHPLACE OF MOTHER Ohio
 (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary Eliza Ridenbaugh
 (Address) Boise Idaho

15. Filed Aug 19 1922 R. H. Fox
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 17 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 6 1922 to Aug 15 1922

that I last saw him alive on Aug 16 1922

and that death occurred on the date stated above, at 2 A. M.

The CAUSE OF DEATH* was as follows:

Valvular disease of heart

(Duration) Yrs. mos. ds.

Contributory
 (Secondary)

(Duration) yrs. mos. ds.

(Signed) E. O. Callister M. D.

19. (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence Boise Idaho

19. PLACE OF BURIAL OR REMOVAL Morris Hill Cemetery DATE OF BURIAL 8/19/1922

20. UNDERTAKER Schreiber & Ridenbaugh ADDRESS Boise

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **38868**Registered No. **200**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH **Adelphi** Registration District No. _____
County of _____ Primary Registration District No. _____
City of **Boise** (No. **115**, No. **17**) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Edna L. Hardy**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **F.** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Married (wid.)**

6. DATE OF BIRTH.

Sep 18 1 **868**
(Month) (Day) (Year)

7. AGE

53 Yrs. **11** Mos. **7** ds.

IF LESS than 1 day
how many hrs. or
..... min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

at home

9. BIRTHPLACE

(State or Country)

Michigan

10. NAME OF FATHER

William Pointer

11. BIRTHPLACE OF FATHER

(State or Country)

Michigan

12. MAIDEN NAME OF MOTHER

Abbie Blanchard

13. BIRTHPLACE OF MOTHER

(State or Country)

Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

J. A. Hardy
115 W. 17th St. Boise

15.

Filed **8-25** 1912

Local Registrar

P. H. Pratt

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 25 1912
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Mich** 1912, to **Aug 25** 1912.

that I last saw her alive on **Aug 24** 1912, and that death occurred on the date stated above, at **12:20 A. M.**

The CAUSE OF DEATH was as follows:

Arthritis deformans.(Duration) **30** Yrs. mos. ds.

Contributory (Secondary)

Fracture of femur.

(Duration) yrs. mos. ds.

(Signed) **M. H. Taelman** M. D.(Address) **Boise, Id.**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery**Aug 27 1912**

20. UNDERTAKER

ADDRESS

Summers & Co.**Boise Id.**

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **38869**Registered No. **201**

1. PLACE OF DEATH

County of **Ada** Registration District No. _____
City of **Bosse** Registration District No. _____
SEASONS 110 E. Bannock, St.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Bernice Marie Beaumgard
Death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

F **White** **Married**
(Write the word.)

6. DATE OF BIRTH.

Feb 29 1898
(Month) (Day) (Year)

7. AGE

24 Yrs. **3** Mos. **27** ds.
IF LESS than 1 day how many hrs. or min. >

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

At Home

9. BIRTHPLACE

(State or Country)

Nebraska

10. NAME OF FATHER

C. F. Callen

11. BIRTHPLACE OF FATHER

(State or Country)

Illinois

12. MAIDEN NAME OF MOTHER

Myra E. Hilsinger

13. BIRTHPLACE OF MOTHER

(State or Country)

Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) **R. H. Pratt**
Bosse Idaho 1005 O'Farrell
(Address)

15.

Filed **Aug. 28 1922** **R. H. Pratt**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

137

16. DATE OF DEATH

Aug - 26 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 21 1922 to **Aug 26 1922**

that I last saw her alive on **Aug 26 1922**

and that death occurred on the date stated above, at **7 P. M.**

The CAUSE OF DEATH* was as follows:

Peripneumonia
(followed by)

(Duration) Yrs. mos. **5** ds.

Contributory (Secondary) **Dead Justice**

(Duration) Yrs. mos. **x** ds.

(Signed) **S. W. Farney** M. D.

28 1922 (Address) **Bosse Idaho**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery **Aug 28 1922**

20. UNDERTAKER

ADDRESS

Summers & Truitt **Boise Idaho**

1. PLACE OF DEATH **RECEIVED**
 County of Ada SEP 7 1922
 City of Near Blediers Home BUREAU OF VITAL STATISTICS
 Registration District No. 2
 Primary Registration District No. 1004
 (St.)
 if death occurs away from usual residence, give facts called for under special information.
 2. FULL NAME John W. Cartmell

CERTIFICATE OF DEATH.

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 38870
 Registered No. 206
 If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
and married
 (Write the word.)

6. DATE OF BIRTH. May 19 1883
 (Month) (Day) (Year)

7. AGE 89 3 Mos. 11 ds.
 IF LESS than 1 day how many hrs. or min. >]

8. OCCUPATION
 (a) Trade, profession or particular kind of work... Veteran Civil War
 (b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
 (State or Country) Illinois

10. NAME OF FATHER Jackson Cartmell

11. BIRTHPLACE OF FATHER
 (State or Country) Kentucky

12. MAIDEN NAME OF MOTHER Mary E. Tackett

13. BIRTHPLACE OF MOTHER
 (State or Country) Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
 (Informant) J. W. Cartmell
 (Address) Waine Or

15. Filed Aug 31 19122 R. H. Pate
 Local Registrar

16. DATE OF DEATH Aug 30 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 26 1922 to Aug 30 1922, that I last saw him alive on Aug 26 1922 and that death occurred on the date stated above, at 12:01.

The CAUSE OF DEATH* was as follows:
diabetes mellitus
 (Duration) 2 Yrs. 0 mos. 0 ds.

Contributory (Secondary)
 (Duration) Yrs. mos. ds.
 (Signed) Roscoe B Ward M. D.
8/30 1922 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
 Where was disease contracted if not at place of death?.....
 Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Morris Hill Cemetery DATE OF BURIAL Aug 31 1922
 20. UNDERTAKER Summers & Telford Boise Idaho ADDRESS

RECEIVED

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

SEP 7 1922

Registration District No. 2

County of Gad
City of Boise

BUREAU OF VITAL STATISTICS

Registration District No. 1004

File No.

38871

Registered No. 207

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Margaret J. Anderson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

28

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

MWhiteSingle
(Write the word.)

6. DATE OF BIRTH.

July 22 - 1891
(Month) (Day) (Year)

7. AGE

31 Yrs. 1 Mos. 8 ds.IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)Stenographer

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

John P. Anderson

11. BIRTHPLACE OF FATHER

(State or Country)

Minnesota

12. MAIDEN NAME OF MOTHER

Marie Erickson

13. BIRTHPLACE OF MOTHER

(State or Country)

Minnesota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

John Anderson

(Address)

1706 Harrison Blvd

15.

Filed Aug 31 1912R. H. Pax
Local Registrar

16. DATE OF DEATH

Aug 30 1912
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from July 1 1912 to Aug 30 1912that I last saw him alive on Aug 30 1912

and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(Duration) 1 Yrs. mos. ds.Contributory
(Secondary)(Duration) yrs. mos. ds.(Signed) Harold W. Stone M. D.Spt 1 1922 (Address) 413 Overland Bldg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill CemeteryAug 2 1922

20. UNDERTAKER

ADDRESS

Chummers & Krebs Boise Id

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-1

RECEIVED

Falk. CERTIFICATE OF DEATH.

1. PLACE OF DEATH. Adair Registration District No. 2
County of Adair BUREAU OF VITAL STATISTICS Primary Registration District No. 1004
City of Boise (No. St. Luke's Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Eduard Amoray

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 38872
Registered No. 205

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married

6. DATE OF BIRTH.

Aug 16 1880
(Month) (Day) (Year)

7. AGE

36 Yrs. — Mos. 13 ds.

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

At Home

9. BIRTHPLACE

(State or Country) Missouri

10. NAME OF FATHER

George W. Mayers

11. BIRTHPLACE OF FATHER

(State or Country) Missouri

12. MAIDEN NAME OF MOTHER

Virginia Amoray

13. BIRTHPLACE OF MOTHER

(State or Country) Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louise M. Wilson

(Address)

15.

Filed Aug 30 1922

R. N. O'Neil
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 29 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, that I attended deceased from

11/8 1922 to 8/29 1922

that I last saw her alive on 8/29 1922

and that death occurred on the date stated above, at 125 P.M.

The CAUSE OF DEATH* was as follows:

lymphatic leukemia(Duration) Yrs. 2 mos. ds.

Contributory (Secondary)

Influenza infection

(Duration) Yrs. mos. ds.

(Signed)

R. N. O'Neil M. D.

(Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho

191.....

20. UNDERTAKER

ADDRESS

Summer St. B.Boise Ida.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE of DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH **RECEIVED**
County of *Adair* SEP 7 1922
City of *Boone* BUREAU OF VITAL STATISTICS
Registration District No. *2*
Primary Registration District No. *1004*
(No. *110 E. Bannock* St.)

State of IDAHO
BOARD OF HEALTH
Bureau of Vital Statistics
File No. *38873*
Registered No. *190*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant Shorman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*
(Write the word.)

6. DATE OF BIRTH

Aug - 5 - 1922
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

None

9. BIRTHPLACE

(State or Country)

Boise Idaho

10. NAME OF FATHER

H. H. Shorman

11. BIRTHPLACE OF FATHER

(State or Country)

Montana

12. MAIDEN NAME OF MOTHER

Elyobies Staire

13. BIRTHPLACE OF MOTHER

(State or Country)

California

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

R. H. Pratt
Shorman, W. H. Co.

15.

Filed *Aug. 5 - 1922*

R. H. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug. 5 - 22
Month Day Year

17. I HEREBY CERTIFY, That I attended deceased from

Aug 5 - 22 1922 to *Aug 8 - 22* 1922
that I last saw him alive on *3 Jan 1922*

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Pre-mature birth
(6 mos.)

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. S. Spruiger M. D.
Boise Idaho (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery *Aug 5 1922*

20. UNDERTAKER

ADDRESS

Summers & Telford *Boise*

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 38874
Registered No. 194

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH **RECEIVED**
 County of **Ada** SEP 7 1922
 City of **Boise** BUREAU OF VITAL STATISTICS
 Registration District No. **2**
 Primary Registration District No. **1004**
 (No. **1617 N 24** St.)

2. FULL NAME **Infant Christensen**

If death occurs away from usual residence, give facts called for under special information.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **M** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Single**
 (Write the word.)

6. DATE OF BIRTH.

Aug 12 1922
 (Month) (Day) (Year)

7. AGE

Yrs. **3** Mos. **3** ds.

IF LESS than 1 day
 how many **3** hrs. or
 min. **2**

8. OCCUPATION

(a) Trade, profession or particular kind of work...
 (b) General nature of industry, business, or establishment in which employed (or employer)...

None

9. BIRTHPLACE

(State or Country)

Boise Idaho

10. NAME OF FATHER

Robert McChesney

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Leila Christensen

13. BIRTHPLACE OF MOTHER

(State or Country)

Haines Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Chas E Summers

(Address)

Boise Idaho

15.

Filed

Aug 14 1922**R. H. Pratt**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 12 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 12 1922, to **Aug 12** 1922,
 that I last saw him alive on **Aug 12** 1922,
 and that death occurred on the date stated above, at **10:00 P.M.**

The CAUSE OF DEATH* was as follows:

Sepsis from mother

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) **Roscoe B Ward** M. D.

19. (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death...yrs....mos....days In the State...yrs....mos....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris's High Cemetery **Aug 14 1922**
 20. UNDERTAKER **Summers & Krebs** **Boise Idaho**

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No.

Primary Registration District No.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 38875

Registered No. 195

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many 2 hrs.
or — min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Aug 15 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from Aug 14 1922 to Aug 14 1922

that I last saw him alive on 1922 and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Contributory (Secondary)

(Signed)

M. D.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For. Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

38879

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Bannock*City of *Postville*

If death occurs away from usual residence, give facts called for under special information.

Registration District No. *216*Primary Registration District No. *216*File No. *52*Registered No. *3870*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

John Labord

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

(Write the word.)

6. DATE OF BIRTH

July 4 1872

(Month)

(Day)

(Year)

7. AGE

50

Yrs.

Mos.

ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)*Sheep Man*

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

7/5 1922

Local Registrar

16. DATE OF DEATH

July 3 1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

*March 1922 to July 3 1922*that I last saw him alive on *July 2 1922*and that death occurred on the date stated above, at *6:10 A.M.*

The CAUSE OF DEATH* was as follows:

Sarcoma of eye with general metastasis(Duration) *1* Yrs. *3* mos. *ds.*

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) *Wm Newton M.D.**July 5 1922* (Address) *Postville Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Postville Ida July 6 1922

20. UNDERTAKER

ADDRESS

Chenue & Hall City

38880

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Bannock*
City of *Lava Hot Springs*Registration District No. *28*Primary Registration District No. *2161*(No. *Residence* St.)File No. *52*Registered No. *3871*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Bingaman Franklin Potter

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Male

4. COLOR OR RACE

*White*5. SINGLE, MARRIED, WID-
OWED OR DIVORCED*Widowed*
(Write the word.)

6. DATE OF BIRTH

July 18 1837
(Month) (Day) (Year)

7. AGE

84 Yrs. *11* Mos. *17* ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)*Retired*

9. BIRTHPLACE

(State or Country)

Unknown

10. NAME OF FATHER

Ransom P Potter

11. BIRTHPLACE OF FATHER

(State or Country)

Kentucky

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mar Thomas Hallman

(Address)

Lava Hot Springs

15.

Filed

7/7 1922

Local Registrar

16. DATE OF DEATH

July 5 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

.....19....., to19.....
that I last saw h..... alive on19.....
and that death occurred on the date stated above, atM.

The CAUSE OF DEATH* was as follows:

Gun Shot wound

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

S. S. Iriguan Corral

1922 (Address)

Bozelle Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Lava Cemetery**July 7 1922*

20. UNDERTAKER

ADDRESS

Schumacher & Hall Bozelle

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Bannock
City of Blaser

If death occurs away from usual residence, give facts called for under special information.

RECEIVED CERTIFICATE OF DEATH

Registration District No. 28
Primary Registration District No. 2161
(No. Blaser Station St.)

38881

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 52Registered No. 3872

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Wm Patrick Stewart

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, *MARRIED, WID-OWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH

August 22 1860
(Month) (Day) (Year)

7. AGE

61 Yrs. 10 Mos. 13 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Section Foreman
A. S. L. R. R.

9. BIRTHPLACE

(State or Country)

Ireland

10. NAME OF FATHER

Samuel Stewart

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Agnes M. Crocker

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mr Wm P Stewart

(Address)

Blaser

15.

Filed

7/7 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 5 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

.....19....., to19.....
that I last saw h..... alive on19.....
and that death occurred on the date stated above, at.....M.

The CAUSE OF DEATH* was as follows:

Accidental, struck by
A. S. L. R. R. train
(Duration) Yrs. mos. ds.Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

S. S. Ferguson Coroner
7-7-1922 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lava Hot Springs7/9 1922

20. UNDERTAKER

ADDRESS

Schumacher HallPocatello

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of *Laurel* Registration District No. *1*
 City of *Pocatello* Primary Registration District No. *1*
 State of *Idaho*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mrs J. J. Braker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*
 (Write the words)

6. DATE OF BIRTH

Feb *1880*
 (Month) (Day) (Year)

7. AGE

42 *5*
 Yrs. Mos. ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

M. O'Leary

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

O'Leary

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. J. Braker
Blackfoot Idaho

15.

Filed

7/9 *1922*

Local Registrar

RECEIVED CERTIFICATE OF DEATH

AUG 10 1922

BUREAU OF VITAL STATISTICS

38882

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No.

52

Registered No.

3873

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 9 *1922*
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 10 *1922* to *July 9* *1922*
 that I last saw her alive on *July 9* *1922*
 and that death occurred on the date stated above, at *10-30* A.M.

The CAUSE OF DEATH* was as follows:

Uremia -
Past operative

(Duration) Yrs. mos. ds.

Contributory (Secondary)

Fibroid uterus

(Duration) Yrs. mos. ds.

(Signed)

J. J. Braker M. D.

July 9 1922 (Address) *Pocatello, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death... yrs. mos. *26* days. In the State... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Blackfoot Idaho *7/11* *1922*

20. UNDERTAKER

ADDRESS

J. J. Braker *Pocatello*

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
AUG 11 1922

CERTIFICATE OF DEATH

38883

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH *Butte*
 County of *Bannock*
 City of *Paerata*
 If death occurs away from usual residence, give facts called for under special information.

Registration District No. *28*
 Primary Registration District No. *2161*
 (No. *624 S.* St.)

2. FULL NAME *Sam Rose*

File No. *52*
 Registered No. *3874*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *Italian* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*
 (Write the word.)

6. DATE OF BIRTH *May 5th 1847*
 (Month) (Day) (Year)

7. AGE *75* Yrs. *2* Mos. *4* ds.
 IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
 (a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

Retired

9. BIRTHPLACE
 (State or Country)

Italy

10. NAME OF FATHER

Francis Rose

11. BIRTHPLACE OF FATHER

(State or Country)

Italy

12. MAIDEN NAME OF MOTHER

unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Lois Pignatone
Paerata, Ida

15.

Filed

7/10 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

7-9- 19 *22*
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

.....19....., to19.....
 that I last saw h..... alive on19.....
 and that death occurred on the date stated above, at.....M.

The CAUSE OF DEATH* was as follows:

Self inflicted gun shot wound

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

7-10-1922(Address) *Paerata, Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Mountain View July 11, 1922

20. UNDERTAKER

ADDRESS

Schmucke, Paerata, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. **REVISED**

CERTIFICATE OF DEATH.

38884

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 57
Registered No. 3895

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH 28
Registration District No. 28
County of Bannock Primary Registration District No. 7161
City of Pocatello (No. General Hosp St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Howard Scott Galbraith

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED. Single

6. DATE OF BIRTH.

May 31, 1914
(Month) (Day) (Year)

7. AGE

8 Yrs. 1 Mos. 9 ds.

IF LESS than 1 day
how many hrs. or
..... min. 2

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

Student

9. BIRTHPLACE

(State or Country)

Pocatello, Idaho

10. NAME OF FATHER

Geo. Galbraith

11. BIRTHPLACE OF FATHER

(State or Country)

N. Y. State

12. MAIDEN NAME OF MOTHER

Ruth Carson

13. BIRTHPLACE OF MOTHER

(State or Country)

New York State

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Geo. Galbraith

(Address)

226 N. Johnson St. Pocatello

15.

Filed

July 10 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 9, 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to 191,
that I last saw h. alive on 191,
and that death occurred on the date stated above, at 9:45 A.M.

The CAUSE OF DEATH* was as follows:

Diabetes mellitus(Duration) not known yrs. mos. ds.

Contributory (Secondary)

(Duration) 2 yrs. mos. ds.(Signed) L. C. Ray M. D.7/10 1922 (Address) Pocatello, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. Life yrs. mos. days. In the State. Life yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mt View Cem.July 11, 1922

20. UNDERTAKER

ADDRESS

M. C. Han Undertaking Co. Pocatello, Idaho

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECORDED

CERTIFICATE OF DEATH

38885

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Bannock*City of *Pocatello*Registration District No. *28*Primary Registration District No. *2161*(No. *St. Anthony Hospital* St.)File No. *52*Registered No. *3876*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Opal H. Taylor*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female*4. COLOR OR RACE *White*5. SINGLE, MARRIED, WIDOWED OR DIVORCED *married*

(Write the word.)

6. DATE OF BIRTH

September 29 1893
(Month) (Day) (Year)

7. AGE

28 Yrs. *9* Mos. *11* ds.

IF LESS than 1 day

how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

House wife

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Bengaman F McLow

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Ora Etta Burgess

13. BIRTHPLACE OF MOTHER

(State or Country)

Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *F. L. Quantrell*(Address) *Aberdeen, Idaho*15. Filed *7/11 22*

19

Local Registrar *M. H. H. H.*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 10 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 3 1922 to July 10 1922
that I last saw h. *alive* on *July 10 1922*
and that death occurred on the date stated above, at *9 P. M.*

The CAUSE OF DEATH* was as follows:

Chronic appendicitis
(operation) (7/3/22)

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

Intestinal stasis

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) *Harmon C. Hurst* M. D.

7/11 1922 (Address) *Pocatello Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Blackfoot Idaho *July 13 1922*

20. UNDERTAKER

ADDRESS

Schumacher & Hall *Pocatello*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-12

RECEIVED

CERTIFICATE OF DEATH.

38886

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. **Registration District No.** 28
County of **Bannock** **Primary Registration District No.** 2161
City of **Pocatello** **St. Anthony's Hosp.** St.)

File No. 52
Registered No. 3877
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Robert Home Donaldson**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Single**

6. DATE OF BIRTH.

May 20 1904
(Month) (Day) (Year)

7. AGE

18 Yrs. **1** Mos. **21** ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

Apprentice Machinist

9. BIRTHPLACE

(State or Country)

Kentucky

10. NAME OF FATHER

Oscar Donaldson

11. BIRTHPLACE OF FATHER

(State or Country)

Kentucky

12. MAIDEN NAME OF MOTHER

Sallie Home

13. BIRTHPLACE OF MOTHER

(State or Country)

Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) **Oscar Donaldson**(Address) **1332 N. 2. ave. Pocatello, Ida**

15.

Filed **July 12 1922**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 10 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 7th 1922 to **July 10 1922**
that I last saw him alive on **7/10 1922**

and that death occurred on the date stated above, at **1 P. M.**

The CAUSE OF DEATH* was as follows:

Septic Peritonitis

(Duration) Yrs. mos. ds.

Contributory (Secondary)

Ruptured Appendix

(Duration) Yrs. mos. ds.

(Signed) **H. A. Wright** M. D.7/12/22 (Address) **Pocatello, Ida**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death **3** yrs. **10** mos. **10** days **Pocatello**
State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence **Utah**

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mt View Cem. July 12 1922

20. UNDERTAKER

ADDRESS

H. L. Mc Han Pocatello

RECEIVED

CERTIFICATE OF DEATH

38887

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

Registration District No.

Primary Registration District No.

(No. 1442 - No. Harrison St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female White

(Write the word.)

6. DATE OF BIRTH

May 19 1909
(Month) (Day) (Year)

7. AGE

12 Yrs. 1 Mos. 25 ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).At Home
School girl

9. BIRTHPLACE

(State or Country)

Boise Idaho

10. NAME OF FATHER

Harve Hummell

11. BIRTHPLACE OF FATHER

(State or Country)

Pennsylvania

12. MAIDEN NAME OF MOTHER

Berth Solberg

13. BIRTHPLACE OF MOTHER

(State or Country)

Logan Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs Solberg

(Address)

1442 - No Harrison

15.

Filed

7/15 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 14 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

7/12 1922 to 7-14 1922

that I last saw her alive on 7-14 1922

and that death occurred on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:

Laryngeal diphtheria

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

7/15 1922

(Address)

Pocatello

M. D.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mountain View Cem

July 15 1922

20. UNDERTAKER

ADDRESS

Schumacher & Hall

Pocatello

38888

FORM V. S. No. 5-25 M. 1-19.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County *Blaine* Registration District No. *28*City of *Pocatello* Primary Registration District No. *2461*City of *Pocatello* STATE *175* Salt Lake City *2461* St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Mrs. Clara T. Burke*File No. *52*Registered No. *2879*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married

6. DATE OF BIRTH

June 27 1874
(Month) (Day) (Year)

7. AGE

43 Yrs. *0* Mos. *14* ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).*Housewife*

9. BIRTHPLACE

Hankesha Miss
(State or Country)

10. NAME OF FATHER

Frank L. Smith

11. BIRTHPLACE OF FATHER

Blaine Duchesne
(State or Country)

12. MAIDEN NAME OF MOTHER

Pauline Brundean

13. BIRTHPLACE OF MOTHER

Blaine Duchesne
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *N. J. Burke*(Address) *Pocatello*

15.

Filed *7/18* 1922 *J. H. Hume*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 16 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 1921 to *July 16 1922*that I last saw her alive on *July 16 1922*and that death occurred on the date stated above, at *738* M.

The CAUSE OF DEATH* was as follows:

Carcinoma Cervix Uteri(Duration) *1* Yrs. *11* mos. *—* ds.Contributory (Secondary) *Uremia*(Duration) *—* yrs. *3* mos. *—* ds.(Signed) *W. J. Howard* M. D.*7/17 1922* (Address) *Pocatello, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

St. Louis

20. UNDERTAKER

M. H. Hume

DATE OF BURIAL

7/19 1922

ADDRESS

Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. (See instructions on back of certificate.)

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH
in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

38889

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH AUG 17 1922
County of Bannock Registration District No. 28
City of Portville Primary Registration District No. 2161
(No. 822 South 3rd St.)

File No. 352
Registered No. 3880

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Francis Raymond Watlington

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED single
(Write the word.)

6. DATE OF BIRTH

July 16 1902
(Month) (Day) (Year)

7. AGE

20 Yrs. - Mos. - ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

Truck driver

9. BIRTHPLACE

(State or Country)

Fredricksburg No Carolina

10. NAME OF FATHER

James E Watlington

11. BIRTHPLACE OF FATHER

(State or Country)

North Carolina

12. MAIDEN NAME OF MOTHER

Sarah Hopkins

13. BIRTHPLACE OF MOTHER

(State or Country)

North Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mr James E Watlington

(Address)

822 S. 3rd

15.

Filed

7/18 1922

Local Registrar

16. DATE OF DEATH

July 16 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 20 1922 to July 16 1922
that I last saw him alive on July 16 1922
and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Malignant Endocarditis(Duration) Yrs. 2 mos. ds.Contributory
(Secondary)Multiple metastases
thrombotic(Duration) yrs. mos. 10 ds.

(Signed)

W. J. Howard

M. D.

7/18 1922 (Address) Portville Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mountain View Cem July 19 1922

20. UNDERTAKER

ADDRESS

Schumacher & Hall Portville

CERTIFICATE OF DEATH

38890

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 28
County of Bannock Primary Registration District No. 2161
City of Pocatello (No. 3 St. M. S. Hall house)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John William AmorFile No. 32
Registered No. 3881

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH

October 25 1881
(Month) (Day) (Year)

7. AGE

40 Yrs. 8 Mos. 26 ds.
IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Farmer

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

John AmorEngland

12. MAIDEN NAME OF MOTHER

Emily Lawson

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

John Amor Sr
Pocatello Ida.

15.

Filed

7/22 1922

Local Registrar

16. DATE OF DEATH

July 21 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

.....19....., to19.....
that I last saw h..... alive on19.....
and that death occurred on the date stated above, at.....M.

The CAUSE OF DEATH* was as follows:

Self inflicted by hanging
(Duration) Yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

7-22-22 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Brigham City 8th July 25 1922

20. UNDERTAKER

ADDRESS

Shumacher Hall Pocatello

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

RECEIVED

AUG 11 1922

CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

(No.) mile so. W. of *Yule & School*
6 miles mo off *Pocatello*

2. FULL NAME

Emma Lappil

38891

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED*Female white**Married*

6. DATE OF BIRTH

March 23 1872
(Month) (Day) (Year)

7. AGE

50 Yrs. *3* Mos. *28* ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

house wife

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

John Berg

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Emma Stonfield

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

William Lappil

(Address)

Pocatello, Idaho

15.

Filed

*July 22 1922**Wm. Lappil*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 21 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 11 1921 to *July 21 1922*

that I last saw her alive on *July 21 1922*and that death occurred on the date stated above, at *9:20 A.M.*

The CAUSE OF DEATH* was as follows:

Uremia poisoning

(Duration) Yrs. mos. ds.

Contributory (Secondary)

Chronic interstitial nephritis + Mitral insufficiency

(Duration) Yrs. mos. ds.

(Signed)

W. H. Madden

M. D.

July 22 1922 (Address) *Pocatello, Id.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death *9* yrs. mos. days. In the State *9* yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mt View Cemetery July 23 1922

20. UNDERTAKER

ADDRESS

McHann Undertaking Co. Pocatello Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

38892

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Pocatello

Registration District No.

County of

Primary Registration District No.

City of

No.

If death occurs away from usual residence, give facts called for under special information.

BUREAU OF VITAL STATISTICS

2. FULL NAME

David Newton Gallant

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male

White

(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

(Year)

7. AGE

Yrs.

Mos.

ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from July 23, 1922, to July 26, 1922, that I last saw him alive on July 26, 1922, and that death occurred on the date stated above, at 3:05 P.M.

The CAUSE OF DEATH* was as follows:

Bronchial pneumonia

(Duration) Yrs. mos. ds.

Contributory (Secondary) abscess, empyema

(Duration) yrs. mos. ds.

(Signed) F. M. Ray M. D.

7-26-1922 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics1. PLACE OF DEATH AUG 1 1922
County of *Bannock*
City of *Pocatello*Registration District No. *28*
Primary Registration District No. *7461*
(No. *720* St.)File No. *52*
Registered No. *3881*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Josiah Call*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Widowed*
(Write the word.)6. DATE OF BIRTH *Jan 25 1847*
(Month) (Day) (Year)7. AGE *75* Yrs. *6* Mos. *2* ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)*Retiree*

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

John Call

11. BIRTHPLACE OF FATHER

(State or Country)

Scotland

12. MAIDEN NAME OF MOTHER

unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Rosa E. Allen
(Address) *720 E. Lauder*15. Filed *7/27* 19*22*Local Registrar *H. Spring*

16. DATE OF DEATH

July 27 19*22*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 30 1922 to *July 27 1922*
that I last saw him alive on *July 27 1922*
and that death occurred on the date stated above, at *7:30* A.M.

The CAUSE OF DEATH* was as follows:

chronic heart disease
& nephritis(Duration) Yrs. *6* mos. ds.

Contributory (Secondary)

dropsy(Duration) yrs. *1* mos. ds.

(Signed)

Dr. J. M. D.(Address) *Pocatello, Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho Springs, Ida. *July 29 1922*

20. UNDERTAKER

ADDRESS

Shumaker Hall *Pocatello*
Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

38894

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH *Receivd*
 County of *Pocatello*
 City of *Pocatello*
 If death occurs away from usual residence, give facts called for under special information.

Registration District No. *1*
 Primary Registration District No. *1*
 (No. *1* St.)

2. FULL NAME *Eddie Wilson*

File No. *52*
 Registered No. *3886*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *Male*
 4. COLOR OR RACE *White*
 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*
 (Write the word.)

6. DATE OF BIRTH *Jan 20 1902*
 (Month) (Day) (Year)

7. AGE *19*
 Yrs. *6* Mos. *4* ds.
 IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION *School Boy*
 (a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE *Shelby Ida*
 (State or Country)

10. NAME OF FATHER *Ed Stephens*

11. BIRTHPLACE OF FATHER *Ogden*
 (State or Country)

12. MAIDEN NAME OF MOTHER *Minnie Wilson*

13. BIRTHPLACE OF MOTHER *Ogden Utah*
 (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) *Minnie Wilson*
 (Address) *7400*

15. Filed *7/28 1922*
 Local Registrar

16. DATE OF DEATH *July 27 1922*
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *July 11th 1922* to *July 27th 1922*
 that I last saw him alive on *July 27th 1922*
 and that death occurred on the date stated above, at *12:00 PM*.

The CAUSE OF DEATH* was as follows:
chronic valvular disease and nephritis

(Duration) *1 1/2* Yrs. mos. ds.
 Contributory (Secondary) *hypertension*

(Duration) *1* yrs. mos. ds.
 (Signed) *Dr. J. H. ...* M. D.

(Address) *Pocatello Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death *from town of Pocatello* yrs. mos. days in the State yrs. mos. days

Where was disease contracted if not at place of death? *Denver Col.*

Former or usual residence *Denver Col.*

19. PLACE OF BURIAL OR REMOVAL *St. Paul Cemetery* DATE OF BURIAL *7/30 1922*

20. UNDERTAKER *W. T. ...* ADDRESS *Pocatello*

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

Registration District No. 84
 County of Bannock Primary Registration District No. 2161
 City of Bancroft (No. _____, _____ St.)

If death occurs away from
 usual residence, give facts
 called for under special in-
 formation.

2. FULL NAME Geo Edward Lorton

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 38895

Registered No. _____

If death occurred in a hos-
 pital, institution or camp,
 give its NAME instead of
 street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED
widower
 (Write the word.)

6. DATE OF BIRTH

May 1
 (Month) (Day) (Year)

7. AGE

65

Yrs. Mos. ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or
 particular kind of work
 (b) General nature of in-
 dustry, business or estab-
 lishment in which employ-
 ed (or employer)

sheep herder

9. BIRTHPLACE

(State or Country) Nebraska

10. NAME OF FATHER

William

11. BIRTHPLACE OF FATHER

(State or Country) "

12. MAIDEN NAME OF MOTHER

"

13. BIRTHPLACE OF MOTHER

(State or Country) "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) S. Nielsen(Address) Bancroft Ida

15.

Filed 8-11922Walter S. Bad

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 24 19
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19
 that I last saw h..... alive on 19
 and that death occurred on the date stated above, at M.
 The CAUSE OF DEATH* was as follows:

(Duration) Yrs. mos. ds.

Contributory
 (Secondary)

(Duration) Yrs. mos. ds.

(Signed) M. D.

19 (Address) _____

*State the Disease Causing Death; or in deaths from Violent Causes, state
 (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days.

Where was disease contracted
 if not at place of death?

Former or
 usual residence

19. PLACE OF BURIAL OR REMOVAL

Bancroft Ida

DATE OF BURIAL

7-26-1922

20. UNDERTAKER

ADDRESS

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bannock

City of _____

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 84Primary Registration District No. 2161

(No. _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 38896

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Gerald Ryan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W5. SINGLE, MARRIED, WID-
OWED OR DIVORCED
married

(Write the word.)

6. DATE OF BIRTH

(Month) May(Day) 28(Year) 1894

7. AGE

23 Yrs.

Mos.

ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Bannock

10. NAME OF FATHER

John T. Ryan

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Susan Grant

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. Wilson Moore

(Address) _____

15.

Filed 8.1-22 19 _____Local Registrar Walter Bach

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July
(Month)28
(Day)19
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19

to

19

that I last saw h. _____ alive on _____ 19 _____

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Electrocuted

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Walter Bach M. D.19 _____ (Address) Bannock

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Logan Utah

DATE OF BURIAL

7-21-19

20. UNDERTAKER

Lindquist & Co

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Dear Lake* Registration District No. *52*
City of *Trout Lake* Registration District No. *2136*
If death occurs away from usual residence, give facts called for under special information.
FULL NAME *Charlotte F. Keeler*

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. *38897*
Registered No. *41*
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*
(Write the word.)

6. DATE OF BIRTH *May 24 1849*
(Month) (Day) (Year)

7. AGE *73* Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work *Housewife*
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) *England*

10. NAME OF FATHER

Thos. Colliprest

11. BIRTHPLACE OF FATHER

(State or Country) *England*

12. MAIDEN NAME OF MOTHER

Fanny Brooks

13. BIRTHPLACE OF MOTHER

(State or Country) *England*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mrs. D. Berta*
(Address) *Rock Springs*

15. Filed *8-20-22* 19*22* Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *Aug 18th 1922*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *July 17th 1922* to *Aug 18th 1922*
that I last saw *her* alive on *Aug 18th 1922*
and that death occurred on the date stated above at *11* P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

Contributory
(Secondary)

(Duration) Yrs. mos. ds.
(Signed) *A. H. H. H.* M. D.
(Address) *Rock Springs*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Rock Springs* DATE OF BURIAL *Aug 21 1922*

20. UNDERTAKER *J. M. Williams* ADDRESS *Rock Springs*

FORM V. S. No. 5-A—25 M. 1-19.

1. PLACE OF DEATH

County of Bear LakeCity of Montpelier

If death occurs away from usual residence, give facts called for under special information.

CERTIFICATE OF DEATH

Registration District No. 52Primary Registration District No. 2136

(No. _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 38898

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Eradriak Stauffer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married.
(Write the word.)

6. DATE OF BIRTH

July 13, 1922
(Month) (Day) (Year)

7. AGE

77 Yrs. 11 Mos. 23 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Farmer.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Switzerland.

10. NAME OF FATHER

Christian Stauffer.

11. BIRTHPLACE OF FATHER

(State or Country)

Switzerland.

12. MAIDEN NAME OF MOTHER

Maria Moser.

13. BIRTHPLACE OF MOTHER

(State or Country)

Switzerland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address) Nounan, Idaho.

15.

Filed 8-20-22

19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 6, 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 6 1922 to July 6 1922
that I last saw him alive on July 6 1922
and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH was as follows:

Accident with horse.
Ran with him.(Duration) _____ Yrs. _____ mos. _____ ds.
(Secondary) Accident(Duration) _____ Yrs. _____ mos. _____ ds.
(Signed) W. F. Culley M. D.July 7, 1922 (Address) Montpelier
State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Ogden, Utah.

DATE OF BURIAL

July 9, 1922

20. UNDERTAKER

F. M. Williams

ADDRESS

Montpelier, Idaho

1. PLACE OF DEATH

County of Bear Lake
City of Mayfield

If death occurs away from usual residence, give facts called for under special information.

CERTIFICATE OF DEATH

Registration District No. 52
Primary Registration District No. 2136

2. FULL NAME

Edna Leola PetersonState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 38899

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE W 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED single
(Write the word.)

6. DATE OF BIRTH

Oct 4 1911
(Month) (Day) (Year)

7. AGE

18 Yrs. 8 Mos. 28 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Chief at Home

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Andrew P. Peterson

11. BIRTHPLACE OF FATHER

(State or Country)

Bloomington

12. MAIDEN NAME OF MOTHER

Mary A. Johnson

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. P. Peterson

(Address)

oid Idaho

15.

Filed

19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 2 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from June 10 1922, to July 2 1922
that I last saw him alive on July 2 1922
and that death occurred on the date stated above, at 5 P. M.
The CAUSE OF DEATH* was as follows:
Appendicitis(Duration) Yrs. mos. ds.
Contributory (Secondary) Pythianites(Duration) Yrs. mos. ds.
(Signed) Est. C. Ashley M. D.1922 (Address) Mayfield, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Idaho, Idaho July 3 1922

20. UNDERTAKER ADDRESS

John J. Peterson oid

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH

County of Benewah
City of Montpelier

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ambrose J. Merrill

CERTIFICATE OF DEATH

RECEIVED
AUG 23 1922
BUREAU OF VITAL STATISTICS

Registration District No. 132
County Registration District No. 2136 St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 38900
Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH August 29 1880
(Month) (Day) (Year)

7. AGE 41 Yrs. 7 Mos. 22 ds. LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION Farmer
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE Idaho
(State or Country)

10. NAME OF FATHER J. G. Merrill

11. BIRTHPLACE OF FATHER Idaho
(State or Country)

12. MAIDEN NAME OF MOTHER Harriett Dunn

13. BIRTHPLACE OF MOTHER Idaho
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs J. G. Merrill
(Address) Montpelier, Idaho

15. Filed 8-27-22 19 22
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 20 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 19____, to _____ 19____
that I last saw h. _____ alive on _____ 19____
and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:
Accidentally shot while attempting to place a loaded 16 gauge shot gun in the corner of his granary
(Duration) Yrs. mos. ds.

Contributory (Secondary) _____
(Duration) Yrs. mos. ds.

(Signed) F. M. Williams M. D.
County Coroner
(Address) Montpelier, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days
Where was disease contracted if not at place of death? _____
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Bennington, Idaho DATE OF BURIAL May 24 1922

20. UNDERTAKER F. M. Williams ADDRESS Montpelier, Idaho

FORM V. S. No. 5-A-25 M. 1 19.

1. PLACE OF DEATH

County of Beauregard Registration District No. 3City of Montpelier Registration District No. 2138 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Annie L. McCarty

CERTIFICATE OF

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 38901

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widow
(Write the word.)6. DATE OF BIRTH April 21 1862
(Month) (Day) (Year)7. AGE 60 Yrs. 28 Mos. ds. IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Housewife
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) England10. NAME OF FATHER Thos. Hatton

11. BIRTHPLACE OF FATHER

(State or Country) England12. MAIDEN NAME OF MOTHER Mary Johnson

13. BIRTHPLACE OF MOTHER

(State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. C. E. Adamson(Address) 822 N. Arthur15. May 22 1922
Filed May 22 1922Local Registrar W. H. Meigs

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 19 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY That I attended deceased from May 14th 1922 to May 19th 1922
that I last saw him alive on May 19th 1922
and that death occurred on the date stated above, at 6 P.M.
The CAUSE OF DEATH* was as follows:
Myocarditis with dilatation(Duration) Yrs. mos. 6 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) E. F. Guyon M. D.5-21-1922 (Address) Montpelier, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Montpelier Idaho May 22 1922

20. UNDERTAKER ADDRESS

F. M. Williams Montpelier Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **38902**

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Bear LakeCity of Montpelier

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 52Primary Registration District No. 213C

St.)

2. FULL NAME

Harold Gruning

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

mar.

(Month)

11

(Day)

1907

(Year)

7. AGE

15 Yrs. 2 Mos. 5 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

At School.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Gottfried Gruning

11. BIRTHPLACE OF FATHER

(State or Country)

Switzerland

12. MAIDEN NAME OF MOTHER

Eliya Oschler

13. BIRTHPLACE OF MOTHER

(State or Country)

Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Eliya Gruning

(Address)

Montpelier

15.

Filed

8-22-22

19

H. H. Gruning

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May

(Month)

16

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 10

19

May 16

19

that I last saw him alive on May 16 19and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Suppurative Appendicitis

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed)

J. H. Gruning(Address) Montpelier

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

MontpelierMay 18 1922

20. UNDERTAKER

J. M. Williams

ADDRESS

Montpelier Idaho

1. PLACE OF DEATH

County of *Ben. Lake*
City of *Montpelier*

If death occurs away from usual residence, give facts called for under special information.

CERTIFICATE OF DEATH

Registration District No. *52*Sary Registration District No. *2130*

(No. _____ St.)

2. FULL NAME

*Rosa S. Barfuss*State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *38903*

Registered No. _____

If death occurred in hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female White

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

Apr 9 1877
(Month) (Day) (Year)

7. AGE

45 Yrs. *27* Mos. *27* ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

House wife

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Switzerland

10. NAME OF FATHER

Jacob Spring

11. BIRTHPLACE OF FATHER

(State or Country)

Switzerland

12. MAIDEN NAME OF MOTHER

Dora Kupper

13. BIRTHPLACE OF MOTHER

(State or Country)

Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Fred Barfuss

(Address)

Ben. Lake

15.

Filed *8-22* 19 *22*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 7 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

*May 1 1922 to May 7 1922*that I last saw her alive on *May 6 1922*and that death occurred on the date stated above, at *109* M.

The CAUSE OF DEATH* was as follows:

Longevity

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

W. H. Kelley M. D.*7-22* (Address) *Montpelier, Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Ben. Lake *May 9 1922*

20. UNDERTAKER

F. M. Williams *Montpelier, Idaho*

N. B.—WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH		IDaho		State Board of Health File No. 38904	
County <u>Bear Lake</u>		DEATH CERTIFICATE			
Precinct or Village <u>Fish Haven</u>		BUREAU OF VITAL STATISTICS			
City <u>Primary Registration District No 5-5</u>		Ward			
2 FULL NAME <u>Edmund Wright Carr</u>					
(a) Residence. No. <u>Ogden Utah</u>		St. <u>Utah</u>		Ward. <u>Ogden, Utah.</u>	
(Usual place of abode)		(IF NON-RESIDENT GIVE CITY OR TOWN AND STATE)			
Length of residence in city or town where death occurred		ysr.	mos.	I ds.	How long in U.S., if of foreign birth? ysr. mos. ds.
PERSONAL AND STATISTICAL PARTICULARS					
3 Sex <u>Male</u>	4 Color or Race <u>White</u>	5 Single, Married, widowed, or Divorced (write the word) <u>Single</u>			
6a If Married, widowed, or Divorced Husband of (or) Wife of					
6 Date of Birth <u>Sept 23 1919</u>					
(Month) (Day) (Year)					
7 Age <u>2</u> yrs. <u>9</u> mos. <u>20</u> ds.					
If LESS than 1 day.....hrs. or.....min.?					
8 Occupation of Deceased (a) Trade, profession or particular kind of work. <u>None</u>					
(b) General nature of industry, business, or establishment in which employed (or employer)					
(c) Name of Employer					
9 Birthplace (City or town) <u>Ogden</u>					
(State or country) <u>Utah</u>					
PARENTS	10 Name of Father <u>Edmund Eugene Carr</u>				
	11 Birthplace of Father (State or country) <u>Ogden Utah</u>				
	12 Maiden Name of Mother <u>Rachel Wright</u>				
	13 Birthplace of Mother (State or country) <u>Ogden Utah</u>				
14 Informant <u>[Signature]</u>					
Address <u>Ogden Utah</u>					
15 Filled <u>Aug 19 1922</u> <u>John Matheson</u>					
Registrar					
21 REGISTERED NUMBER		22 NO OF BURIAL PERMIT			
MEDICAL CERTIFICATE OF DEATH					
16 Date of Death <u>July 13 1922</u>					
(Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from <u>169</u>					
that I last saw him alive on <u>after death July 13</u>					
and that death occurred, on the date stated above, at <u>1422</u> m.					
The CAUSE OF DEATH* was as follows: <u>Accidental Drowning</u>					
(Duration).....ysr.....mos.....ds.					
Contributory (Secondary) (Duration).....ysr.....mos.....ds.					
18 Where was disease contracted if not at place of death?					
Did an operation precede death? Date of					
Was there an autopsy?					
What test confirmed diagnosis?					
(Signed) <u>W. B. Baller</u> M. D.					
July 13 1922 (Address) <u>Ogden Utah</u>					
*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury; and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)					
19 Place of Burial, Cremation, or Removal <u>Ogden Utah</u>				Date of Burial <u>July 13 1922</u>	
20 Undertaker <u>Karludal Under</u>				Address <u>Ogden Ut</u>	

READ CAREFULLY INSTRUCTIONS ON BACK OF CERTIFICATE.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **38906**
Registered No. **33**

1. PLACE OF DEATH

County of Bennett
City of St. MariesRegistration District No. 32Primary Registration District No. 2049

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Washington White

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

single
(Write the word.)

6. DATE OF BIRTH

Apr. 25 1918
(Month) (Day) (Year)

7. AGE

4 Yrs. 2 Mos. 8 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work..... X(b) General nature of industry, business or establishment in which employed (or employer)..... X

9. BIRTHPLACE

(State or Country)

Wisconsin

10. NAME OF FATHER

Washington P. White

11. BIRTHPLACE OF FATHER

(State or Country)

Kentucky

12. MAIDEN NAME OF MOTHER

Ada. Beel Utter

13. BIRTHPLACE OF MOTHER

(State or Country)

Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Washington P. White
(Address) St. Maries, Ida.

15.

Filed July 5 1922 Osmerger
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 3 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from June 16 1922 to July 3 1922that I last saw her alive on July 2 1922and that death occurred on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Acute infectious adenitis(Duration) Yrs. mos. 10 ds.Contributory (Secondary) Scarlatina(Duration) yrs. mos. 10 ds.(Signed) Dr. P. L. Platt M. D.1922 (Address) St. Maries, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Woodlawn

DATE OF BURIAL

7/5 1922

20. UNDERTAKER

Mitchell & Mearns St. Maries, Ida.

ADDRESS

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH **RECEIVED** **CERTIFICATE OF DEATH**
 County of *Bennett* Registration District No. *32*
 City of *St. Mary* Primary Registration District No. *2049*
 (No.) (St.)
 If death occurs away from usual residence, give facts called for under special information.
 2. FULL NAME *Margaret Ruth Gueman*
 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. *38907*
 Registered No. *35*
 If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *female* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *single*
 (Write the word.)

6. DATE OF BIRTH *July 13 1900*
 (Month) (Day) (Year)

7. AGE *22* Yrs. *0* Mos. *3* ds.
 IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION *student*
 (a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE *Spokane, Wash.*
 (State or Country)

10. NAME OF FATHER *William Gueman*

11. BIRTHPLACE OF FATHER *Canada*
 (State or Country)

12. MAIDEN NAME OF MOTHER *Annie Marian Hankins*

13. BIRTHPLACE OF MOTHER *Ireland*
 (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) *Mrs. A. C. Estep*
 (Address) *St. Mary, Ida.*

15. Filed *July 18 1922* *O. Sullenger*
 Local Registrar

16. DATE OF DEATH *July 16 1922*
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *July 1 1922* to *July 16 1922*
 that I last saw her alive on *July 5 1922*
 and that death occurred on the date stated above, at *9:00* M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) Yrs. *6* mos. ds.
 Contributory (Secondary) *Influenza*

(Duration) yrs. mos. ds.
 (Signed) *Owen D. Hall* M. D.

July 17 1922 (Address) *St. Mary, Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Woodlawn* DATE OF BURIAL *7/19 1922*

20. UNDERTAKER *Mitchell & Menager* ADDRESS *St. Mary, Ida.*

1. PLACE OF DEATH

County of Benewah Registration District No. 3
 City of St. Maries Primary Registration District No. 2049
 (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Robert Clarence Bouffieux

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 58508
 Registered No. 36

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male white single
 (Write the word.)

6. DATE OF BIRTH

June 10 1913
 (Month) (Day) (Year)

7. AGE

9 Yrs. 1 Mos. 14 ds.
 IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

student

9. BIRTHPLACE

(State or Country)

Wisconsin

10. NAME OF FATHER

John Henry Bouffieux

11. BIRTHPLACE OF FATHER

(State or Country)

Wisconsin

12. MAIDEN NAME OF MOTHER

Hattie Joyal

13. BIRTHPLACE OF MOTHER

(State or Country)

Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John Henry Bouffieux
St. Maries, Ida.

15. Filed

July 25 1922 Osmerager
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

7 24 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 24, 1922 to July 24, 1922
 that I last saw him alive on July 24, 1922
 and that death occurred on the date stated above, at _____ M.
 The CAUSE OF DEATH* was as follows:

Heart failure
following acute rheumatism
10 days (Duration) yrs. mos. ds.
 Contributory angina pectoris and diabetes
 (Secondary) half hour
 (Duration) yrs. mos. ds.
 (Signed) Oliver D. Hall M. D.
July 25, 1922 (Address) St. Maries, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Woodlawn

DATE OF BURIAL

7-26 1922

20. UNDERTAKER

Mitchell & Merago

ADDRESS

St. Maries, Ida.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **38909**Registered No. **37**

1. PLACE OF DEATH

County of **Benedict**City of **St. Marie**Registration District No. **32**Primary Registration District No. **2049**

(No. _____) (St. _____)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Sam Dorick (or Simon Agres)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

Austrian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married

6. DATE OF BIRTH

1865
(Month) (Day) (Year)

7. AGE

57 Yrs. — Mos. — ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Woodsman

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Austria

10. NAME OF FATHER

Not known

11. BIRTHPLACE OF FATHER

(State or Country)

Not known

12. MAIDEN NAME OF MOTHER

Not known

13. BIRTHPLACE OF MOTHER

(State or Country)

Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

CA Robins

(Address)

St. Marie, Ida

15.

Filed **July 31** 19**22** **Guerrayer**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 28 19**22**
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from **July 6** 19**22**, to **July 28** 19**22**, that I last saw him alive on **July 28** 19**22**, and that death occurred on the date stated above, at **4:30 A.M.**

The CAUSE OF DEATH was as follows:

Chronic Nephritis

Contributory (Secondary)

Myocarditis
Probable Cancer of Pancreas

(Signed)

7/28/1922 (Address) **St. Marie, Ida**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. **22** mos. **2** days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Unknown

Former or usual residence

Clarkia, Ida

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

19

20. UNDERTAKER

Mitchell & Munger

ADDRESS

St Marie

1. PLACE OF DEATH

County of Benedict Registration District No. 32
 City of St. Maries Primary Registration District No. 2049
 (State) _____ (St.) _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Robert Moore

CERTIFICATE OF DEATH

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 38910

Registered No. 38

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

single
 (Write the word.)

6. DATE OF BIRTH

Dec 24 1915
 (Month) (Day) (Year)

7. AGE

6 Yrs. 7 Mos. 7 ds.

IF LESS than 1 day
 how many _____ hrs.
 or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

student

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Robert Moore

11. BIRTHPLACE OF FATHER

(State or Country)

Canada

12. MAIDEN NAME OF MOTHER

not known

13. BIRTHPLACE OF MOTHER

(State or Country)

Montana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John P. Crosgrove
 (Address) St Maries Ida

15. Filed July 31 1922 Ommerager
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 31 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 30 1922 to July 31 1922
 that I last saw him alive on July 30 1922
 and that death occurred on the date stated above, at 2:15 P.
 The CAUSE OF DEATH* was as follows:

Endocarditis

(Duration) Yrs. _____ mos. 1 ds.
 Contributory (Secondary) Scarlet fever

(Duration) Yrs. _____ mos. 3 ds.
 (Signed) Dr. Platt M. D.

Sept 19 22 (Address) St Maries, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Woodlawn

DATE OF BURIAL

8-1 1922

20. UNDERTAKER

Mitchell & Mcraeger

ADDRESS

St Maries

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH

Registration District No. 27
 County of Bernard Primary Registration District No. _____
 City of Desmet (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Bernardine Theodore

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 38911Registered No. 15

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

7. Indian Widowed
 (Write the word.)

6. DATE OF BIRTH

Feb. 15 1882
 (Month) (Day) (Year)

7. AGE

70 Yrs. 5 Mos. 23 ds.

IF LESS than 1 day
 how many _____ hrs.
 or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

George Paulothan

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Ursula

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Louis Luke

(Address)

Farmington Wash.

15.

Filed

8/9

1922

Y. L. Biliham

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 8 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 10 1922, to Aug 6 1922
 that I last saw him alive on Aug 8 1922
 and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) 2 Yrs. _____ mos. _____ ds.

Contributory
 (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Fred. Barkan

M. D.

8/9 1922 (Address) Desmet, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Desmet Idaho

DATE OF BURIAL

8/10/1922

20. UNDERTAKER

J. Falcon

ADDRESS

Desmet

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **38912**Registered No. **46**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH **Benewah**
 County of **Benewah** SEP 5
 City of **Dennet** BUREAU
 Registration District No. **21**
 Principal Registration District No. _____
 St. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Anthony Campo

PERSONAL AND STATISTICAL PARTICULARS

3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED

M.**Indian****Single**
(Write the word.)

6. DATE OF BIRTH

July 6 1904
 (Month) (Day) (Year)

7. AGE

18 Yrs. **1** Mos. **20** ds.

IF LESS than 1 day
 how many _____ hrs.
 or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

Farm laborer

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Louis Campo

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Susan Timothy

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Dominic Timothy

(Address)

Dennet, Ida

15.

Filed **Aug 27** 1922

G. E. Bihlan
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 26 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb. 10 1922 to **Aug 26** 1922

that I last saw him alive on **Aug 26** 1922,
 and that death occurred on the date stated above, at **6¹⁵** P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(Duration) Yrs. **7** mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) **Fred Barberan** M. D.

8/26/1922 (Address) **Dennet Ida**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Dennet, Ida

DATE OF BURIAL

8/28 1922

20. UNDERTAKER

J. Falcon

ADDRESS

Dennet

1. PLACE OF DEATH

County of Bingham
 City of Pinegre

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No. 131Primary Registration District No. 1911

(No. _____ St.)

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 38914Registered No. 117

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
 (Write the word.)

6. DATE OF BIRTH July 18 1922
 (Month) (Day) (Year)

7. AGE 1 Yrs. 1 Mos. 1 ds. IF LESS than 1 day how many 8 hrs. or 30 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

None

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Clarence E. Collins

11. BIRTHPLACE OF FATHER

(State or Country)

Kentucky

12. MAIDEN NAME OF MOTHER

Maud May Woody

13. BIRTHPLACE OF MOTHER

(State or Country)

Oklahoma

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

H H Woody
Pinegre, Idaho

15. Filed Jul 18 1922
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 18 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 18 1922 to July 18 1922
 that I last saw him alive on July 18 1922
 and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Premature birth
due to over work
 (Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W. E. Beck M. D.
7/19/22 (Address) Blackfoot Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Thomas Burial Jul 19 1922

20. UNDERTAKER

ADDRESS

H H Woody

1. PLACE OF DEATH

County of Bingham
City of Blackfoot

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No. 1822Primary Registration District No. 2-1-1(No. 1822 St.)Peter IsaacsonState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 38915Registered No. 106

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widower
(Write the word.)

6. DATE OF BIRTH

April 30 1839
(Month) (Day) (Year)

7. AGE

83 Yrs. 2 Mos. 2 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Sweden

10. NAME OF FATHER

Isaac Petrusen

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME OF MOTHER

Weyt Know.

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

P. A. Isaacson
(Address) P.O. 721 Blackfoot, Ida.Filed July 3 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 3 1922
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from June 1 1922, to June 30 1922 that I last saw him alive on June 30 1922 and that death occurred on the date stated above, at 12 M. The CAUSE OF DEATH* was as follows:Endocarditis(Duration) 2 Yrs. — mos. — ds.Contributory
(Secondary)(Duration) — yrs. — mos. — ds.(Signed) F. W. Mitchell M. D.73 1922 (Address) Blackfoot, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death — yrs. — mos. — days. In the State — yrs. — mos. — days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

20. UNDERTAKER

ADDRESS

Rich Idm 7-6-1922
Ed Beck Blackfoot Idaho

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Bingham
City of Blackfoot

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Laura B. Roberts

CERTIFICATE OF DEATH

Registration District No. 121Registration District No. 2174No. 38916

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 38916Registered No. 107

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

Caucasian5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Widow
(Write the word.)

6. DATE OF BIRTH

1857
(Month) (Day) (Year)

7. AGE

65 Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Housewife

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

Kentucky

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

according to Asylum Records(Informant) Mary E. High-Booth(Address) Blackfoot, IdahoFiled July 5 1922 Mrs. Helen E. Roberts

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 4, 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY That I attended deceased from

May 2 1921, to July 4 1922that I last saw her alive on July 4 1922and that death occurred on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Expansion of Inanition(Duration) 1 Yrs. 2 mos. 2 ds.Contributory Arthritis Deformans
(Secondary)(Duration) 3 yrs. 1 mos. 1 ds.(Signed) C. F. Hogan M. D.7-5 1922 (Address) Blackfoot, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 1 yrs. 2 mos. 2 days. In the State 1 yrs. mos. daysWhere was disease contracted if not at place of death? UnknownFormer or usual residence Twin Falls, Idaho

19. PLACE OF BURIAL OR REMOVAL

Asylum Cemetery

DATE OF BURIAL

7/5 1922

20. UNDERTAKER

ADDRESS

Blackfoot, Ida.

1. PLACE OF DEATH **RECEIVED**
 County of Bingham AUG 17 1922
 City of Blackfoot Registration District No. 2194
 State of Idaho

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Samuel Mathew

CERTIFICATE OF DEATH

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 38917
 Registered No. 108

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE Caucasian 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
 (Write the word.)

6. DATE OF BIRTH December 10, 1872
 (Month) (Day) (Year)

7. AGE 49 Yrs. 6 Mos. 27 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION Laborer
 (a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE Utah
 (State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER
 (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
 (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE according to asylum records
 (Informant) Martha C. High - Bookkeeper
 (Address) Idaho Insane Asylum, Blackfoot

15. Filed July 7, 1922 Mr. H. E. Farnum
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 6, 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, that I attended deceased from Sept. 12, 1920, to July 6, 1922, that I last saw him alive on July 6, 1922, and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage following Convulsion

(Duration) Yrs. mos. 1 1/2 ds.
 Contributory (Secondary) Psychosis Exalted, Recurrent form
 (Duration) Yrs. mos. ds.
 (Signed) W. J. Farnum M. D.
 7.7.22 (Address) Blackfoot, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 1 yrs. 9 mos. 25 days. In the State 5 yrs. 5 mos. 5 days

Where was disease contracted if not at place of death? Unknown

Former or usual residence Blackfoot, Idaho

19. PLACE OF BURIAL OR REMOVAL Hyde Park Utah DATE OF BURIAL 7 - 19

20. UNDERTAKER E. J. Farnum ADDRESS Blackfoot

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **38918**Registered No. **109**

1. PLACE OF DEATH

County of **Bingham**
City of **Moreland**Registration District No. **121**Primary Registration District No. **211**

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Darwin Weaver Clement

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

6. DATE OF BIRTH

April 1 1917
(Month) (Day) (Year)

7. AGE

5 Yrs. 3 Mos. 6 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

None

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Clarence M. Clement

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Florence Weaver

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

C. M. Clement

(Address)

Moreland Idaho

15. Filed

July 8 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 7 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 8 1922 to July 8 1922
that I last saw him alive on **July 8 1922**and that death occurred on the date stated above, at **1:35 P. M.**

The CAUSE OF DEATH* was as follows:

Circumstances of Illness(Duration) Yrs. **4** mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

G. W. Mitchell

M. D.

7/8 1922 (Address) **Blackfoot, Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Moreland Cemetery

DATE OF BURIAL

7-9 1922

20. UNDERTAKER

E. H. Egli

ADDRESS

Blackfoot

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of *Bingham*
City of *Blackfoot*

If death occurs away from usual residence, give facts called for under special information.

RECEIVED

AUG 17 1922

CERTIFICATE OF DEATH

Registration District No. *121*Primary Registration District No. *2194*

(No.) (St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **38919**Registered No. *110*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

William H. Thomas

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

Caucasian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

January 29 1874
(Month) (Day) (Year)

7. AGE

48 Yrs. *5* Mos. *11* ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)*Farmer*

9. BIRTHPLACE

(State or Country)

California

10. NAME OF FATHER

Daniel D. Thomas

11. BIRTHPLACE OF FATHER

(State or Country)

✓

12. MAIDEN NAME OF MOTHER

Hattie Milling

13. BIRTHPLACE OF MOTHER

(State or Country)

✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

according to Asylum Records
(Informant) *Dr. W. H. E. High - Bookkeeper*
(Address) *Idaho Insane Asylum, Blackfoot*

15.

Filed *July 11th 1922* *Dr. W. H. E. High*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 10 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *April 7 1922* to *July 10 1922* that I last saw him alive on *July 10, 1922* and that death occurred on the date stated above, at *4 P. M.*

The CAUSE OF DEATH* was as follows:

Paresis, exhaustion from Psychosis of same(Duration) Yrs. *4* mos. ds.Contributory (Secondary) *Specific*(Duration) Yrs. *5* mos. ds.(Signed) *C. V. Hooper* M. D.*7-11-1922* (Address) *Blackfoot, Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. *3* mos. *3* days. In the State *16* yrs. mos. daysWhere was disease contracted if not at place of death? *Unknown*Former or usual residence *Pinegre, Idaho*

19. PLACE OF BURIAL OR REMOVAL

Thomas Riverdale Cem.

DATE OF BURIAL

7-12 1922

20. UNDERTAKER

E. L. Egli

ADDRESS

Blackfoot

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 38920

1. PLACE OF DEATH

County of Buyham Registration District No. 121
City of Smith Primary Registration District No. 2174
City of STA (No. _____) (St.) _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

James Albert White

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

infant

(Write the word.)

6. DATE OF BIRTH

July 11 1922
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many 18 hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Infant

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Firth Idaho

10. NAME OF FATHER

James A White

11. BIRTHPLACE OF FATHER

(State or Country)

Iowa

12. MAIDEN NAME OF MOTHER

Marietta Farrer

13. BIRTHPLACE OF MOTHER

(State or Country)

Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Firth - Idaho

(Address)

James A White

15.

Filed

July 12 1922 Mr. Thales E. Farnum

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 11 1922
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from July 11 1922 to July 11 1922
that I last saw him alive on July 11 1922
and that death occurred on the date stated above, at 11:14 A.M.

The CAUSE OF DEATH* was as follows:

very weak at birth no specific cause known by me
(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

F. W. Repbert M. D.(Address) Shelley Id

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Firth Idaho 19____

20. UNDERTAKER

ADDRESS

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Bingham*City of *Bluffton*

If death occurs away from usual residence, give facts called for under special information.

Registration District No. *1 1 1*Primary Registration District No. *2 1 1 4*(No. *1*)

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *38921*Registered No. *112*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Sarah Jane Mutter

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many _____ hrs.

or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed *July 14 1922*19 *22*

Local Registrar

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw her alive on *July 10 1922*and that death occurred on the date stated above, at *8:45 P.M.*

The CAUSE OF DEATH* was as follows:

Endocarditis(Duration) *5* Yrs. *—* mos. *—* ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

(Address) *Bluffton, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bluffton, Idaho *July 15 1922*

20. UNDERTAKER

ADDRESS

E. J. Peck *Bluffton, Idaho*

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH

AUG 1 1922

Registration District No. 121

County of *Bingham*

BUREAU

Primary Registration District No. 2194

City of *Blackfoot*

STAT

(No. 100)

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Albert Schmidt*State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 38922

Registered No. 113

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

Caucasian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

8/5/1922
(Month) (Day) (Year)

7. AGE

71 Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)*Miner*

9. BIRTHPLACE

(State or Country)

Prussia

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

according to Asylum records
(Informant) *Martha W. High - Bookkeeper*
(Address) *Idaho Insane Asylum - Blackfoot*

15.

Filed *July 13* 1922 *Wm. Victor C. Pater*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 13 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 21 1922, to *July 13* 1922
that I last saw him alive on *July 12* 1922,
and that death occurred on the date stated above, at *4:35 a.m.*

The CAUSE OF DEATH* was as follows:

General Paralysis following Cerebral hemorrhage(Duration) Yrs. mos. ds.
Contributory (Secondary) *Cerebral Hemorrhage*(Duration) Yrs. mos. ds.
(Signed) *Dr. H. H. Hooper* M. D.*7-13-1922* (Address) *Blackfoot, Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. 2 mos. 22 days In the State 40 yrs. mos. days

Where was disease contracted if not at place of death? *Unknown*Former or usual residence *Samhi Co. Ida. Poor Farm*

19. PLACE OF BURIAL OR REMOVAL

Asylum Cemetery

20. UNDERTAKER

Frank Hilker

ADDRESS

Blackfoot, Ida.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **38923**

1. PLACE OF DEATH

County of *Bingham* Registration District No. *121*
City of *Blackfoot* Primary Registration District No. *2194*
(No. *ST* St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Thomas Benton Runk

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-OWED OR DIVORCED

Male Caucasian *Divorced*
(Write the word.)

6. DATE OF BIRTH

Aug *31* *1854*
(Month) (Day) (Year)

7. AGE

68 Yrs. *10* Mos. *14* ds.
IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Pennsylvania

10. NAME OF FATHER

Thomas C. Runk

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Elizabeth Roeschelm

13. BIRTHPLACE OF MOTHER

(State or Country)

Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

according to ascertained records
(Informant) *My - Martha C. Runk - Bookkeeper*
(Address) *Idaho Insane Asylum, Blackfoot*

15.

Filed *July 16 1922*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July *15* *1922*
(Month) (Day) (Year)

17. I HEREBY CERTIFY That I attended deceased from

March 27 *1922*, to *July 15* *1922*,that I last saw him alive on *July 15* *1922*,and that death occurred on the date stated above, at *11 A. M.*

The CAUSE OF DEATH* was as follows:

Shock, following a burn from hot water

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed)

W. H. Hopper M. D.*7-16-1922* (Address) *Blackfoot, Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. *3* mos. *18* days. In the State *6* yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

Caldwell, Idaho

19. PLACE OF BURIAL OR REMOVAL

Anthony Kansas

DATE OF BURIAL

Quarrel

20. UNDERTAKER

E. L. Egli

ADDRESS

Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE
in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of

FORM V. & No. 1-1-15

RECEIVED
AUG 17 1922
BUREAU

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **38924**
Registered No. **115-**

City of Blackfoot (No. _____, _____ St.)
on District No. _____
Registration District No. 2174

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henry Power

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE Caucasian 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH _____
(Month) (Day) (Year) 1850

7. AGE 72 Yrs. _____ Mos. _____ ds.
IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION Farmer
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE Iowa
(State or Country)

10. NAME OF FATHER _____
✓

11. BIRTHPLACE OF FATHER _____
(State or Country) ✓

12. MAIDEN NAME OF MOTHER _____
✓

13. BIRTHPLACE OF MOTHER _____
(State or Country) ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
according to register records
(Informant) By: Martha C. High - Bookkeeper
(Address) Idaho Ins. & Asylum, Blackfoot

15. Filed _____ 19 _____
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 16, 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 12, 1919 to July 16, 1922
that I last saw him alive on July 16, 1922
and that death occurred on the date stated above, at 7 A. M.
The CAUSE OF DEATH* was as follows:

Status Epilepticus

(Duration) _____ Yrs. _____ mos. _____ ds.
Contributory (Secondary) Epilepsy
(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed) Dr. J. Power M. D.
7/17/22 (Address) Blackfoot, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 16 yrs. 5 mos. 2 days. State 7 yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? Unknown
Former or usual residence Carey, Idaho

19. PLACE OF BURIAL OR REMOVAL Asylum cemetery DATE OF BURIAL July 17, 1922

20. UNDERTAKER H. E. Wilkerson ADDRESS Blackfoot

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH Blackfoot, Idaho Registration District No. 131
 County of Blaine Primary Registration District No. 2194
 City of Blackfoot, Ida. (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME State Perry Walker

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 38925
 Registered No. 176

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
 (Write the word.)

6. DATE OF BIRTH April 15th 1850
 (Month) (Day) (Year)

7. AGE 72 Yrs. 3 Mos. 1 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. House wife
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Covington, Clinton Co. Ky.

10. NAME OF FATHER

Houston Perry

11. BIRTHPLACE OF FATHER

(State or Country) Ky.

12. MAIDEN NAME OF MOTHER

Don't know

13. BIRTHPLACE OF MOTHER

(State or Country) Ky.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John M. Walker (Husband)
 (Address) Blackfoot, Ida.

15. Filled July 17 1922 Mr. H. E. Walker
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 16 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 16 1922 to 19
 that I last saw him alive on 19
 and that death occurred on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage(Duration) Instantly Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. A. Hays M. D.

7/17 1922 (Address) Blackfoot, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Grover City, Conn. 7-17 1922

20. UNDERTAKER

ADDRESS

E. J. Peck

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bingham Registration District No. 121
 City of Blackfoot Primary Registration District No. 2194
 (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Edwin Hays

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 38926Registered No. 118

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male Caucasian Single
 (Write the word.)

6. DATE OF BIRTH

8/4
 (Month) (Day) (Year)

7. AGE

78 Yrs. Mos. ds. IF LESS than 1 day
 how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

Laborer

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

Andrew Hays

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

According to Asylum Records
 (Informant) Martha E. High - Bookkeeper
 (Address) Idaho Insane Asylum, Blft.

15.

Filed July 17 1922 Min. Hales & Co.
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 18 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 8, 1922 to July 18, 1922
 that I last saw him alive on July 18, 1922
 and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Exhaustion & Senility

(Duration) Yrs. mos. ds.

Contributory
 (Secondary)

(Duration) Yrs. mos. ds.

(Signed)

Chas. J. Hays
 (Address) Blackfoot, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. 10 days. In the State 50 yrs. mos. days

Where was disease contracted if not at place of death? Unknown

Former or usual residence Ada Co. Poor Farm, Boise, Ida.

19. PLACE OF BURIAL OR REMOVAL

Asylum Cemetery

DATE OF BURIAL

7/19 1922

20. UNDERTAKER

F. E. Wilkerson

ADDRESS

Blackfoot, Ida.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **38927**
Registered No. **177**

1. PLACE OF DEATH

County of **Burgess**
City of **Blackfoot**Registration District No. **121**Primary Registration District No. **1007**

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Thomas E Price

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married

(Write the word.)

6. DATE OF BIRTH

December**27****1865**

(Month)

(Day)

(Year)

7. AGE

56

Yrs.

6

Mos.

21

ds.

IF LESS than 1 day

how many _____ hrs.

or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Farmer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

John E Price

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Marquet Edwards

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

B E Price

(Address)

Maad**Ida**

15.

Filed

July 19**1922**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July**18****1922**

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from **July 8** 1922, to **July 18** 1922, that I last saw him alive on **July 18** 1922, and that death occurred on the date stated above, at **7 P.M.**

The CAUSE OF DEATH* was as follows:

Carcinoma of liver

(Duration)

Yrs.

4

mos.

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

F. W. Metcher

M. D.

7/19 1922 (Address) **Blackfoot, Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Maad Ida

DATE OF BURIAL

July 19 1922

20. UNDERTAKER

E. J. Beck

ADDRESS

Blackfoot

1. PLACE OF DEATH

County of BinghamCity of Blackfoot

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary E. CorduckRegistration District No. 121Primary Registration District No. 2174

(No. St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 38528Registered No. 121

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female Caucasian

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

May 12 1857
(Month) (Day) (Year)

7. AGE

65 Yrs. 2 Mos. 13 ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Illinois

10. NAME OF FATHER

John W. McVey

11. BIRTHPLACE OF FATHER

(State or Country)

✓

12. MAIDEN NAME OF MOTHER

✓

13. BIRTHPLACE OF MOTHER

(State or Country)

✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

According to Assessor Records
(Informant) Martha E. High-Birkbecker(Address) Idaho Insane Asylum Bldg.

15.

Filed

July 26 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 25 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 8, 1922 to July 25, 1922that I last saw her alive on July 25, 1922and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Exhaustion of Psychosis Depressive(Duration) Yrs. 4 mos. 17 ds.Contributory
(Secondary)(Duration) Yrs. 6 mos. — ds.

(Signed)

7.25.22 (Address) Blackfoot, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. 4 mos. 17 days. In the State 20 yrs. mos. daysWhere was disease contracted if not at place of death? UnknownFormer or usual residence Nampa, Idaho

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Nampa Idaho July 28, 1922

20. UNDERTAKER

ADDRESS

E. S. Rusk Blackfoot Idaho

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Bingham
City of Blackfoot

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No. 121
Primary Registration District No. 1007
(No. _____) (St. _____)State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 38929Registered No. 122

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female White Single
(Write the word.)

6. DATE OF BIRTH

Dec 10 1908
(Month) (Day) (Year)

7. AGE

13 Yrs. 7 Mos. 18 ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Student

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Willard W. Maughan

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Margaret Parker

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Willard W. Maughan
(Address) Blackfoot, Idaho

15.

Filed

July 28, 1922
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 28 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 10 1922, to July 28 1922
that I last saw her alive on July 28 1922
and that death occurred on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH* was as follows:

Postoperative Ileus

(Duration) _____ Yrs. _____ mos. 1 ds.

Contributory
(Secondary)

Ruptured appendix

(Duration) _____ yrs. _____ mos. 21 ds.

(Signed)

W. W. Beck M. D.

7/28 1922 (Address) Blackfoot, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. 18 days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Blackfoot Ida.

Former or usual residence

Blackfoot Ida.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Wellsville ret On arrival

20. FUNERAL

ADDRESS

E. K. Egli, Blackfoot

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bingham Registration District No. 121
 City of Shelley Primary Registration District No. 2114
 (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Myrtle Marion Farrell

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 38930
 Registered No. 123

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED Married
 (Write the word.)

6. DATE OF BIRTH

Feb - 20 - 1872
 (Month) (Day) (Year)

7. AGE

50 Yrs. 5 Mos. 11 ds.

IF LESS than 1 day
 how many..... hrs.
 or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

House wife

9. BIRTHPLACE

(State or Country)

Indiana

10. NAME OF FATHER

Lewis Marian

11. BIRTHPLACE OF FATHER

(State or Country)

West Virginia

12. MAIDEN NAME OF MOTHER

Mary Benton

13. BIRTHPLACE OF MOTHER

(State or Country)

Pennia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Parley Bates
Shelley Idaho.

15.

Filed

Feb 31 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 31 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6-16-1922 to 7-30-1922

that I last saw her alive on 7-30-1922

and that death occurred on the date stated above, at 2:45 P.M.,

The CAUSE OF DEATH* was as follows:

Nephritis

(Duration) Yrs. mos. ds.

Contributory (Secondary) Arterio Sclerosis

(Duration) yrs. mos. ds.

(Signed) Edwin Bentley M. D.

8/1-1922 (Address) Shelley Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Shelley Idaho 8-2-1922

20. UNDERTAKER

ADDRESS

E. J. Pugh Blackfoot Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

AUG 17 1922

Registration District No.

121

County of

Benewah

Primary Registration District No.

3194

City of

Blackfoot

(No.

R P D 4

St.)

File No.

38931

Registered No.

124

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Joseph Clark

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male White

Married

(Write the word.)

6. DATE OF BIRTH

Jan

16

1866

(Month)

(Day)

(Year)

7. AGE

56 yrs. 6 mos. 14 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Farmer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Scotland

10. NAME OF FATHER

Joseph Clark

11. BIRTHPLACE OF FATHER

(State or Country)

Scotland

12. MAIDEN NAME OF MOTHER

Jenny Nelson

13. BIRTHPLACE OF MOTHER

(State or Country)

Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Thomas Clark

(Address)

Blackfoot R.P.D. 4

15.

Filed Aug 1 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July

31

1922

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from July 30 1922, to July 31 1922

that I last saw him alive on July 31 1922

and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Unusual

(Duration)

Yrs.

mos.

2 ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

F. W. W. W. W.

M. D.

1922

(Address)

Blackfoot Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Marland Idaho

8-2-22

20. UNDERTAKER

ADDRESS

E. J. Clark

Blackfoot Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **38932**Registered No. **135**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of **Bingham**City of **Rose**

If death occurs away from usual residence, give facts called for under special information.

Registration District No. **121**Primary Registration District No. **2174**

(No. _____ St.)

2. FULL NAME

Georgia Ashton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single (word.)

6. DATE OF BIRTH

June 18 1901
(Month) (Day) (Year)

7. AGE

21 Yrs. **1** Mos. **13** ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

At home

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

B. W. Ashton

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Mary A Pettit

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

**Wellard Ashton
Salt Lake City, Utah**

15.

Filed

Aug 2 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 31

(Month)

(Day)

1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to **19**that I last saw him alive on **19**and that death occurred on the date stated above, at **6:30** P. M.

The CAUSE OF DEATH* was as follows:

**Choking in American Falls
canal Accidental**

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) **E. L. Egli, Coroner** D.**8/1 1922** (Address) **Blackfoot Ida**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Salt Lake City, Utah

DATE OF BURIAL

Aug 3 1922

20. UNDERTAKER

E. L. Egli

ADDRESS

Blackfoot

FORM V. S. No. 5-25 M. 1-19.

RECORDED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **38933**Registered No. **126**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of **Bingham**City of **Rose**

If death occurs away from usual residence, give facts called for under special information.

Registration District No. **121**Primary Registration District No. **2174**

(No. _____ St.)

2. FULL NAME **Blanchard R. Ashton**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married

(Write the word.)

6. DATE OF BIRTH

August 24 1893
(Month) (Day) (Year)

7. AGE

28 Yrs. **11** Mos. **7** ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Farmer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) **Utah**

10. NAME OF FATHER

B. W. Ashton

11. BIRTHPLACE OF FATHER

(State or Country) **Utah**

12. MAIDEN NAME OF MOTHER

Mary A Pettit

13. BIRTHPLACE OF MOTHER

(State or Country) **Utah**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

**Willard Ashton
Salt Lake City**

15.

Filed **Aug 27 1922**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 31 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____ 19____ to _____ 19____

that I last saw him _____ alive on _____ 19____

and that death occurred on the date stated above, at **6:30** P. M.

The CAUSE OF DEATH* was as follows:

**Drowning in American
Falls Canal Accidental**

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed)

E. L. Egli, Coroner
Blackfoot Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Salt Lake City, Utah

DATE OF BURIAL

Aug 3 1922

20. UNDERTAKER

E. L. Egli
Blackfoot

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of *Boise*
City of *Gardena*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No. *12*Primary Registration District No. *12*

BUREAU

STATE

*Lloyd Hoops*State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *38935*

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

*White*5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

April 2

(Month)

(Day)

1

(Year)

7. AGE

Yrs.

Mos.

2/day

ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

Harry Hoops

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Mamie Hoops

13. BIRTHPLACE OF MOTHER

(State or Country)

Id

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

*July 20*19*22**Mrs E S Rokison*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 28

(Month)

(Day)

19*22*
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19

to

19

that I last saw him alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

19 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Gardena

DATE OF BURIAL

April 28

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
 Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH
 in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of

City of

If death occurs away from
 usual residence, give facts
 called for under special in-
 formation.

2. FULL NAME

AUG 11 1922

Registration District No. 12

BUREAU OF VITAL STATISTICS

Registration District No. 12

(No.)

St.)

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 38936

Registered No.

If death occurred in a hos-
 pital, institution or camp,
 give its NAME instead of
 street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or
 particular kind of work(b) General nature of in-
 dustry, business or estab-
 lishment in which employ-
 ed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF
 FATHER11. BIRTHPLACE
 OF FATHER

(State or Country)

12. MAIDEN NAME
 OF MOTHER13. BIRTHPLACE
 OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

July 15 1922

1922

Mrs C. R. Rohrer
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 10th

(Month)

(Day)

19..... (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19.....

to

19.....

that I last saw h..... alive on..... 19.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration)..... Yrs..... mos..... ds.

Contributory
 (Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed)..... M. D.

19..... (Address).....

*State the Disease Causing Death; or in deaths from Violent Causes, state
 (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
 Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted
 if not at place of death?.....

Former or
 usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Horse Shod

June 11 1922

20. UNDERTAKER

ADDRESS

Dr. Page

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of **Bonner**City of **Sandpoint**

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
AUG 11
BUREAU OF
HEALTHRegistration District No. **78**Primary Registration District No. **2155**

No. _____ St.)

2. FULL NAME

Thomas GormanState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **38937**

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widowed

(Write the word.)

6. DATE OF BIRTH

Unknown

(Month) (Day) (Year)

7. AGE

about 75 or 80 yrs

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

Laborer

9. BIRTHPLACE

(State or Country)

Ireland

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

"

12. MAIDEN NAME OF MOTHER

"

13. BIRTHPLACE OF MOTHER

(State or Country)

"

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(Address) _____

15.

Filed **Aug 4** 19**22****Viola Allen**
Deputy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 11, 1922.

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 7 1922, to July 11 1922.that I last saw him alive on **July 10 1922,**and that death occurred on the date stated above, at **5 A.M.**

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage.

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) **D. J. Page** M. D.19. (Address) **Sandpoint Idaho.**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Lakeview Cemetery

DATE OF BURIAL

7/13/22.

20. UNDERTAKER

MOON & DALE

ADDRESS

Sandpoint, Idaho.by **H. E. Moon**

Dr. Jones ✓
CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Banner* Registration District No. *78*
 City of *Sandpoint* Primary Registration District No. *2155* St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Kate Ladd Davey

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. **38938**
 Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* **4. COLOR OR RACE** *White* **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** *Married.*
 (Write the word.)

6. DATE OF BIRTH

Nov. *30* *1*
 (Month) (Day) (Year)

7. AGE

47 Yrs. _____ Mos. _____ ds.

IF LESS than 1 day
 how many _____ hrs.
 or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

Housewife

9. BIRTHPLACE

(State or Country)

Ill.

10. NAME OF FATHER

John Ladd

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown.

12. MAIDEN NAME OF MOTHER

"

13. BIRTHPLACE OF MOTHER

(State or Country)

"

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Harry Allen Davey*
 (Address) _____

15.

Filled *Aug 4* 19*22*

Viola Allen
 Deputy Local Registrar

MEDICAL CERTIFICATE OF DEATH**16. DATE OF DEATH**

July *21* *1922*
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Dec. 27 19*19*, to *May 8* 19*22*
 that I last saw her alive on *June 1* 19*22*
 and that death occurred on the date stated above, at *10 A.M.*

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) *4* Yrs. *6* mos. _____ ds.

Contributory
 (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

T. J. Jones

M. D. C.

July 22 19*22* (Address) *Sandpoint, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL**DATE OF BURIAL**

Lakewood Cemetery

July 23, 1922

20. UNDERTAKER**ADDRESS**

Wm. H. Moon
By L. H. Moon *Sandpoint Idaho*

Dr. Wallentine

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **38939**

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Bonneville Registration District No. 78
City of Sandpoint Primary Registration District No. 2155
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Byron Bruce Pixley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH

July 23 1. (Month) (Day) (Year)

7. AGE

19 Yrs. — Mos. 1 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Valcanizer

9. BIRTHPLACE

(State or Country)

Michigan

10. NAME OF FATHER

J. B. Pixley

11. BIRTHPLACE OF FATHER

(State or Country)

Michigan

12. MAIDEN NAME OF MOTHER

Clara Darkee

13. BIRTHPLACE OF MOTHER

(State or Country)

Michigan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Julia Olson Pixley

(Address)

15.

Filed Aug 4 1922Viola Allen
Deputy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 24 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from June 21 1922 to July 24 1922
that I last saw him alive on July 24 1922
and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease.(Duration) 12 Yrs. mos. ds.Contributory nephritis with edema
(Secondary)(Duration) yrs. 24 mos. ds.(Signed) M. R. Wallentine, D.2-3 1922 (Address) Sandpoint, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lakeview Cemetery July 26, 1922

20. UNDERTAKER

ADDRESS

Moore & Daley Sandpoint, Ida.By L. G. Moore

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH

County of **Bonner**
City of **Sandpoint**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Matt Aro.

CERTIFICATE OF DEATH

Registration District No. **78**

Primary Registration District No. **2155**

(No. _____)

(St. _____)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **38940**

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

(Write the word.)

6. DATE OF BIRTH

Unknown

(Month) _____

(Day) _____

(Year) _____

7. AGE

36

Yrs. _____ Mos. _____ ds. _____

IF LESS than 1 day

how many _____ hrs.

or _____ min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Day Laborer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Unknown

10. NAME OF FATHER

"

11. BIRTHPLACE OF FATHER

(State or Country)

"

12. MAIDEN NAME OF MOTHER

"

13. BIRTHPLACE OF MOTHER

(State or Country)

"

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(Address) _____

15.

Filed **Aug 4** 19**22**

Viola Allen
Deputy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July
(Month)

9
(Day)

19 22
(Year)

17. I HEREBY CERTIFY, That I attended deceased from _____

19 _____ to _____

19 _____

that I last saw him _____ alive on _____

19 _____

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Fracture of Skull
Homicidal

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) **J. M. Mours**

7/10/1922 (Address) **Sandpoint, Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL
Lakeview Cemetery

DATE OF BURIAL
7/11 19 **22**

20. UNDERTAKER
MOON & DALE

ADDRESS
Sandpoint, Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

RECEIVED CERTIFICATE OF DEATH

38942

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 86
County of Bonner Primary Registration District No. 2185
City of (No. , St.)

File No. 2
Registered No. 66

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Cal D. Wayner Clark.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE Wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH May 29 1922
(Month) (Day) (Year)

7. AGE 0 yrs. 1 mos. 1 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Infant.
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Blanchard Ida
(State or Country)

10. NAME OF FATHER Geo Clark

11. BIRTHPLACE OF FATHER Wyo
(State or Country)

12. MAIDEN NAME OF MOTHER Blanche Bridges

13. BIRTHPLACE OF MOTHER W D
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo. Clark
(Address) Blanchard Ida

15. Filed August 1 1922 C. P. Gearty
Local Registrar

MEDICAL CERTIFICATE OF DEATH. 610

16. DATE OF DEATH July June 30th 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6-30 1922, to 6-30 1922
that I last saw him alive on 6-30 1922
and that death occurred on the date stated above, at 8:30 P.M.

The CAUSE OF DEATH* was as follows:

meningitis

(Duration) yrs. mos. 1 ds.

Contributory Infant Diphtheria
(Secondary)

(Duration) yrs. mos. few ds.

(Signed) E. D. Pruitt M. D.
7-8 1922 (Address) Spirit Lake Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Blanchard July 1 1922
20. UNDERTAKER ADDRESS

RECEIVED AUG 11 1922 BUREAU

CERTIFICATE OF DEATH

38943

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 85

County of Bonner

Primary Registration District No. 2185

City of Priest River, Ida.

File No. 2

Registered No. 67

If death occurs away from
usual residence, give facts
called for under special in-
formation.

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

2. FULL NAME Grant Wray

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

M

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Single

(Write the word.)

6. DATE OF BIRTH

April

6

1865

(Month)

(Day)

(Year)

7. AGE

57 Yrs. 3

Mos. 11

ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work

Rancher

(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF
FATHER

Valentine Wray

11. BIRTHPLACE
OF FATHER

(State or Country)

Ohio.

12. MAIDEN NAME
OF MOTHER

Margurite Miller.

13. BIRTHPLACE
OF MOTHER

(State or Country)

Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

August 1 1922

C. P. Getzloff
Local Registrar

16. DATE OF DEATH

July

17

1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from
July 15 1922 to July 17 22

that I last saw him alive on July 15 1922

and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(Duration) 2 Yrs. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) C. P. Getzloff M. D.

July 17 (Address) Priest River,

*State the Cause of Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

RECEIVED

SEP 5 1922

CERTIFICATE OF DEATH

38945

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bonneville Registration District No. 80

City of Clark Fork (No. 2157 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Rachel Johnson

File No. 1.28

Registered No. 28
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Sept 10 1843
(Month) (Day) (Year)

7. AGE

78 yrs. 9 mos. 6 ds.

IF LESS than 1 day
how many hrs. or
..... mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Mich. Flint.

10. NAME OF FATHER

Hiram Johnson

11. BIRTHPLACE OF FATHER

(State or Country)

New York State

12. MAIDEN NAME OF MOTHER

Rachel Parker

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Anna Rebecca Johnson

(Address)

Clark Fork, Ida.

15.

Filed

Aug 5 1922 W. H. Larson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 16 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 12 1922 to June 16 1922
that I last saw him alive on June 16 1922

and that death occurred on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:

Old age

(Duration) yrs. mos. ds.

Contributory (Secondary)

Cerebral Paralysis

(Duration) yrs. mos. ds.

(Signed)

D. G. Francis
8-3 1922 (Address) Clark Fork, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 21 yrs. 6 mos. 16 days. In the State 32 yrs. 2 mos. 24 days.

Where was disease contracted if not at place of death?

at place of death

Former or usual residence

Clark Fork, Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Owens Cemetery June 18 1922

20. UNDERTAKER

ADDRESS

Purchased from Clark Fork
of Sandpoint, Ida.
W. H. Whitcomb of Clark Fork, Ida.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

38946

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH was as follows:

Contributory (Secondary)

(Signed)

19

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

1. PLACE OF DEATH

County of BannerCity of Hope

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Margaret Trotterman

RECEIVED CERTIFICATE OF DEATH

SEP 1922

Registered District No. 80

BUREAU OF VITAL STATISTICS

Registration District No. 2157

38947

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 1Registered No. 29

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female White

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widowed
(Write the word.)

6. DATE OF BIRTH

Oct 13, 1835
(Month) (Day) (Year)

7. AGE

86 Yrs. 9 Mos. 16 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Mimmie Brown
Hope Idaho

(Address)

15.

Filed

Aug 2 1922 John Larson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug - 1 - 22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 1922 to June 1922that I last saw her alive on June 1922and that death occurred on the date stated above, at 5 PM

The CAUSE OF DEATH* was as follows:

Senility

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Physician M. D.

(Address)

Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

Avon, Mont.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Avon, Mont.

19

20. UNDERTAKER

ADDRESS

Moore & DaleSandpoint Ida.By L. L. Moon.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH

County of Bonneville Registration District No. 73
City of Idaho Falls Primary Registration District No. 21170
State No. _____ St. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Halter Shelby Huffaker

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 38948Registered No. 73

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Child
(Write the word.)

6. DATE OF BIRTH

July 21 1920
(Month) (Day) (Year)

7. AGE

1 Yrs. 10 Mos. 19 ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Asaiah Huffaker

11. BIRTHPLACE OF FATHER

(State or Country) Idaho

12. MAIDEN NAME OF MOTHER

Alvina Lovitt

13. BIRTHPLACE OF MOTHER

(State or Country) Nevada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A Huffaker

(Address) Idaho Falls

15.

Filed July 7 1922

W. J. Munn

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 9 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

5/31 1922 to 6/8 1922
that I last saw him alive on 6/8 1922

and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Leucoditis

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed) J. C. Haller

6/10 1922 (Address) Idaho Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Idaho Falls, Ida

DATE OF BURIAL

6/10 1922

20. UNDERTAKER

B. B. Woodward

ADDRESS

Idaho Falls

J. C. Haller

CERTIFICATE OF DEATH

38949

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 63

County of Bear Lake

Primary Registration District No.

City of Paris

(No.)

St.)

File No. 30

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Owen Price Stucki

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED
single

male

White

(Write the word.)

6. DATE OF BIRTH

July
(Month)12
(Day)1922
(Year)

7. AGE

Yrs.

Mos.

10 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Paris, Idaho

10. NAME OF FATHER

Joseph Smith Stucki

11. BIRTHPLACE OF FATHER

(State or Country)

Paris, Idaho

12. MAIDEN NAME OF MOTHER

Mary Price

13. BIRTHPLACE OF MOTHER

(State or Country)

Laketown, Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed July 1 1922

Local Registrar

16. DATE OF DEATH

July
(Month)22
(Day)1922
(Year)17. I HEREBY CERTIFY, That I attended deceased from
July 12, 1922, to July 22, 1922,

that I last saw him alive on July 19,

and that death occurred on the date stated above, at 1:15 PM.

The CAUSE OF DEATH* was as follows:

Premature

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

(Address)

M. D.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Paris

7/23 1922

20. UNDERTAKER

ADDRESS

E. Gra Stucki

Paris, Idaho

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

4. CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED
(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

(Duration) Yrs. mos. ds.
Contributory (Secondary)

(Duration) yrs. mos. ds.
(Signed) M. D.

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

1. PLACE OF DEATH

County of Bannock
 City of Idaho Falls

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mabel Sappington

CERTIFICATE OF DEATH

Registration District No. 73

Primary Registration District No. 214-0

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 38952

Registered No. 9V-

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Infant
 (Write the word.)

6. DATE OF BIRTH

July 16 1922
 (Month) (Day) (Year)

7. AGE

0 Yrs. 0 Mos. 0 ds.

IF LESS than 1 day
 how many 1 hrs.
 or min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho Falls

10. NAME OF FATHER

Phillip Sappington

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Mabel Heath

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Sappington
Idaho Falls

15.

Filed July 19 1922

Upmanned
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 16 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, that I attended deceased from July 16 1922 to July 16 1922
 that I last saw her alive on July 16 1922
 and that death occurred on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Still Birth - First presentation - Premature Septuaginta
placenta
 (Duration) Yrs. mos. ds.

Contributory
 (Secondary)

(Duration) Yrs. mos. ds.

(Signed) H. H. Upmanned M. D.

7-17-22 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Idaho Falls

DATE OF BURIAL

7-17-22

20. UNDERTAKER

Idaho Falls

ADDRESS

Idaho Falls

H. H. Upmanned

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
 N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County *Bannock*
City of *Idaho Falls*Registration District No. *73*
Primary Registration District No. *21V-0*
(No. _____ St.)File No. *38954*
Registered No. *71*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary E. Baker

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*
(Write the word.)

6. DATE OF BIRTH

June 16 1877
(Month) (Day) (Year)

7. AGE

45 Yrs. *0* Mos. *19* ds.IF LESS than 1 day
how many _____ hr.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).*At Home*

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Wm. Brundshaw

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Eliz. Thompson

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

H. D. Baker

(Address)

Ashton, Ida

15.

Filed

9/17 1922

Local Registrar

16. DATE OF DEATH

July 25 1922
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from *June 27 1922* to *July 5 1922*that I last saw her alive on *July 5 1922* and that death occurred on the date stated above, at *4 P.M.*

The CAUSE OF DEATH* was as follows:

Gangrenous Appendicitis(Duration) _____ Yrs. _____ mos. *9* ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

A. P. Soler M. D.
July 3 1922 (Address) *Idaho Falls, Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Ashton, Ida

DATE OF BURIAL

7-5 1922

20. UNDERTAKER

B. B. Woodward

ADDRESS

Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

Registration District No. 73
 County of Bonanza Primary Registration District No. 210-0
 City of Idaho Falls (No. Idaho Falls St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mrs. Elliott

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 38955

Registered No. 77

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

(Write the word.)

6. DATE OF BIRTH

1 18 9
 (Month) (Day) (Year)

7. AGE

33 Yrs. Mos. ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Miller

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

Monroe Elliott

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Margaret L Wood

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

C C Hayes (1897)

(Address)

Idaho Falls, Ida.

15.

Filed

July 17 1922 W. H. H. H.

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 1 22
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 1 1921, to May 1 1922

that I last saw him alive on May 1 1922

and that death occurred on the date stated above, at 7:45 A.M.

The CAUSE OF DEATH* was as follows:

Actinomycosis of
Bowels.

(Duration) 1 Yrs. mos. ds.

Contributory
 (Secondary)

(Duration) yrs. mos. ds.

(Signed)

A. R. Soderquist M. D.

May 1 1922 (Address) Idaho Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Ross, Idaho Falls May 3 1922

20. UNDERTAKER

ADDRESS

Chas. H. H. Idaho Falls

CERTIFICATE OF DEATH

1. PLACE OF DEATH
 County of BONNEVILLE
 City of IDAHO FALLS
 Registration District No. 73
 Primary Registration District No. 214-6
 (No. _____ St.)

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 38956
 Registered No. 76

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME LOUIE A HALEY

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX MALE 4. COLOR OR RACE WHITE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED MARRIED
 (Write the word.)

6. DATE OF BIRTH 6/14/1867
 (Month) (Day) (Year)

7. AGE 54 Yrs. 10 Mos. 3 ds.
 IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION
 (a) Trade, profession or particular kind of work SALESMAN
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE
 (State or Country) NORTHVILLE MICH.

10. NAME OF FATHER SAMUEL HALEY

11. BIRTHPLACE OF FATHER CANADA
 (State or Country)

12. MAIDEN NAME OF MOTHER ELECTA LOCKWOOD

13. BIRTHPLACE OF MOTHER NEW YORK
 (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Mrs. L. A. Haley
 (Address) Idaho Falls

15. Filed July 14 1922 C. J. Erickson
 Local Registrar

16. DATE OF DEATH

4/17/22
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2/23/22 19____, to 4/17/22 19____, that I last saw him alive on 4/16/22 19____, and that death occurred on the date stated above, at 5.30 AM.
 The CAUSE OF DEATH* was as follows:

ADDISON'S DISEASE

(Duration) UNKNOWN Yrs. _____ mos. _____ ds.
 Contributory (Secondary) INFLUENZA

(Duration) _____ Yrs. _____ mos. 10 ds.
 (Signed) F. J. ERNEST M. D.
4/17/1922 (Address) IDAHO FALLS, IDAHO

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ Yrs. _____ mos. _____ days. In the State _____ Yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Walton Hill DATE OF BURIAL 4/20/1922

20. UNDERTAKER Chas. Mayo ADDRESS Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bannock
City of Sun Valley

Registration District No. 73

Primary Registration District No. 2117

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Peiper

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 38957

Registered No. 200

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

Oct 21 1860
(Month) (Day) (Year)

7. AGE

61 Yrs. 8 Mos. 28 ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Farming

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

Henry Peiper

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Margaret Decker

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

John Peiper
Idaho Falls

15. Filed

July 26 1922 W. H. H. H.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 19 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____ 19____, to _____ 19____,
that I last saw h. _____ alive on _____ 19____,
and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Lightning = Accidental

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

E. E. Newberry, Coroner
Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Idaho Falls

DATE OF BURIAL

7-23-22

20. UNDERTAKER

E. E. Newberry

ADDRESS

Idaho Falls

1. PLACE OF DEATH

County of Bannockville
 City of Idaho Falls

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No. 73
 Primary Registration District No. 21N-0
 (No.) Peoples Hospital St.)

Louis John Nelson

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 38958

Registered No. 101

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
 (Write the word.)

6. DATE OF BIRTH July 17 1865
 (Month) (Day) (Year)

7. AGE 54 Yrs. 11 Mos. 7 ds. IF LESS than 1 day
 how many..... hrs.
 or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

Farmer

9. BIRTHPLACE

(State or Country)

Norway

10. NAME OF FATHER

John Nelson

11. BIRTHPLACE OF FATHER

(State or Country)

Norway

12. MAIDEN NAME OF MOTHER

Elij. ?

13. BIRTHPLACE OF MOTHER

(State or Country)

Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr Nelson
 (Address) Rd 5 Elij.

15. Filed July 18 19 22

W. J. ...
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 9 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 8 1922, to July 9 1922, that I last saw him alive on July 9 1922, and that death occurred on the date stated above, at 9:15 am

The CAUSE OF DEATH* was as follows:

Pentoxitis following perforation of gastric ulcer
24 hrs

(Duration) Yrs. mos. ds.

Contributory (Secondary) gastric ulcer

(Duration) Yrs. mos. ds.

(Signed) J. J. ... M. D.

7-10-1922 (Address) Idaho Falls, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Idaho Falls, Ida DATE OF BURIAL 7-12-1922

20. UNDERTAKER W. J. ... ADDRESS Idaho Falls

MARGIN RESERVED FOR BINDING
 WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **38959**
Registered No. **99**

1. PLACE OF DEATH

County of **Bannock**
City of **Idaho Falls**

Registration District No. **73**
Primary Registration District No. **21V-0**
(No.) (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Abigail Lauer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **Mexican** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Single**
(Write the word.)

6. DATE OF BIRTH

Aug 24 1920
(Month) (Day) (Year)

7. AGE

1 Yrs 10 Mos 26 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Lincoln Idaho

10. NAME OF FATHER

Louis Lauer

11. BIRTHPLACE OF FATHER

(State or Country)

Mexico

12. MAIDEN NAME OF MOTHER

Tenney Garcia

13. BIRTHPLACE OF MOTHER

(State or Country)

Mexico

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Louis Lauer
Box 1 - City

15.

Filed **July 24 1922**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 20 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY That I attended deceased from

19 to 19
that I last saw him alive on 19
and that death occurred on the date stated above, at **30** M.
The CAUSE OF DEATH* was as follows:

accidental drowning

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Edwin Woodley
7-749 72 (Address) **Idaho Falls**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lincoln, Ida

7-20 1922

20. UNDERTAKER

ADDRESS

Edwin Woodley

Idaho Falls

V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **38960**
Registered No. **76**

1. PLACE OF DEATH

County of **Bonner** Registration District No. **3**
City of **Idaho Falls** Primary Registration District No. **21V-0**
State **Idaho** 19th day of **July** 19th 1922

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

M. A. Earl

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Married**
(Write the word.)

6. DATE OF BIRTH

May 30 1852
(Month) (Day) (Year)

7. AGE

70 Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Farmer - Retired - 5 years.

9. BIRTHPLACE

(State or Country)

Penn

10. NAME OF FATHER

Josiah Earl

11. BIRTHPLACE OF FATHER

(State or Country)

Penn

12. MAIDEN NAME OF MOTHER

Hannah Brinkman

13. BIRTHPLACE OF MOTHER

(State or Country)

Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

M. A. Earl
Dwight Mont.

15.

Filed

July 26 1922

U. S. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 73 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Not at all

that I last saw him alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Cardiac Disease

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

W. S. Culler

M. D.

19

(Address)

Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Billing Mont.

DATE OF BURIAL

July 1922

20. UNDERTAKER

Chaffetz

ADDRESS

Idaho Falls

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 3
County of Bannock Primary Registration District No. 2156
City of Idaho Falls (No. _____ St.)File No. 38961
Registered No. 77

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Annie Eliza Charlesworth

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widowed
(Write the word.)6. DATE OF BIRTH Feb 13 1859
(Month) (Day) (Year)7. AGE 62 Yrs. 5 Mos. 6 ds. IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).at Home

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

Wm Wildblood

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Bird

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Idaho Falls

15.

Filed July 20 19 22 Wm Charlesworth
Local Registrar16. DATE OF DEATH July 19 19 22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 19 _____, to _____ 19 _____

that I last saw him _____ alive on _____ 19 _____

and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma Pylorus(Duration) _____ Yrs. 6 mos. _____ ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Wm Charlesworth M. D.

19 _____

(Address) Idaho Falls, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho Falls 7-21-22

20. UNDERTAKER

ADDRESS

Wm Charlesworth Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH

County of *Bannock*City of *Idaho Falls*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ann Valate Regby

RECEIVED CERTIFICATE OF DEATH

Registration District No. *73*Primary Registration District No. *2140*(No. *2140*)

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *38962*Registered No. *72*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WID-

OWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

*Dec 11**1881*

(Month)

(Day)

(Year)

7. AGE

40 yrs. *7* Mos. *8* ds.

IF LESS than 1 day

how many hrs.

or min. 7

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

at Home

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Jerome Remington

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Ely Jackson

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

*Samuel E. Regby
Idaho Falls, Ida.*

15.

Filed

*July 20 1922**Wm. J. Regby*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July

(Month)

19

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

*July 15 1922 to July 19 1922*that I last saw *her* alive on *July 19 1922*and that death occurred on the date stated above, at *10 P. M.*

The CAUSE OF DEATH* was as follows:

Post Partum Septicemia

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

H. Ray Hatch M. D.*7/20 1922* (Address) *Idaho Falls*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho Falls, Ida. *7-20 1922*

20. UNDERTAKER

ADDRESS

B. E. Lumbodger *Idaho Falls*

1. PLACE OF DEATH

County of Bannock
 City of Idaho Falls

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No. 73Primary Registration District No. 214-0

No. _____ St.)

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 38963Registered No. 94

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Child
 (Write the word.)

6. DATE OF BIRTH

Sep 8 1919
 (Month) (Day) (Year)

7. AGE

7 Yrs. 10 Mos. 7 ds.

IF LESS than 1 day
 how many _____ hrs.
 or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

July 15 1922 Idaho Falls
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 15 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY That I attended deceased from

_____ 19____ to _____ 19____

that I last saw h. _____ alive on _____ 19____

and that death occurred on the date stated above, at 1230 P. M.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
 (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

7-17-22 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho Falls 7-17-22

20. UNDERTAKER

ADDRESS

B. E. Dinwoodey Idaho Falls

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of BonnevilleCity of Idaho Falls

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 23Primary Registration District No. 214-0

(No. _____ St.)

2. FULL NAME

Oneta BowenState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 38964Registered No. 93

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDChild
(Write the word.)

6. DATE OF BIRTH

January 26 1922
(Month) (Day) (Year)

7. AGE

5 Yrs. 5 Mos. 19 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Virgil Bowen

11. BIRTHPLACE OF FATHER

(State or Country)

Mo

12. MAIDEN NAME OF MOTHER

Ornealo Chaffin

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. Seaver

(Address)

Idaho Falls

15.

Filed

July 18 1922 W. K. Kinnard
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 15 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____ 19____, to _____ 19____

that I last saw him _____ alive on _____ 19____

and that death occurred on the date stated above, at 1230 P.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

W. K. Kinnard
7-17-22 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho Falls 7-17-22

20. UNDERTAKER

ADDRESS

W. K. Kinnard Idaho Falls

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-

OWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

Registration District No.

Primary Registration District No.

(No.)

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Contributory (Secondary)

(Signed)

19.

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

1. PLACE OF DEATH

Registration District No. 73
 County of Burnville AUG
 Primary Registration District No. 2140
 City of Idaho Falls (No. 8th St) St. Idaho Falls

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Harold G. Butler

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 38967
 Registered No. 27

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED

Male White Single
 (Write the word.)

6. DATE OF BIRTH

Dec 15 1922
 (Month) (Day) (Year)

7. AGE

1 Yrs. 6 Mos. ds.
 IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Idaho Falls

10. NAME OF FATHER

Geo W Butler

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Flora Butler

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

George Wilford Butler
Idaho Falls, Idaho

(Address)

15.

Filed

July 17 1922 William
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 9 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 9, 1922 to July 9, 1922
 that I last saw him alive on July 9, 1922
 and that death occurred on the date stated above, at 10:30 A.M.

The CAUSE OF DEATH* was as follows:

Laryngeal Diphtheria

(Duration) Yrs. 2 mos. ds.

Contributory (Secondary)

(Duration) Yrs. ds.

(Signed)

W. Ray, M.D.
July 11, 1922 (Address) Idaho Falls, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Rose Hill July 11, 1922

20. UNDERTAKER

Chaffetz ADDRESS Idaho Falls

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **38968**Registered No. **At**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of **Burnetts**City of **Idaho Falls**Registration District No. **73**Primary Registration District No. **21476**(No. **4** St. **Shel**)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Thomas Brinson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCED**Married**
(Write the word.)

6. DATE OF BIRTH

Jan

(Month)

15

(Day)

1922

(Year)

7. AGE

80

Yrs.

Mos. **4**ds. **21**IF LESS than 1 day
how many **14** hrs.
or **min.**?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Blocksmith

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Indiana

10. NAME OF FATHER

Thomas Brinson

11. BIRTHPLACE OF FATHER

(State or Country)

Indiana

12. MAIDEN NAME OF MOTHER

Sarah Ann Miller

13. BIRTHPLACE OF MOTHER

(State or Country)

Dayton Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Jos E Brinson

(Address)

Idaho Falls Idaho

15.

Filed **July 17****1922****W. E. Brinson**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 5

(Month)

(Day)

1922
(Year)17. I HEREBY CERTIFY, That I attended deceased from **May 28th** 1922 to **June 5th** 1922that I last saw him alive on **May 28th** 1922and that death occurred on the date stated above, at **8 A.M.**

The CAUSE OF DEATH* was as follows:

Myocarditis 2 or 3 years

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Thomas C. Willson M.D.**June 6** 1922(Address) **Idaho Falls Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Idaho Falls Idaho June 11, 1922

20. UNDERTAKER

Chiffetayre

ADDRESS

Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **38969**
Registered No. **21**

1. PLACE OF DEATH
County of **Bonerville** Registration District No. **73**
City of **Idaho Falls** Primary Registration District No. **21**
St. **Idaho Falls**
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME **H. C. Traughber**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Married**
(Write the word.)

6. DATE OF BIRTH **Jan 4 1899**
(Month) (Day) (Year)

7. AGE **87** Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION **Retired**
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE **Ill.**
(State or Country)

10. NAME OF FATHER **Wm. H. ?**

11. BIRTHPLACE OF FATHER **Ky.**
(State or Country)

12. MAIDEN NAME OF MOTHER **Elizabeth Ashmore**

13. BIRTHPLACE OF MOTHER **Ill.**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) **R. H. Traughber**
(Address) **Swan Valley Ida**

15. Filled **July 14 1922** Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **June 16 1922**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **June 5 1922** to **June 16 1922**
that I last saw him alive on **June 16 1922**
and that death occurred on the date stated above, at **Idaho Falls** M.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
(Duration) yrs. mos. **11** ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) **Occident** M. D.
19 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **Rose Hill Cemetery** DATE OF BURIAL **June 18 1922**
20. UNDERTAKER **Idaho Falls** ADDRESS **Idaho Falls**

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **38970**
Registered No. **24**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of **Bonneville**
City of **Idaho Falls**Registration District No. **3**
Primary Registration District No. **21**
(No. **Idaho Falls** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

James Hoffman

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Married**
(Write the word.)

6. DATE OF BIRTH

Sept 22, 1894
(Month) (Day) (Year)

7. AGE

42
Yrs. Mos. ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work **Carpenter**
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) **Mo.**

10. NAME OF FATHER

Henry J. Hoffman

11. BIRTHPLACE OF FATHER

(State or Country) **Id.**

12. MAIDEN NAME OF MOTHER

Martha E. Gilbert

13. BIRTHPLACE OF MOTHER

(State or Country) **Ark.**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **C. S. Hays**(Address) **Idaho Falls, Ida.**

15.

Filed **July 14, 1922****1922****W. H. Spence**
Local Registrar

16. DATE OF DEATH

May 7, 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from **April 30, 1922** to **May 7, 1922**
that I last saw him alive on **May 7, 1922**
and that death occurred on the date stated above, at **12:00 P.M.**

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) **H. S. Hays**

M. D.

May 8, 1922 (Address) **Idaho Falls, Ida.**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

May 9, 1922
Idaho Falls

20. UNDERTAKER

ADDRESS

Idaho Falls

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 38971

Registered No. 79

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of *Bonneville*City of *Idaho Falls*Registration District No. *73*Primary Registration District No. *2140*(No. *Spencer Hosp.* St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Vincent Vanoni

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

?

(Write the word.)

6. DATE OF BIRTH

1885
(Month) (Day) (Year)

7. AGE

67

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Rancher

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Switzerland

10. NAME OF FATHER

Don't know

11. BIRTHPLACE OF FATHER

(State or Country)

" "

12. MAIDEN NAME OF MOTHER

" "

13. BIRTHPLACE OF MOTHER

(State or Country)

" "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Lee Vanoni

(Address)

Hamer, Ida

15.

Filed

July 17 1922 W. F. Fennell

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 19 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *June 12 1922* to *June 19 1922*that I last saw him alive on *June 19 1922* and that death occurred on the date stated above, at *6 P.M.*

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *H. J. Fennell* M. D.*July 5 1922* (Address) *Idaho Falls, Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Rose, Idaho Falls June 23 1922

20. UNDERTAKER

Chas. Hays ADDRESS *Idaho Falls**Dr. Spencer*

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED

CERTIFICATE OF DEATH

Registration District No.

Registration District No.

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MARDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

19 22

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19

that I last saw h. alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows;

Post mortem examination -
Fractured skull -
Cerebral hemorrhage

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

8/29/22

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Blackfoot, Idaho 9/1 19 22

20. UNDERTAKER

ADDRESS

1. PLACE OF DEATH

County of Butte Registration District No. 09
 City of Arco Registration District No. _____
 _____ St.)

If death occurs away from
 usual residence, give facts
 called for under special in-
 formation.

2. FULL NAME

Anna Elizabeth Savaria

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 38973

Registered No. _____

If death occurred in a hos-
 pital, institution or camp,
 give its NAME instead of
 street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED married
 (Write the word.)

6. DATE OF BIRTH

July 26 1886
 (Month) (Day) (Year)

7. AGE

36 Yrs. _____ Mos. _____ ds.

IF LESS than 1 day
 how many _____ hrs.
 or _____ min.?

8. OCCUPATION

(a) Trade, profession or
 particular kind of work
 (b) General nature of in-
 dustry, business or estab-
 lishment in which employ-
 ed (or employer)

House wife

9. BIRTHPLACE

(State or Country) Kansas

10. NAME OF FATHER

Gayle Fry

11. BIRTHPLACE OF FATHER

(State or Country) Penn

12. MAIDEN NAME OF MOTHER

Eve Montgomery

13. BIRTHPLACE OF MOTHER

(State or Country) Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Laurance Savaria
 (Address) Moore, Arco

15. Filed 8/23 19 22

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

August 23 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
8/23 19 22 to 8/23 19 22
 that I last saw h. 11 alive on 8/23 19 22
 and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH was as follows:

Embolism of Heart

(Duration) _____ Yrs. _____ mos. _____ ds.
 Contributory Peritonitis & Pus tube
 (Secondary) Swamp & appendix 5
 (Duration) _____ Yrs. _____ mos. _____ ds.

(Signed) E. W. H. M. D.

23 1922 (Address) Arco, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state
 (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted
 if not at place of death?

Former or usual residence Moore, Arco

19. PLACE OF BURIAL OR REMOVAL

Moore, Arco

20. UNDERTAKER

Wm King

ADDRESS

Moore Arco

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **38974**

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of _____

City of _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No. _____

Primary Registration District No. _____

(No. VITAL)

St.) _____

RECEIVED
SEP 5 1922
BUREAU OF VITAL STATISTICS

Mrs Christine Carlson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

March 25 1858
(Month) (Day) (Year)

7. AGE

64

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Home wife

9. BIRTHPLACE

(State or Country)

Sweden

10. NAME OF FATHER

Johnson

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MARDEN NAME OF MOTHER

Mrs Brown

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John Carlson

(Address)

Moore, Idaho

15.

Filed

8/21 1922

E. W. H. Local Registrar

MEDICAL CERTIFICATE OF DEATH

120

16. DATE OF DEATH

Aug 20 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

8/1 1922 to 8/20 1922
that I last saw him alive on 8/20 1922
and that death occurred on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Arthritis deformans

(Duration) 26 Yrs. mos. ds.

Contributory
(Secondary)

(Duration) 25 Yrs. mos. ds.

(Signed)

E. W. H. M. D.
1922 (Address) Area, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Twin Falls, Idaho

19

20. UNDERTAKER

Egle Pacheco

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED

SEP 3 1922 CERTIFICATE OF DEATH.

1. PLACE OF DEATH.

County of

City of

Registration District No.

BUREAU OF VITAL STATISTICS
Registration District No.

(No.)

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Erich R. Erickson

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 38975

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

6. DATE OF BIRTH.

7. AGE

IF LESS than 1 day
how many.....hrs. or
.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1912

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 3 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191..... to 191.....

that I last saw him alive on 191.....

and that death occurred on the date stated above, at 3:30 P.M.

The CAUSE OF DEATH* was as follows:

Struck by lightning
(Duration) inst. yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

8/5 (Signed) E. R. Erickson M. D.

1922 Address) Arco, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death.....yrs.....mos.....days State.....yrs.....mos.....days

Where was disease contracted
if not at place of death?.....

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Spanish Fork, Utah 8/7 1922

20. UNDERTAKER ADDRESS

Egle Blackfoot, Idaho

FORM V. S. No. 5-A-25 M. 1-19

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH *AUG 1 1922* Registration District No. *58^d*
 County of *Camas* ~~BUREAU OF VITAL STATISTICS~~ Primary Registration District No. *2138*
 City of *Fairfield* (No.) St.)

File No. *38976*

Registered No. _____

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Dick Pettingill

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED *single*
(Write the word.)

6. DATE OF BIRTH

june 30^d 1922
(Month) (Day) (Year)

7. AGE

Yrs. Mos. *3* ds.

IF LESS than 1 day
how many hrs.
or min. ?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

None

9. BIRTHPLACE

(State or Country)

Camas County, Idaho

10. NAME OF FATHER

John Basil Pettingill

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho.

12. MAIDEN NAME OF MOTHER

Luez Carolina Parish

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. Basil Pettingill (per LW)
Fairfield, Idaho

15.

Filed

july 3^d 1922

LWilencheck
Local Registrar

16. DATE OF DEATH

july 3^d 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
june 30^d 1922, to *july 3^d 1922*
that I last saw him alive on *july 3^d 1922*
and that death occurred on the date stated above, at *5:30 P.M.*
The CAUSE OF DEATH* was as follows:

*Premature Birth (Eight months
gestation)*

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

LWilencheck

M. D.

july 3^d 1922 (Address) *Fairfield, Idaho.*

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Elba, Idaho.

19

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **38977**

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

Registration District No. **58th**
County of **Camas** Primary Registration District No. **2138**
City of **Fairfield** (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary Ellen Dalling

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

widowed.
(Write the word.)

6. DATE OF BIRTH

January 7th 1858
(Month) (Day) (Year)

7. AGE

64 Yrs. 6 Mos. 2 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Housework

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Beardstown, Illinois

10. NAME OF FATHER

William Daugherty

11. BIRTHPLACE OF FATHER

(State or Country)

United States

12. MAIDEN NAME OF MOTHER

Nancy Hodge

13. BIRTHPLACE OF MOTHER

(State or Country)

United States

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Arthur L. Dalling

(Address)

Fairfield Idaho

15.

Filed

July 10th 1922**L. W. Lencheck**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 9th 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from **May 7th 1922**, to **July 9th 1922**, that I last saw h. **ls.** alive on **July 6th 1922**, and that death occurred on the date stated above, at **2³⁰ P.M.**
The CAUSE OF DEATH* was as follows:**Carcinoma uteri**(Duration) **3** Yrs. _____ mos. _____ ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

L. W. Lencheck

M. D.

July 10 1922 (Address) **Fairfield, Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **38978**

1. PLACE OF DEATH. **Butte** Registration District No. **39**
County of **Butte** Primary Registration District No. **39**
City of **Butte** (No. **39**) St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME **Minosque Savaria**

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Widowed**
(Write the word.)

16. DATE OF DEATH **July 19** 191**22**
(Month) (Day) (Year)

6. DATE OF BIRTH **Sept. 25** 18**42**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **7-19** 191**22** to **7-19** 191**22** that I last saw him alive on **7-19** 191**22** and that death occurred on the date stated above, at **230 P.M.**

7. AGE **80** If LESS than 1 day how many hrs. or min.?

The CAUSE OF DEATH* was as follows:

8. OCCUPATION
(a) Trade, profession or particular kind of work... **Housewife**
(b) General nature of industry, business, or establishment in which employed (or employer).....

Senility

9. BIRTHPLACE
(State or Country) **Canada**

(Duration) Yrs. mos. ds.
Contributory (Secondary) **General Paralysis of the insane**
(Duration) **one** yrs. mos. ds.

10. NAME OF FATHER **Savage**

(Signed) **E. L. Moore** M. D.
7/19/22 (Address) **Arco, Idaho**

11. BIRTHPLACE OF FATHER
(State or Country) **Canada**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

12. MAIDEN NAME OF MOTHER **Not known**

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

13. BIRTHPLACE OF MOTHER
(State or Country) **France**

At place of death.....yrs.....mos.....days In the **36** State.....yrs.....mos.....days

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

Where was disease contracted if not at place of death?.....

(Informant) **Mrs. H. Savaria**
(Address) **Moore, Idaho**

Former or usual residence

15. Filed **7/20** 191**22** **E. L. Moore**
Local Registrar

19. PLACE OF BURIAL OR REMOVAL **Moore, Idaho** DATE OF BURIAL **7/21** 191**22**

20. UNDERTAKER **L. Savaria** ADDRESS **Moore, Idaho**

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **38979**Registered No. **17**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of **Canyon** Registration District No. **3**
City of **Parma** Primary Registration District No. **2007** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jane P Dexter

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F.

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

widow

(Write the word.)

6. DATE OF BIRTH

Apr 27 1834
(Month) (Day) (Year)

7. AGE

88 Yrs. **3** Mos. **5** ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Retired

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Penn

10. NAME OF FATHER

Albert Shenwood

11. BIRTHPLACE OF FATHER

(State or Country)

Penn

12. MAIDEN NAME OF MOTHER

Polly wood

13. BIRTHPLACE OF MOTHER

(State or Country)

Cann

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

G. L. Hayes
Parma Ida

15.

Filed

9/1**1922****Lulu Aldrich**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 2 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jane 18 1922 to Aug 2 1922that I last saw her alive on **Aug 1 1922**and that death occurred on the date stated above, at **5:40 A.M.**

The CAUSE OF DEATH* was as follows:

Apoplexy(Duration) Yrs. **1** mos. **14** ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

D. M. Mitchell M. D.**8-2 1922** (Address) **Parma Ida**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Leavenworth Kansas**19**

20. UNDERTAKER

ADDRESS

Leckham Funeral Home **Parma**

1 CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Canyon
 City of Parma

RECEIVED

Primary Registration District No. 2007
 (No. 1922 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mattie L. Ross

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 38980
 Registered No. 19

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F. 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
 (Write the word.)

6. DATE OF BIRTH

March 5 1869
 (Month) (Day) (Year)

7. AGE

53 Yrs. 5 Mos. 14 ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

Housewife

9. BIRTHPLACE

(State or Country)

Tennessee

10. NAME OF FATHER

Do not know

11. BIRTHPLACE OF FATHER

(State or Country)

Do not know

12. MAIDEN NAME OF MOTHER

Do not know

13. BIRTHPLACE OF MOTHER

(State or Country)

Do not know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Chas Ross

(Address)

Parma

15.

Filed

9/1

1922

Lulu Hatchup
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 18 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 15 1922, to Aug 18 1922 that I last saw her alive on Aug 18 1922 and that death occurred on the date stated above, at 10 P.M. The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) 3 Yrs. mos. ds.

Contributory
 (Secondary)

(Duration) yrs. mos. ds.

(Signed)

B M Mitchell M. D.

8-19-1922 (Address) Parma Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR CREMATION

Parma Cemetery

DATE OF BURIAL

Aug 20 1922

20. UNDERTAKER

Beckham Lumber Co

ADDRESS

Parma

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
38981
File No. 7007
Registered No. 7007

1. PLACE OF DEATH
County of _____
City of _____
Registration District No. _____
Primary Registration District No. 7007
St. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Albert G. Barker*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *married*
(Write the word.)

6. DATE OF BIRTH *Oct 7 1869*
(Month) (Day) (Year)

7. AGE *52* Yrs. *10* Mos. *15* ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work *Kancher*
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE *Ill*
(State or Country)

10. NAME OF FATHER *Leander Barker*

11. BIRTHPLACE OF FATHER *Maine*
(State or Country)

12. MAIDEN NAME OF MOTHER *Amie Hawkridge*

13. BIRTHPLACE OF MOTHER *England*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *Rev Dr Helms*
(Address) *Carrollville Ida*

15. Filed _____ 19 _____
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *Aug 22 1922*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Aug 22 1922* to *Aug 22 1922* that I last saw him alive on *Aug 22 1922* and that death occurred on the date stated above, at *3 P.M.*

The CAUSE OF DEATH* was as follows:

Hemorrhage from ruptured artery for accident
(Duration) Yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) *W M Hiltchee* M.D.
19 _____ (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2), whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Parma* DATE OF BURIAL *Aug 25 1922*

20. UNDERTAKER *Beckham Fur Co* ADDRESS *Parma*

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Canyon Registration District No. 3
 City of Caldwell Primary Registration District No. 2007
 St. Idaho

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Charles Lewis Wagner

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 38982
 Registered No. 20

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

S

(Write the word.)

6. DATE OF BIRTH

29 29 1918
 (Month) (Day) (Year)

7. AGE

4 Yrs. 3 Mos. 1 ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Boise Idaho

10. NAME OF FATHER

Peter S Wagner

11. BIRTHPLACE OF FATHER

(State or Country) Arkansas

12. MAIDEN NAME OF MOTHER

Belle Sterling

13. BIRTHPLACE OF MOTHER

(State or Country) Ind

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

P S Wagner

(Address)

Parma Ida

15.

Filed 9/1 1922 Hubert Waldrop
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 30 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 26 1922 to June 30 1922
 that I last saw him alive on June 30 1922

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Appendicitis

(Duration) Yrs. mos. 6 ds.

Contributory
 (Secondary)

(Duration) Yrs. mos. ds.

(Signed)

M M Motekece M. D.

7-1 1922 (Address) Parma Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Roswell

DATE OF BURIAL

July 1 1922

20. UNDERTAKER

Pearman Fur Co
 (over)

ADDRESS

Parma Ida

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

AUG 17 1922 CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 38983

Registered No. 84

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Canyon Registration District No. 3
City of Huston R#2 (No. 2005- St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Lynch

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female white (Write the word.)

6. DATE OF BIRTH

Aug 6- 1922
(Month) (Day) (Year)

7. AGE

— Yrs. — Mos. — ds. IF LESS than 1 day how many... hrs. or... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Idaho.

10. NAME OF FATHER

B. M. Lynch.

11. BIRTHPLACE OF FATHER

(State or Country) Missouri.

12. MAIDEN NAME OF MOTHER

Kathryn Walsh.

13. BIRTHPLACE OF MOTHER

(State or Country) Missouri.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) B. M. Lynch

(Address) Huston R#2

15.

Filed Aug 7- 1922 John H. Meyer

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 6- 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 6 1922 to Aug 6 1922

that I last saw him alive on Aug 6 1922

and that death occurred on the date stated above, at 10 M.

The CAUSE OF DEATH* was as follows:

Premature

(Duration) Yrs. mos. 1 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

1922 (Address) Caldwell, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death... yrs... mos... days. In the State... yrs... mos... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Canyon Hill. Aug 7. 1922

20. UNDERTAKER

C. V. Pickham ADDRESS Caldwell, Idaho

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **38984**
Registered No. **83**

1. PLACE OF DEATH **AUG 1 1922**
BUREAU Registration District No. **3**
County of **Canyon** STATE **Idaho** Primary Registration District No. **2005**
City of **Wilder** (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Elinor Josephine Barnes

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **(Write the word.)**

6. DATE OF BIRTH

March 7 1919
(Month) (Day) (Year)

7. AGE

3 Yrs. **4** Mos. **24** ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

at home

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Ray W. Barnes

11. BIRTHPLACE OF FATHER

(State or Country)

Nebraska

12. MAIDEN NAME OF MOTHER

Flora E. Vandewilt

13. BIRTHPLACE OF MOTHER

(State or Country)

Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ray W. Barnes

(Address)

Wilder, Ida

15.

Filled **Aug. 2 1922** **John H. Meyer**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 1 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 26 1922 to **Aug 1 1922**
that I last saw her alive on **July 31 1922**

and that death occurred on the date stated above, at **7:30 A.M.**

The CAUSE OF DEATH* was as follows:

Septicæmia

(Duration) Yrs. _____ mos. **6** ds.

Contributory
(Secondary)

Nephritis acute

(Duration) yrs. _____ mos. **3** ds.

(Signed)

C. M. Koley M. D.

1922

(Address) **Caldwell, Ida.**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Canyon Hill **Aug 2 1922**

20. UNDERTAKER

ADDRESS

C. V. Beckham **Caldwell**

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 3
County of Canyon Primary Registration District No. 1005
City of Caldwell (No. 378) St. File No. 38985Registered No. 82

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Paul Clarence Johnston

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

male white (Write the word.)

6. DATE OF BIRTH

Oct 14 1922
(Month) (Day) (Year)

7. AGE

4 Yrs. 9 Mos. 1 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).at home

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Harold E. Johnston

11. BIRTHPLACE OF FATHER

(State or Country)

Kansas

12. MAIDEN NAME OF MOTHER

Almeda Cupp

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Harold E. Johnston
Caldwell, Ida

15.

Filed

July 17 - 1922 John V. Meyers
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 15 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

called in on him dying
that I last saw him alive on July 15 1922
and that death occurred on the date stated above, at 2-P M.

The CAUSE OF DEATH* was as follows:

Septic throat(Duration) Yrs. mos. 5 ds.Contributory
(Secondary)Christian Science

(Duration) yrs. mos. ds.

No physician in attendance

(Signed)

G. W. Montgomery M. D.July 17, 1922 (Address) Caldwell, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Canyon Hill 7-17-1922

20. UNDERTAKER

ADDRESS

W. Beckham Caldwell

FORM V. S. No. 5-25 M. 1-19.

RECORD

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **38986**
Registered No. **81**

1. PLACE OF DEATH

County of *Canyon*City of *Greentleaf*Registration District No. *3*Primary Registration District No. *2005*

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Homer W. Tozier

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male white

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

April 27th 1911

7. AGE

11 Yrs. 2 Mos. 18 ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

at home

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

E. C. Tozier

11. BIRTHPLACE OF FATHER

(State or Country)

Kansas

12. MAIDEN NAME OF MOTHER

Hulda A. Cox

13. BIRTHPLACE OF MOTHER

(State or Country)

Indianapolis

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

*E. C. Tozier
Greentleaf, Idaho*

15.

Filed

*July 17-1922**John L. Meyer*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 15-1922

17. I HEREBY CERTIFY, That I attended deceased from

July 15-1922 to July 15-1922
that I last saw him _____ alive on *Casualty April 1922*
and that death occurred on the date stated above, at *6:30 P.M.*

The CAUSE OF DEATH* was as follows:

(Drowning) asphyxiation(Duration) _____ Yrs. _____ mos. *a* ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) *S. B. Dunsley* M. D.19. _____ (Address) *Caldwell, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Greentleaf**7-18-1922*

20. UNDERTAKER

ADDRESS

W. Beckham Caldwell

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
AUG 1 1922

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Canyon*
City of *Notus*Registration District No. *3*Primary Registration District No. *2005*

(No. St.)

File No. *38987*Registered No. *88*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Emory J. Proctor

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *married*

6. DATE OF BIRTH

November 3 18*92*
(Month) (Day) (Year)

7. AGE

29 Yrs. *8* Mos. *9* ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).*Rancher*

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

Andrew H. Proctor

11. BIRTHPLACE OF FATHER

(State or Country)

Kentucky

12. MAIDEN NAME OF MOTHER

Lary Alsop

13. BIRTHPLACE OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. J. Proctor

(Address)

Notus, Ida.

15.

Filed

*July 13 - 1922**John V. Meyer*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 12 19*22*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 13 1922 to *July 13* 1922that I last saw him alive on *July 10* 1922and that death occurred on the date stated above, at *1-30* M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(Duration) *one* Yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. M. Mitchee

M. D.

7-13 1922 (Address) *W. M. Mitchee*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Canyon Hill

DATE OF BURIAL

7-13 19*22*

20. UNDERTAKER

V. P. Buchanan

ADDRESS

Caldwell

RECEIVED
AUG 1 1922

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **38988**
Registered No. **79**

1. PLACE OF DEATH

County of CaldwellCity of Canyon Co. Ida.Registration District No. 3Primary Registration District No. 1009

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Andrew Bodenhamer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married.
(Write the word.)

6. DATE OF BIRTH

Sept 3

1853

(Month)

(Day)

(Year)

7. AGE

68

Yrs.

10

Mos.

9

ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

City Street Work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

North Carolina

10. NAME OF FATHER

Wm Bodenhamer

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Not Known

13. BIRTHPLACE OF MOTHER

(State or Country)

Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address) Caldwell Idaho

15.

Filed July 13- 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 12-22

(Month)

(Day)

19

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 1922 to July 12 1922

that I last saw him alive on July 11 1922

and that death occurred on the date stated above, at 10 M.

The CAUSE OF DEATH* was as follows:

Ch. Nephritis

(Duration) Yrs. mos. ds.

Contributory (Secondary) Cardiac Insufficiency

(Duration) yrs. mos. ds.

(Signed) Chas. H. Meyer M. D.(Address) Caldwell Id.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Canyon Hill

DATE OF BURIAL

7-13-22

20. UNDERTAKER

Paul L. Case

ADDRESS

Caldwell Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Canyon*City of *Caldwell*Registration District No. *3*Primary Registration District No. *1005*(No. *3*)St. *Idaho*File No. *38989*Registered No. *78*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Thelma B. Cupp

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

17 Yrs. *4* Mos. *21* ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work *at home*

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) *Idaho*

10. NAME OF FATHER

Char. H. Cupp

11. BIRTHPLACE OF FATHER

(State or Country) *Ohio*

12. MAIDEN NAME OF MOTHER

Lilly L. Blawell

13. BIRTHPLACE OF MOTHER

(State or Country) *Kansas*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *H. B. Cupp*(Address) *Caldwell, Ida.*

15.

Filed *July 14-1922**John V. Inyeg*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 11 19*22*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19..... to 19.....

that I last saw h..... alive on..... 19.....

and that death occurred on the date stated above, at *5-30* M.

The CAUSE OF DEATH* was as follows:

Had Convulsions.
Cause unknown & indeterminate death sudden

(Duration)..... Yrs..... mos..... ds.

Contributory (Secondary) *Christian Science**No physician in attendance*

(Duration)..... Yrs..... mos..... ds.

(Signed) *John V. Inyeg, M.D.**7/14/1922* (Address) *Caldwell, Idaho.*
Local Registrar

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... Yrs..... mos..... days. In the State..... Yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Canyon Hill *7-14-1922*

20. UNDERTAKER

ADDRESS

V. Beckham Caldwell

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 3
County of Canyon Primary Registration District No. 2003
City of Caladwell (No. _____ St.)File No. 38990Registered No. 77

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Hattie Orlica Beal

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDfemale white married
(Write the word.)

6. DATE OF BIRTH

Oct 5 1880
(Month) (Day) (Year)

7. AGE

41 Yrs. 8 Mos. 4 ds.
IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work House Wife
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Ohio

10. NAME OF FATHER

John Johnston

11. BIRTHPLACE OF FATHER

(State or Country) Ohio

12. MAIDEN NAME OF MOTHER

Hattie Clark

13. BIRTHPLACE OF MOTHER

(State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. H. Beal(Address) Wilder Place

15.

Filed July 11 1922 John V. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 9 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY That I attended deceased from

January 1922 to July 9 1922
that I last saw her alive on July 9 1922
and that death occurred on the date stated above, at 4:30 P.

The CAUSE OF DEATH* was as follows:

Carcinoma of
Esophagus & stomach(Duration) 1 Yrs. _____ mos. _____ ds.Contributory (Secondary) venous ecsthesia(Duration) 20 yrs. _____ mos. _____ ds.(Signed) A. B. Borch M. D.19 (Address) Wilder Pl.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Wilder Cem. DATE OF BURIAL 7-11-1922

20. UNDERTAKER

J. V. Beckham ADDRESS Caladwell

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of *Salate*
City of *Genese*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Theodor Schlueter

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WID-

OWED OR DIVORCED

married
(Write the word.)

6. DATE OF BIRTH

*The 18th May 1867**May* (Month) *18* (Day) *1867* (Year)

7. AGE

55 Yrs. *2* Mos. *2* ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

Henry Schlueter

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Elisabet Genteman

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Karilia Schlueter

(Address)

Genese, Idaho

15.

Filed

*July 32 1922**10.11.1922*

Local Registrar

CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

(No.

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

38991

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July (Month) *21* (Day) *1922* (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 21 1922 to *July 21 1922*
that I last saw him alive on *July 21 1922*
and that death occurred on the date stated above, at *6 A.* M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage(Duration) Yrs. mos. *1 hr.* ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

C. F. Thorry M. D.(Address) *Genese Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

*F. E. Lambert**Genese Idaho*

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Camp Registration District No. 7
 City of _____ Primary Registration District No. 2056
 (State) _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Samuel A. Sailer

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 38996
 Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED Single
 (Write the word.)

6. DATE OF BIRTH Nov 27 1887
 (Month) (Day) (Year)

7. AGE 34 Yrs. 7 Mos. 6 ds. IF LESS than 1 day
 how many _____ hrs.
 or _____ min.?

8. OCCUPATION Farmer
 (a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE Iowa
 (State or Country)

10. NAME OF FATHER H. Sailer

11. BIRTHPLACE OF FATHER Germany
 (State or Country)

12. MAIDEN NAME OF MOTHER Nelson Miller

13. BIRTHPLACE OF MOTHER Ill
 (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) D. A. Sailer
 (Address) _____

15. Filed July 25 1922 Pearl D. Wade
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 5 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY That I attended deceased from July 5 1922 to July 5 1922
 that I last saw him alive on last September 1921
 and that death occurred on the date stated above, at 12 noon
 The CAUSE OF DEATH* was as follows:

Suicide
gun shot #32 thru heart
 (Duration) _____ Yrs. in same day mos. _____ ds. _____

Contributory (Secondary) _____
 (Duration) _____ yrs. _____ mos. _____ ds. _____
 (Signed) Horace P. Belknap M. D.
7/6 1922 (Address) Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Ogden Utah DATE OF BURIAL 1922

20. UNDERTAKER J. K. Robinson ADDRESS Nampa

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 7
County of Canyon Primary Registration District No. 1006
City of Nampa (St.)

File No. 38997

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

William Thomas Patterson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDMale white Married
(Write the word.)

6. DATE OF BIRTH

May 4 1885
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day
how many..... hrs.
or..... min.?67 Yrs. 1 Mos. 15 ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Farmer

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

Wm. Patterson

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Mc Cormick

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Earl M. Patterson(Address) Nampa Ida R 7

15.

Filed Aug. 10 1922Earl M. Patterson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 19 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 19, 1922 to June 19, 1922
that I last saw him alive on June 19, 1922and that death occurred on the date stated above, at 3:30 M.

The CAUSE OF DEATH* was as follows:

Heart Failure - instant

(Duration) Yrs. mos. ds.

Contributory
(Secondary)Heart failure (Duration) Yrs. 4 mos. ds.

(Signed)

J. R. Proctor M. D.

19

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Kohlman Cem6-22-22

20. UNDERTAKER

ADDRESS

Frank RobinsonNampa

RECEIVED

AUG 17 1922

CERTIFICATE OF DEATH

1. PLACE OF DEATH Bureau of Registration District No. 7
 County of Camp STATIS Primary Registration District No. 1886
 City of _____ (No. _____) St. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary C. Hammond

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 38998

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married

6. DATE OF BIRTH

unknown 1. _____
 (Month) (Day) (Year)

7. AGE

67 Yrs. _____ Mos. _____ ds. _____
 IF LESS than 1 day
 how many _____ hrs.
 or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Ill

10. NAME OF FATHER

Bridges

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Flahardy

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Charles M. Weaver

(Address)

Nampa, Ida.

15.

Filed Aug 18 1922

Pearl D. Dodd
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 4 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 4 1922 to Aug 4 1922
 that I last saw her alive on Aug 4 1922
 and that death occurred on the date stated above, at P.M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Geo R. Proctor M. D.

(Address) Nampa

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

K.L. Cemetery

Aug 7 1922

20. UNDERTAKER

ADDRESS

J.K. Robinson

Nampa

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **38999**

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of **Campa**City of **Nampa**

If death occurs away from usual residence, give facts called for under special information.

Registration District No. _____

Primary Registration District No. _____

(No. **1006** St.)

2. FULL NAME

Lakie Burch

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married

6. DATE OF BIRTH

Unknown

(Month) (Day) (Year)

7. AGE

25

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).**Housework**

9. BIRTHPLACE

(State or Country)

Unknown

10. NAME OF FATHER

C. H. Woody

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. J. E. Hyman

(Address)

#1 Caldwell

15.

Filed **Aug. 16, 1922**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

6 **30** **1922**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 23, 1922 to **6-30-1922**that I last saw her alive on **June 29, 1922**and that death occurred on the date stated above, at **2 P.** M.

The CAUSE OF DEATH* was as follows:

Septicemia & Septicemia

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) **Thos E. Magnus** M. D.**7-10-1922** (Address) **Nampa Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Kohkuluam Cem**July 1922**

20. UNDERTAKER

ADDRESS

F. K. Robinson**Nampa Idaho**

RECEIVED
AUG 12 1922
BUREAU

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Canyon
City of _____
Registration District No. 1254
(No. _____ St.)

File No. 39000

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Maria Turner

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married

6. DATE OF BIRTH April 22 1898
(Month) (Day) (Year)

7. AGE 64 Yrs. 2 Mos. 4 ds.
IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE Macksburg, Ohio
(State or Country)

10. NAME OF FATHER L. C. Waller

11. BIRTHPLACE OF FATHER Virginia
(State or Country)

12. MAIDEN NAME OF MOTHER Rebecca Cermickle

13. BIRTHPLACE OF MOTHER Ohio
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Bertha Roy (daughter)
(Address) Bozice, Idaho

15. Filled Aug 12 1922 P. A. Robinson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 26 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 26 1922, to June 26 1922, that I last saw her alive on June 26 1922, and that death occurred on the date stated above, at P. M.

The CAUSE OF DEATH* was as follows:

embolus to brain

(Duration) four hours Yrs. _____ Mos. _____ Ds. _____
Contributory (Secondary) Phlebitis of left leg
(Duration) _____ Yrs. _____ Mos. 10 Ds. _____
(Signed) Geo. R. Proctor M. D.
(Address) Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ Yrs. _____ Mos. _____ Days _____ In the State _____ Yrs. _____ Mos. _____ Days _____

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Kahului Cemetery DATE OF BURIAL 6-27-22

20. UNDERTAKER P. A. Robinson ADDRESS Idaho

FORM V. S. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39001**

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH **Canby**
County of **Camden** Registration District No. **7**
City of **Nampa** Primary Registration District No. **1556**
(No. _____) (St.) _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Chas. W. Lynde**

MEDICAL CERTIFICATE OF DEATH

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Married**6. DATE OF BIRTH **July 15 1856**
(Month) (Day) (Year)7. AGE **65** Yrs. **11** Mos. **14** ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. **Farmer**
(b) General nature of industry, business or establishment in which employed (or employer).9. BIRTHPLACE **Vermont**
(State or Country)10. NAME OF FATHER **W. H. Lynde**11. BIRTHPLACE OF FATHER **Va**
(State or Country)12. MAIDEN NAME OF MOTHER **Rebecca Walker**13. BIRTHPLACE OF MOTHER **Mass.**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Day Lynde**
(Address) **Nampa Ida**15. Filed **July 20 1922** **George D. Dicks**
Local Registrar16. DATE OF DEATH **July 9 1922**
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from **April 25 1921** to **July 1 1922**
that I last saw him alive on **July 1 1922**
and that death occurred on the date stated above, at **3 P.** M.

The CAUSE OF DEATH* was as follows:

Tuberculosis, Diabetes
(Duration) **4** Yrs. **20** mos. **20** ds.
Contributory **Diabetes & Chronic Nephritis**
(Secondary) **High Blood Pressure 240**
(Duration) **10** yrs. **+** mos. **+** ds.
(Signed) **Horace P. Behrman** M. D.
7/6/22 (Address) **Nampa Ida**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL **Kohlman** DATE OF BURIAL **7-3 1922**20. UNDERTAKER **F. K. Robinson** ADDRESS **Nampa Ida**

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH **REC'D** Registration District No. **7**
County of **Canyon** Primary Registration District No. **1006**
City of **Naupaka** (No. **Naupaka** Hospital St.)
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME **Edna Lillian Watt**

File No. **39002**
Registered No. **1508**
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED
(Write the word.)

16. DATE OF DEATH

6. DATE OF BIRTH **July 24 1922**
(Month) (Day) (Year)

July 28 1922
(Month) (Day) (Year)

7. AGE **4** yrs. **4** mos. **4** ds. IF LESS than 1 day how many hrs. or min.?

17. I HEREBY CERTIFY, That I attended deceased from **July 24 1922** to **July 28 1922**
that I last saw her alive on **July 27 1922**
and that death occurred on the date stated above, at **M.**

8. OCCUPATION

The CAUSE OF DEATH* was as follows:
Patulous foramen ovale

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

(Duration) Yrs. mos. **4** ds.

9. BIRTHPLACE

Contributory (Secondary)

(State or Country) **Idaho**

10. NAME OF FATHER **W W Watt**

(Duration) Yrs. mos. ds.

11. BIRTHPLACE OF FATHER **Nebo**

(Signed) **Geo. R. Proctor** M. D.

(State or Country)

12. MAIDEN NAME OF MOTHER **Ada R. Elmore**

(Address) **July 28 1922**

13. BIRTHPLACE OF MOTHER **Iowa**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

(Informant) **W W Watt**

At place of death yrs. mos. days. In the State yrs. mos. days.

(Address) **Naupaka Ida**

Where was disease contracted if not at place of death?

15. Filed **Aug 3 1922** **Pearle Dadds** Local Registrar

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **Star Ida**

DATE OF BURIAL **7-28 1922**

20. UNDERTAKER **None**

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Blaine Registration District No. 2066

City of Nampa St.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Les W Williams

File No. 39003
Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widowed
(Write the word.)

6. DATE OF BIRTH

Jan 11 1888
(Month) (Day) (Year)

7. AGE

64 Yrs. 6 Mos. 16 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Farmer

9. BIRTHPLACE

(State or Country)

Indiana

10. NAME OF FATHER

Tom Williams

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Miss Elmer Rightfoot

(Address)

Nampa, Ida

15.

Filed Aug. 18 1922

Pearl Dadds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July, 27 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 19 1922, to July 27 1922,
that I last saw him alive on July 27 1922,
and that death occurred on the date stated above, at 8 P. M.
The CAUSE OF DEATH* was as follows:

Result of a burn (accidental)

(Duration) Yrs. mos. ds.
Contributory (Secondary) Pl. had very low mental condition to previous fire and explosion.
(Duration) Yrs. mos. ds.

(Signed) Thos. E. Mangum M. D.

7 1922 (Address) Nampa, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Nampa, Ida

DATE OF BURIAL

7/28 1922

20. UNDERTAKER

FK Robinson

ADDRESS

Nampa, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B. - Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE in terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of form.

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

Supplement of No. 38758.
CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County: **Blaine** Registration District No. **22**
City: **Boise** Primary Registration District No. **2152**
(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Mike Bojovich**

File No. **39004**
Registered No. **10**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **M** 4. COLOR OR RACE **W** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Single**

(Write the word.)

6. DATE OF BIRTH

Feb. 10, 1878
(Month) (Day) (Year)

7. AGE

44 Yrs. **5** Mos. **5** ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. **Miner**
(b) General nature of industry, business, or establishment in which employed (or employer).

9. BIRTHPLACE

(State of Country) **Austria**

10. NAME OF FATHER

Joseph Bojovich

11. BIRTHPLACE OF FATHER

(State of Country) **Austria**

12. MAIDEN NAME OF MOTHER

Marie Farlan

13. BIRTHPLACE OF MOTHER

(State of Country) **Austria**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) **Edis Karsney**
(Address) **Boise Springs, Idaho**

15. **July 15, 1922**

Filed **191**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 15, 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **July 14, 1922** to **July 15, 1922**
that I last saw **him** alive on **July 15, 1922**
and that death occurred on the date stated above, **11** M.

The CAUSE OF DEATH* was as follows:

Operatin for Ulcer of Stomach

(Duration) Yrs. mos. ds.

Contributing Cause (Secondary) **chronic ulcer of stomach**

(Duration) **14** yrs. mos. ds.

(Signed) **Edis Karsney** M. D.

7/15/22 (Address) **Boise Springs, Idaho**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs mos days In the State yrs mos days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Boise Springs, Idaho

St. Luke's Hall

Pchunski & Hall

Boise

Boise

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39005**Registered No. **9**

1. PLACE OF DEATH **RECEIVED SEP 1 1922**
 County of **San Juan** Registration District No. **82**
 City of **Santa Fe** Secondary Registration District No. **2159**
 (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Joseph Stanley Grave

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

M**W****B**

(Write the word.)

6. DATE OF BIRTH.

April 18**1922**

(Month)

(Day)

(Year)

7. AGE

Yrs. **3** Mos. **25** ds.

If LESS than 1 day
how many.....hrs. or
.....min.]

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Lova Hot Springs Idaho

10. NAME OF FATHER

Joseph E. Grave

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Ernest D. Godfrey

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Lova Hot Springs Idaho

15.

Filed

Aug 12**1922****Ernest D. Godfrey**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug**12****1922**

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 30**1922****to Aug 12****1922**

that I last saw him alive on

Aug 11**1922**and that death occurred on the date stated above, at **8 P.** M.

The CAUSE OF DEATH* was as follows:

Empysemata

(Duration)

Yrs.

mos. **14**

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

Ernest D. Godfrey

M. D.

(Address)

Lova Hot Springs Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death.....yrs.....mos.....days

In the

State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lova Hot Springs**Aug 13 1922**

20. UNDERTAKER

Ed Whelan

ADDRESS

Santa Fe

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH

County of *Caribou*

City of _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Edith Davis

CERTIFICATE OF DEATH.

District No. *82*Registration District No. *2159*

St.) _____

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *39006*Registered No. *8*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.*Female**White**Single*

(Write the word.)

6. DATE OF BIRTH.

*Nov.**20**1921*

(Month)

(Day)

(Year)

7. AGE

*8**22*

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work...(b) General nature of in-
dustry, business, or estab-
lishment in which employ-
ed (or employer).....*name*

9. BIRTHPLACE

(State or Country)

*Idaho*10. NAME OF
FATHER*Jenkins Davis*11. BIRTHPLACE
OF FATHER

(State or Country)

*Idaho*12. MAIDEN NAME
OF MOTHER*Annie Woodland*13. BIRTHPLACE
OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Joyce Davis

(Address)

Side Spring, etc

15.

Filed

*Aug. 31*191*2**Edw. Kacey*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

*August 12,**1922*

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from
Dead when I saw her to *191*that I last saw h..... alive on *191*and that death occurred on the date stated above, at *M.*

The CAUSE OF DEATH* was as follows:

Drowning

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)*name*

(Duration)

yrs.

mos.

ds.

(Signed)

*Russell Ziegler M. D.*8/12 1922 (Address) *Side Spring, Idaho**State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place

In the

of death.....yrs.....mos.....days State.....yrs.....mos.....days

Where was disease contracted
if not at place of death?.....

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Side Spring, etc**Aug. 16, 1912*

20. UNDERTAKER

ADDRESS

name

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

Cooper.

State of Idaho
BOARD OF HEALTH

Bureau of Vital Statistics

File No. 39007

Registered No. 608

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Cassia Registration District No. RE
City of Burley Primary Registration District No. AUG
(No. 100 St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hellie Alberta Parke

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single

6. DATE OF BIRTH. April 1st 1922
(Month) (Day) (Year)

7. AGE 12 Yrs. 3 Mos. 8 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION In School
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE Albion Ida.
(State or Country)

10. NAME OF FATHER Arson Parke

11. BIRTHPLACE OF FATHER Centerville Utah
(State or Country)

12. MAIDEN NAME OF MOTHER Alberta Julia Harris

13. BIRTHPLACE OF MOTHER Connor Creek Ida.
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Arson Parke
(Address) Decla. Ida.

15. Filed July 9 1922 Dr. J. C. Patterson
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 8 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1 1922 to July 8 1922
that I last saw her alive on July 7 1922
and that death occurred on the date stated above, at 3:50 P.M.

The CAUSE OF DEATH* was as follows:
Cardiac Paralysis

(Duration) Yrs. 1 mos. 1 ds.
Contributory (Secondary) Dysphthoria

(Duration) Yrs. 4 mos. 4 ds.
(Signed) Ed. J. Cooper M. D.
.....19.... (Address) Burley Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of deathyrs.mos.days, State.....yrs.mos.days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Decla. Ida. DATE OF BURIAL July 10 1922

20. UNDERTAKER None ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M, 6-15-17.

CERTIFICATE OF DEATH

39008

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.
Registered No. 607
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of CassiaRegistration District No. 117City of BurleyPrimary Registration District No. 2196

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Albert Posey

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH.

Nov.

(Month)

(Day)

(Year)

7. AGE

12

Yrs.

Mos.

ds.

IF LESS than 1 day
how many hrs. or
..... min.?"

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

In School.

9. BIRTHPLACE

(State or Country)

Oakley Ida.

10. NAME OF FATHER

A. W. Posey.

11. BIRTHPLACE OF FATHER

(State or Country)

Waco Texas

12. MAIDEN NAME OF MOTHER

Mary Annie Sayley.

13. BIRTHPLACE OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

L. E. Posey.

(Address)

R. F. D. # 2 Burley Ida.

15.

Filed

Aug. 11th 1922Dr. J. C. Patterson
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July

(Month)

12

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 10 1922 to July 12 1922
that I last saw him alive on July 12 1922

and that death occurred on the date stated above, at 9 a. M.

The CAUSE OF DEATH* was as follows:

Meningitis following fracture of skull

(Duration) Yrs. mos. 3 ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) J. C. Patterson M. D.

7-13-1922 (Address) Burley, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days, In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Little Basin Ida.

DATE OF BURIAL

July 13 1922

20. UNDERTAKER

L. B. Gallagher.

ADDRESS

Burley Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17

RECORDED

CERTIFICATE OF DEATH

39009

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.
Registered No. 606
If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

1. PLACE OF DEATH

County of Cassia

Registration District No. 117

City of Burley

Primary Registration District No. 2196

(No. St.)

If death occurs away from
usual residence, give facts
called for under special
information.

2. FULL NAME

Robert A. Gibson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

Married

(Write the word.)

6. DATE OF BIRTH.

May 25 1897
(Month) (Day) (Year)

7. AGE

26 Yrs. 2 Mos. 3 ds.

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of in-
dustry, business, or estab-
lishment in which em-
ployed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Nebraska

10. NAME OF
FATHER

William A. Gibson

11. BIRTHPLACE
OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME
OF MOTHER

Bertha Bray

13. BIRTHPLACE
OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wm. A. Gibson

(Address)

Albion, Idaho

15.

Filed

Aug. 11 1922

H. J. Patterson

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 28 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 20 1922 to July 25 1922
that I last saw him alive on July 25 1922

and that death occurred on the date stated above, at 9 a. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) Yrs. mos. 8 ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) J. C. Patterson M. D.

7-29-22 (Address) Burley, Idaho

*State the Disease Causing Death; or in deaths from Violent
Causes, state (1) Means of Injury; and (2) whether Accidental,
Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Albion Idaho

DATE OF BURIAL

July 29 1922

20. UNDERTAKER

L. B. Galloway

ADDRESS

Burley Idaho

CERTIFICATE OF DEATH

39010

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No.
Registered No. 605
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Cassia
City of Burley
If death occurs away from usual residence, give facts called for under special information.
Registration District No. 117
Primary Registration District No. 2196
(No. St.)

2. FULL NAME Joan Judd Smith

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married (Write the word.)

6. DATE OF BIRTH May 17 1878
(Month) (Day) (Year)

7. AGE 47 Yrs. 2 Mos. 11 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE Utah
(State or Country)

10. NAME OF FATHER William Riley Judd

11. BIRTHPLACE OF FATHER Canada
(State or Country)

12. MAIDEN NAME OF MOTHER Ann Reid

13. BIRTHPLACE OF MOTHER England
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. H. Smith

(Address) Burley, Ida.

15. Filed Aug. 11 1922
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 28 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 22 1922 to July 28 1922
that I last saw her alive on July 28 1922
and that death occurred on the date stated above, at 2 A. M.

The CAUSE OF DEATH* was as follows:
Obstruction of bowels, due to adhesive operation for same
(Duration) Yrs. mos. 6 ds.

Contributory (Secondary)
(Duration) Yrs. mos. ds.
(Signed) J. C. Patterson M. D.
7-29-22 (Address) Burley, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days, State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Burley, Ida.
DATE OF BURIAL July 30-1922

20. UNDERTAKER L. B. Galloway
ADDRESS Burley, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39011**Registered No. **604**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of *Idaho*
City of *Burley*Registration District No. *117*Primary Registration District No. *2196*

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

David A. Harding

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.*M* *White* *Married*

6. DATE OF BIRTH

Aug *18* *1868*
(Month) (Day) (Year)

7. AGE

53 Yrs. *11* Mos. *6* ds.IF LESS than 1 day
how many hrs. or
..... min. 2

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....*Farmer*

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Alma Harding

11. BIRTHPLACE OF FATHER

(State or Country)

don't know

12. MAIDEN NAME OF MOTHER

Margaret Jones

13. BIRTHPLACE OF MOTHER

(State or Country)

Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. D. A. Harding
Burley, Idaho

(Address)

15.

Filed

Aug. 7 *1912* *Dr. J. C. Patterson*
Local Registrar

16. DATE OF DEATH

July *24* *1912*
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
Dec. 20 *1912*, to *July 24* *1912*.that I last saw him alive on *July 1* *1912*,
and that death occurred on the date stated above, at *11 A.M.*

The CAUSE OF DEATH* was as follows:

*Tuberculosis of lungs
and bone (iliacum)*(Duration) *several* Yrs. mos. ds.Contributory
(Secondary)(Duration) *yes* Yrs. mos. ds.(Signed) *J. C. Patterson* M. D.*7-26-1912* (Address) *Burley, Idaho*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Reposers Hill Cemetery**7/27* *1912*

20. UNDERTAKER

ADDRESS

*R. N. Matt**Burley, Idaho*

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. **39012**
 Registered No. **603**

1. PLACE OF DEATH. Registration District No. **117**
 County of **Cassia** Primary Registration District No. **2196**
 City of **Almo** (No. _____ St.)
 If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME **Isabelle Perrod**

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX **F** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Married**

16. DATE OF DEATH

6. DATE OF BIRTH.

7. AGE

IF LESS than 1 day how many _____ hrs. or _____ min. 2

17. I HEREBY CERTIFY, That I attended deceased from **May 1, 1922** to **July 20, 1922**

that I last saw her alive on **July 14, 1922** and that death occurred on the date stated above, at **5 P. M.**

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(Duration) **several** Yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) **J. C. Patterson M. D.**

7-22-1922 (Address) **Burley, Ida**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. _____ yrs. _____ mos. _____ days. In the State. _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Deeds Cemetery **July 22, 1922**

20. UNDERTAKER

R. W. Waid **Burley Ida**

15. Filed **Aug. 7, 1922** **Dr. J. C. Patterson**
 Local Registrar

CERTIFICATE OF DEATH

39013

State of Idaho
BOARD OF HEALTH

Bureau of Vital Statistics

File No. 607

Registered No. 607
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Cassia

Registration District No. 117

Primary Registration District No. 2192

City of Burley

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Thomas Allen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single (Write the word.)

6. DATE OF BIRTH.

Aug. 14 1877.
(Month) (Day) (Year)

7. AGE

44 Yrs. 11 Mos. 5 ds.

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Laborer

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Elijah M. Allen

11. BIRTHPLACE OF FATHER

(State or Country)

California

12. MAIDEN NAME OF MOTHER

Mary E. Graham

13. BIRTHPLACE OF MOTHER

(State or Country)

California

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

John F. Allen
Burley, Ida. R.D.#2

15.

Filed

7-18-22

191

Dr. J. C. Patterson

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 18 1922.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 12 1922 to July 18 1922
that I last saw him alive on July 18 1922
and that death occurred on the date stated above, at 8 a. M.

The CAUSE OF DEATH* was as follows:

Ulcer of stomach

(Duration) 2 wks. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

7-18-22

(Address)

J. C. Patterson M. D.
Burley, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death yrs. mos. days, State yrs. mos. days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Ogden Utah

20. UNDERTAKER

L. B. Galloway

DATE OF BURIAL

July 20 1922

ADDRESS

Burley Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 117
County of Cassia Primary Registration District No. 2196
City of Burley (No. _____ St.)

File No. 39014
Registered No. 598

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Reba Parker Long

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

F

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married (Write the word.)

6. DATE OF BIRTH.

March 17 1896
(Month) (Day) (Year)

7. AGE

26 Yrs. 3 Mos. 17 ds.

IF LESS than 1 day
how many hrs. or
..... min. 2)

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

Stenographer

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

L. Parker

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Mary Ann Farlow

13. BIRTHPLACE OF MOTHER

(State or Country)

Mich

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

L. Parker
(Address) American Fork, Utah

15.

Filed 7-6-22 1912 H. J. C. Patterson
Local Registrar

16. DATE OF DEATH

7 4 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6-26-1922 to 7-5-1922

that I last saw her alive on 7-4-1922 and that death occurred on the date stated above, at 2:30 a.m.

The CAUSE OF DEATH was as follows:

Acute Pulmonary embolism

(Duration) Yrs. mos. ds.
Contributory (Secondary) Sanguineous appendix

(Signed) Joseph Freinstadt M. D.
19..... (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

American Fork Utah July 8, 1922

20. UNDERTAKER

ADDRESS

N. N. Nare Burley, Id.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

1. PLACE OF DEATH

Registration District No. 90
 County of Clearwater Primary Registration District No. 2168
 City of Orlando St.)

If death occurs away from
 usual residence, give facts
 called for under special
 information.

2. FULL NAME

Ellie White

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 39015Registered No. 36

If death occurred in a hos-
 pital, institution or camp,
 give its NAME instead of
 street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

Single
 (Write the word.)

6. DATE OF BIRTH.

Sept 2 1902
 (Month) (Day) (Year)

7. AGE

19 Yrs. Mos. ds.
 IF LESS than 1 day
 how many hrs. or
 min.?

8. OCCUPATION

(a) Trade, profession or
 particular kind of work...
 (b) General nature of in-
 dustry, business, or estab-
 lishment in which employ-
 ed (or employer)...

none

9. BIRTHPLACE

(State or Country)

Virginia

10. NAME OF
FATHER

Frank White

11. BIRTHPLACE
OF FATHER

(State or Country)

Virginia

12. MAIDEN NAME
OF MOTHER

Greta White

13. BIRTHPLACE
OF MOTHER

(State or Country)

Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Frank White

(Address)

Orlando Fla

15.

Filed July 31 1922

J. M. Kiley
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 7 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1916 to 1922
 that I last saw her alive on July 1 1922
 and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 6 Yrs. mos. ds.

Contributory
 (Secondary)

(Duration) 1 Yrs. mos. ds.

(Signed) E. H. Morswell M. D.

8/5 1922 (Address) Orlando Fla.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
 MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death....yrs....mos....days In the State....yrs....mos....days

Where was disease contracted
 if not at place of death?

Former or
 usual residence

19. PLACE OF BURIAL OR REMOVAL

Florida

DATE OF BURIAL

7/11 1922

20. UNDERTAKER

V. A. Shaw

ADDRESS

Orlando

CERTIFICATE OF DEATH.

1. PLACE OF DEATH.

County of Clearwater Registration District No. 90
 City of Orlando Primary Registration District No. 2168
 (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Andrew Stitzel

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 39016
 Registered No. 35

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male White Single
 (Write the word.)

6. DATE OF BIRTH.

Nov 18 1857
 (Month) (Day) (Year)

7. AGE

65 Yrs. Mos. ds.

IF LESS than 1 day
 how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business, or establishment in which employed (or employer).

Labor

9. BIRTHPLACE

(State or Country)

Austria

10. NAME OF FATHER

Andrew Stitzel

11. BIRTHPLACE OF FATHER

(State or Country)

Austria

12. MAIDEN NAME OF MOTHER

Mary Creaser

13. BIRTHPLACE OF MOTHER

(State or Country)

Austria

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Math Stitzel

(Address)

Pierce Ida

15.

Filed

July 31 1922

J. M. Daily
 Local Registrar

16. DATE OF DEATH

July 3 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 28 1922 to July 3 1922, that I last saw him alive on July 3 1922 and that death occurred on the date stated above, at 2:30 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) Yrs. mos. 6 ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed)

July 3 1922 (Address) Orlando Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Orlando Ida

July 5 1922

20. UNDERTAKER

ADDRESS

W. A. Shaw

Orlando

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39017**Registered No. **34**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of ClearwaterCity of Orfino

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 90Sundry Registration District No. 2168

(No. _____ St.)

2. FULL NAME

Matilda Rowley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

About

(Month)

(Day)

852

(Year)

7. AGE

About 70

Yrs.

Mos.

ds.

IF LESS than 1 day

how many _____ hrs.

or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Laborer's Wife

(b) General nature of industry, business or establishment in which employed (or employer)

Housework

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown.

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. W. McHenry
Orfino, Idaho

15.

Filed

Aug 1, 1922J. W. McHenry
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 26th

(Month)

(Day)

1922
(Year)17. I HEREBY CERTIFY, That I attended deceased from February 22, 1922 to July 26th, 1922 that I last saw her alive on July 26th, 1922 and that death occurred on the date stated above, at 3:30 P.M.

The CAUSE OF DEATH* was as follows:

Epilepsy

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

July 26, 1922

(Address)

Orfino, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 12 yrs. 5 mos. 5 days. In the State 40 yrs. ✓ mos. ✓ days

Where was disease contracted if not at place of death?

Unknown

Former or usual residence

Kootenai County, old Mission

19. PLACE OF BURIAL OR REMOVAL

City

DATE OF BURIAL

July 28, 1922

20. UNDERTAKER

Wayne Johnson

ADDRESS

Orfino, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12 1/2 M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39018**
Registered No. **32**

1. PLACE OF DEATH. Registration District No. **90**
County of **Clearwater** Primary Registration District No. **2168**
City of **Prosser** (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Margaret E. Morris

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Single**
(Write the word.)

6. DATE OF BIRTH **7** **3** **1881**
(Month) (Day) (Year)

7. AGE **about 41** yrs. mos. ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. **None**
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) **Washington**

10. NAME OF FATHER **?**

11. BIRTHPLACE OF FATHER **?**
(State or Country)

12. MAIDEN NAME OF MOTHER **?**

13. BIRTHPLACE OF MOTHER **?**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) **J. W. Hetherington**
(Address) **Prosser, Idaho**

15. Filed **Aug 1 1922** **J. W. Hetherington**
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH **July 1 1922**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **June 16 1920** to **July 1 1922**
that I last saw her alive on **July 1 1922**
and that death occurred on the date stated above, at **3 P. M.**
The CAUSE OF DEATH* was as follows:
Senility

(Duration) yrs. **2** mos. ds.
Contributory (Secondary) **Senility**
(Duration) yrs. **?** mos. ds.
(Signed) **John E. Screen** M. D.
July 1 1922 (Address) **Prosser, Idaho**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death **2** yrs. **15** mos. **15** ds. State. yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Hendrick, Idaho **July 3 1922**
20. UNDERTAKER ADDRESS
B. B. Bobo **Prosser, Id**

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39019**
Registered No. **32**

1. PLACE OF DEATH. **Clearwater, Oregon**
County of **Clearwater** Registration District No. **90**
City of **Orfino** (No. **2168** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Geo W M Osbire**

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH **3** **3** **1837**
(Month) (Day) (Year)

7. AGE **about 85** yrs. mos. ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work **None**
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) **America**

10. NAME OF FATHER **3**

11. BIRTHPLACE OF FATHER (State or Country) **3**

12. MAIDEN NAME OF MOTHER **3**

13. BIRTHPLACE OF MOTHER (State or Country) **3**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) **J W Atterbury**
(Address) **Orfino, Idaho**

15. Filed **July 31 1922** **J M. Finley**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **July 4 1922**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **June 21 1922** to **July 24 1922**
that I last saw him alive on **July 24 1922**
and that death occurred on the date stated above, at **9:30** M.

The CAUSE OF DEATH* was as follows:
Arterio Sclerosis

(Duration) yrs. mos. ds.
Contributory (Secondary) **Insanity**
(Duration) yrs. mos. ds.
(Signed) **John W. Osbire M. D.**
7/5 1922 (Address) **Orfino, Ida**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the **3** **3**
of death yrs. mos. **13** ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or usual residence **Lewis, County,**

19. PLACE OF BURIAL OR REMOVAL **Hamilah** DATE OF BURIAL **7/7 1922**

20. UNDERTAKER **A. A. Shaw** ADDRESS **Orfino Ida**

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V, S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39020**
Registered No. **30**

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH. **AUG Registration District No. 90**
County of **Clearwater** Primary Registration District No. **2168**
City of **Orfino** (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Care Hedlund**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Single**
(Write the word.)

6. DATE OF BIRTH **Aug 11 1890**
(Month) (Day) (Year)

7. AGE **31** yrs. **11** mos. **2** ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION **Laborer**
(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE **Sweden**
(State or Country)

10. NAME OF FATHER **Andrew Hedlund**

11. BIRTHPLACE OF FATHER **?**
(State or Country)

12. MAIDEN NAME OF MOTHER **?**

13. BIRTHPLACE OF MOTHER **?**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) **J. W. G. G. G. G.**
(Address) **Orfino, Idaho**

15. Filed **Aug 1 1922** **J. M. G. G.**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **July 13 1922**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **April 9 1921**, to **July 13 1922** that I last saw him alive on **July 13 1922** and that death occurred on the date stated above, at **1 P. M.** The CAUSE OF DEATH* was as follows:
Epilepsy

(Duration) yrs. mos. ds.
Contributory (Secondary)

(Duration) yrs. mos. ds.
(Signed) **John W. G. G. G. M. D.**
7/13 1922 (Address) **Orfino, Idaho**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the **1 3 3**
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or usual residence. **Orfino, Idaho**

19. PLACE OF BURIAL OR REMOVAL **Palouse, Id.** DATE OF BURIAL **July 16 1922**

20. UNDERTAKER **E. E. Bolo** ADDRESS **Orfino, Idaho**

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

1. PLACE OF DEATH.

County of Clematis Registration District No. 90
 City of Limore Registration District No. 2168 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Geo. W. Gilmore

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. **39021**Registered No. 30

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WID-
 | | OWED OR DIVORCED.

male | white | married

6. DATE OF BIRTH.

Feb 22 1883
 (Month) (Day) (Year)

7. AGE

66 Yrs. 4 Mos. ds.

IF LESS than 1 day
 how many hrs. or
 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
 (b) General nature of industry, business, or establishment in which employed (or employer).....

farmer

9. BIRTHPLACE

(State or Country)

Randolph, W. Vir

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles H. Crumacker(Address) Limore, Ida.

15.

Filed

June 24 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 24 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 12 1922 to June 24 1922
 that I last saw him alive on June 12 1922

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis -
Chronic nephritis

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) E. W. Houslee M. D.

6/24 1922 (Address) Clefio, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Limore, Ida.6/26 1922

20. UNDERTAKER

ADDRESS

W. A. ShawClefio

RECEIVED
AUG 17 1922
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39022**

Registered No. **295**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of *Clearwater* Registration District No. *90*
City of *Arctic* Registration District No. *2168* St.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Betha Ellen Webb

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

Female *white*

Single
(Write the word.)

6. DATE OF BIRTH.

Jan *12* *1913*
(Month) (Day) (Year)

7. AGE

9 Yrs. *6* Mos. *ds.*

IF LESS than 1 day
how many *hrs.* or
min.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

none

9. BIRTHPLACE

(State or Country)

Ida

10. NAME OF FATHER

Delbert Webb

11. BIRTHPLACE OF FATHER

(State or Country)

Cal

12. MAIDEN NAME OF MOTHER

Ala Webb

13. BIRTHPLACE OF MOTHER

(State or Country)

Oreg

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Del Webb

(Address)

Arctic

15.

Filed *June 31* *1922*

J. M. Gaily
Local Registrar

16. DATE OF DEATH

Jan *12* *1922*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *May 1* *1922* to *June 12* *1922*
that I last saw him alive on *June 11* *1922*
and that death occurred on the date stated above, at *11:30 PM*.

The CAUSE OF DEATH* was as follows:

Chronic Endo-Myocarditis

(Duration) Yrs. mos. ds.

Contributory (Secondary) *Rheumatic Fever*

(Duration) yrs. mos. ds.

(Signed) *E. M. Gaily* M. D.

6/19/22 (Address) *Arctic, Ida*

*State the DISEASE CAUSING DEATH; in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Arctic, Ida *Jan 12* *1922*

20. UNDERTAKER

ADDRESS

W. A. Shaw *Arctic*

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39023**

Registered No. **21**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Clearwater Registration District No. 90
City of Orfino Registration District No. 2168
St. Idaho

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

BUREAU OF VITAL STATISTICS

Fay Rose St. Claire

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH.

May 21 1922
(Month) (Day) (Year)

7. AGE

Yrs. 21 Mos. 1 ds.

IF LESS than 1 day
how many hrs. or min.

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

none

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Frank St. Claire

11. BIRTHPLACE OF FATHER

(State or Country)

Wyoming

12. MAIDEN NAME OF MOTHER

Pansy Reeves

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Frank St. Claire

(Address)

Orfino, Idaho

15.

Filed

June 22 1922 J. M. Bailey
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 11 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 11 1922, to June 11 1922
that I last saw him alive on June 11 1922
and that death occurred on the date stated above, at 4:22 M.

The CAUSE OF DEATH* was as follows:

Convulsions & active
indigestion

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) E. L. Mowbray M. D.

6/11/1922 (Address) Orfino, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Orfino, Idaho 6/12 1922

20. UNDERTAKER

ADDRESS

W. A. Shaw Orfino

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED
AUG 17 1922
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39026**Registered No. **25**

1. PLACE OF DEATH

County of **Elmore**
City of **Mont Home**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lillie Bennett Stein

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **F** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Married**
(Write the word.)

6. DATE OF BIRTH

August 7 1884
(Month) (Day) (Year)

7. AGE

37 Yrs. **11** Mos. **11** ds.
or LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).**Housewife**

9. BIRTHPLACE

(State or Country) **Idaho**

10. NAME OF FATHER

Richard Bennett

11. BIRTHPLACE OF FATHER

(State or Country) **England**

12. MAIDEN NAME OF MOTHER

Flora Anna Bennett

13. BIRTHPLACE OF MOTHER

(State or Country) **England**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address) **Mont Home Idaho**

15.

Filed **8-1-22** 19 **22**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 18 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from **May 10 1922** to **July 18 1922** that I last saw her alive on **July 18 1922** and that death occurred on the date stated above, at **3:45 P.M.**

The CAUSE OF DEATH was as follows:

Uterine hemorrhage - placenta praevia(Duration) Yrs. **8** mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

O. P. Hamilton M. D.**7-20-22** (Address) **Mont Home Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Mont Home Cemetery

DATE OF BURIAL

7/21 1922

20. UNDERTAKER

Wm McBratney

ADDRESS

Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD - Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 39027

Registered No. 17

1. PLACE OF DEATH

County of

City of

AUG 17 1922

Registration District No.

BUREAU OF VITAL STATISTICS

Primary Registration District No.

(No.)

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Roman Bideganeta

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

Spanish

5. SINGLE, MARRIED, WID-

OWED OR DIVORCED
Married
(Write the word.)

6. DATE OF BIRTH

Aug 15 1883
(Month) (Day) (Year)

7. AGE

39

78

Yrs. 10 Mos. 23 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Sheep Man.

9. BIRTHPLACE

(State or Country)

Spain.

10. NAME OF FATHER

Juan M. Bideganeta

11. BIRTHPLACE OF FATHER

(State or Country)

Spain

12. MAIDEN NAME OF MOTHER

Eugenia Grano.

13. BIRTHPLACE OF MOTHER

(State or Country)

Spain

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Agapito Bideganeta
Pachu, Pachu

(Address)

15.

Filed

8-1-1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 8th 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

9-10-1922 to 7-8-1922

that I last saw him alive on April 15 1922

and that death occurred on the date stated above, at 10:30 AM.

The CAUSE OF DEATH* was as follows:

Neuralgia of Heart

(Duration) Yrs. 4 mos. ds.

Contributory
(Secondary)

Intercostal Neuralgia

(Duration) yrs. mos. ds.

(Signed)

J. E. Grano M. D.

7-10-1922 (Address) Mtn Home, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Mountain Home, Ida.

DATE OF BURIAL

July 11, 1922

20. UNDERTAKER

Wm. D. Talley.

ADDRESS

Mtn Home, Ida.

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Elmore* District No. *34*
City of *Mountain Home* Primary Registration District No. *2020*
(No. *Mountain Home - Idaho*) Registered No. *39028*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Washington Kellogg

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M* 4. COLOR OR RACE *W.* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Widower*
(Write the word.)6. DATE OF BIRTH *1839*
August 27 - 1839
(Month) (Day) (Year)7. AGE *82* *10* —
Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)*Veteran of Civil War*

9. BIRTHPLACE

(State or Country)

New York

10. NAME OF FATHER

Don't Know

11. BIRTHPLACE OF FATHER

(State or Country)

"

12. MAIDEN NAME OF MOTHER

"

13. BIRTHPLACE OF MOTHER

(State or Country)

"

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. McBratney

(Address)

Baino Idaho

15.

Filed

*7-1-1922**J. E. Evans*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 27 - 1922
(Month) (Day) (Year)I HEREBY CERTIFY That I attended deceased from *June 19 1922* to *June 27 1922*
that I last saw him alive on *June 27 1922*

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia(Duration) Yrs. mos. *7* ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *O. J. Hamilton* M. D.*1922* (Address) *Mountain Home Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Mountain Home Cemetery

DATE OF BURIAL

7-29-1922

20. UNDERTAKER

W. McBratney

ADDRESS

Baino Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of *Blaine*
City of *Mountain Home*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Anna Marie Trampton

CERTIFICATE OF DEATH

RECEIVED
AUG 17 1922

Registration District No.

Primary Registration District No.

(No. *1109*)

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *39029*Registered No. *17*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F.

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married

(Write the word.)

6. DATE OF BIRTH

May 18, 1883
(Month) (Day) (Year)

7. AGE

39 Yrs. *1* Mos. *2* ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

House Wife

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

William Gistel

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Hofmeister

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Clark Trampton
(Address) *Mountain Home*

15.

Filed *7-1-1922**J. E. Egan*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 20, 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

5-1-1922 to *6-20-1922*that I last saw him alive on *6-1-1922*and that death occurred on the date stated above, at *12:30* M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver(Duration) Yrs. *8* mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. E. Egan M. D.*7-1-1922* (Address) *Mountain Home*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Mountain Home**6-22-1922*

20. UNDERTAKER

ADDRESS

*W. D. Talley**Mountain Home*

1. PLACE OF DEATH

County of Elmore Registration District No. 34
 City of Mountain Home Primary Registration District No. 2028 (St.)
RECEIVED
AUG 17 1922
BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Almeda Grace Edgar

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 39030
 Registered No. 15

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
 (Write the word.)

6. DATE OF BIRTH Nov 4 1909
 (Month) (Day) (Year)

7. AGE 12 Yrs. 6 Mos. 22 ds.
 IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. School Girl
 (b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE Pine Idaho
 (State or Country)

10. NAME OF FATHER R. T. Edgar

11. BIRTHPLACE OF FATHER Ill
 (State or Country)

12. MAIDEN NAME OF MOTHER Bessie Meeker

13. BIRTHPLACE OF MOTHER Kans.
 (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs R T Edgar
 (Address) Mtn Home Ida

15. Filed 8-1-1922 J E Evans
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 27 22
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5-12-1922 to 5-27-1922
 that I last saw her alive on 5-27-1922
 and that death occurred on the date stated above, at 12:30 M.

The CAUSE OF DEATH* was as follows:

Endocarditis

(Duration) Yrs. mos. ds.
 Contributory (Secondary) Acute Arterial Phlebitis

(Duration) yrs. mos. ds.

(Signed) J. E. Evans M. D.

5-28-1922 (Address) Mtn Home

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Mtn. Home Ida DATE OF BURIAL May 28 1922

20. UNDERTAKER A W Conover ADDRESS Mtn Home

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39031**
Registered No. **14**

1. PLACE OF DEATH

County of **Elmore**
City of **Mountain View**
Registration District No. **2020**
St. **Idaho**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Cecelia Murphy Lee

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

F.**W.****married**
(Write the word.)

6. DATE OF BIRTH

Apr. 11 - 1924
(Month) (Day) (Year)

7. AGE

38 Yrs. **1** Mos. **22** ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).**Housewife**

9. BIRTHPLACE

(State or Country)

Mich.

10. NAME OF FATHER

Daniel D. Murphy

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Ellen Sullivan

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. McBratney

(Address)

Boise, Idaho

15.

Filed **6-5** 19**22**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 3 - 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 1922 to **June 1922**
that I last saw him alive on **June 1922**
and that death occurred on the date stated above, at **2:50 A.** M.

The CAUSE OF DEATH* was as follows:

Pericardial Anemia(Duration) **3** Yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) **Harold W. Stone** M. D.**6/3 1922** (Address) **Boise, Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mountain Home Cemetery**6/5 1922**

20. UNDERTAKER

ADDRESS

W. McBratney**Boise, Idaho**

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

OREGON STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

33032

1922-3-4
80
7542, 20

1 PLACE OF DEATH

County

State

State Registered No.

Local Registered No. 16

Township

or

Village

or

City

No.

St.

Ward

(If death occurred in a hospital or institution, give its name instead of street and number)

2 FULL NAME

(a) Residence. No.

St.

(Usual place of abode)

(If nonresident, give city or town and state)

Length of residence in city or town where death occurred yrs. 2 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If less than

1 day, hrs.

or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)14 Informant
(Address)

15 Filed 8-1

1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-25 1922

17 I HEREBY CERTIFY, That I attended deceased from

, 19, to, 19, that I last

saw h. alive on, 19, and that death

occurred on the date stated above, at m.

The CAUSE OF DEATH* was as follows: Accidental.

Hit by train on bridge
and knocked into river

(duration) yrs., mos., days.

CONTRIBUTORY

(Secondary)

(duration) yrs., mos., days.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? Date of.

Was there an autopsy?

What test confirmed diagnosis?

6/29/22 (Signed) E. L. Gale M. D.

19 (Address) in care of

* State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

RECEIVED

AUG 17 1922

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Twin FallsCity of HansenRegistration District No. 36

Primary Registration District No. _____

(No. _____)

St. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henry Hemer

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 39033Registered No. 10

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male

White

Single

(Write the word.)

6. DATE OF BIRTH

Dec 6

889

(Month)

(Day)

(Year)

7. AGE

32

Yrs.

4

Mos.

25

ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry, business or establishment in which employed (or employer)

Owner.

9. BIRTHPLACE

(State or Country)

Germany.

10. NAME OF FATHER

D A Hemer

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Margeete Schrod.

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

D A Hemer

(Address)

Hansen, Ida.

15.

Filed

July 17

19 22

J. M. Davis

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 1 '22

(Month)

(Day)

19

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 1 19²² to July 1 19²²
that I last saw h. alive on not seen alone
and that death occurred on the date stated above, at about 7 P. M.

The CAUSE OF DEATH* was as follows:

Electrocuted
accidental

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

Address

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hoxie Kas.

19

20. UNDERTAKER

ADDRESS

R. J. Grassman & Co
Twin Falls, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

RECEIVED

SEP 7 1922

CERTIFICATE OF DEATH

1. PLACE OF DEATH.

Registration District No. 35

County of Elmore

Primary Registration District No. 2021

City of Bliss Ferry

(No.

St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Chris Royal Gardling

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

Male White

Single
(Write the word.)

6. DATE OF BIRTH

May 7 1908
(Month) (Day) (Year)

7. AGE

14 yrs. 2 mos. 20 ds.

IF LESS than 1 day
how many.....hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of industry
business or establishment in
which employed (or employer)

at Home

9. BIRTHPLACE

(State or Country)

Salt Lake City, Utah

10. NAME OF
FATHER

Chris Gardling

11. BIRTHPLACE
OF FATHER

(State or Country)

Denmark

12. MAIDEN NAME
OF MOTHER

Nellie Kathryn Young

13. BIRTHPLACE
OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Chris Gardling

(Address)

Bliss Ferry, Idaho

15.

Filed

July 29 1922

J. W. Davis

Local Registrar

MEDICAL CERTIFICATE OF DEATH

169

16. DATE OF DEATH

July 27 1922
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from

July 27 1922 to July 27 1922
that I last saw h. alive on 191

and that death occurred on the date stated above, at about 4 P. M.

The CAUSE OF DEATH* was as follows:

Drowned in Snake river while
Swimming.

(Duration).....yrs.....mos.....ds.

Contributory
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) J. W. Davis M. D.

July 28 1922 (Address) Bliss Ferry Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

15. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bliss Ferry Idaho July 30 1922

20. UNDERTAKER

ADDRESS

J. W. Davis Bliss Ferry

Form V. S. No. 5. 10M. 6-20-11.

RECEIVED CERTIFICATE OF DEATH ✓

1. PLACE OF DEATH.

Registration District No. 36

County of

Elmore

Primary Registration District No. 2021

City of

Glenn Ferry

(State)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Joseph D. Shaw.

Registered No.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Jan

21st1878
(Month) (Day) (Year)

7. AGE

44 yrs. 6 mos. 1 ds.

IF LESS than 1 day
how many.....hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Stationary Engineer

9. BIRTHPLACE

(State or Country)

Wyoming

10. NAME OF FATHER

Joseph Shaw

11. BIRTHPLACE OF FATHER

(State or Country)

Eng.

12. MAIDEN NAME OF MOTHER

Anna Combs

13. BIRTHPLACE OF MOTHER

(State or Country)

Eng.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

James H. Shaw
Shamrock Okla

(Address)

15.

Filed Aug 25 1922

J. W. Shaw
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug

22

1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug. 22 1922, to Aug. 22nd 1922that I last saw him alive on Aug. 22nd 1922, and that death occurred on the date stated above, at 11⁰⁰ A.M.

The CAUSE OF DEATH* was as follows:

Crushing R.R. Injury

(Duration).....yrs.....mos.....ds.

Contributory
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) J. W. Davis M. D.

Aug 22 1922 (Address) Glenn's Ferry, Okla.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted.

If not at place of death?
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Pocatello Ida

Aug 27 1922

20. UNDERTAKER

ADDRESS

J. W. Dickson

Glenn Ferry

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39038**
Registered No. _____

1. PLACE OF DEATH
County of Emmett Registration District No. _____
City of Emmett Primary Registration District No. _____
St. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Charlie Maxwell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH June 12 1898
(Month) (Day) (Year)

7. AGE 32 Yrs. 1 Mos. 8 ds. IF LESS than 1 day how many.....hrs. or.....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Carpenter
(b) General nature of industry, business or establishment in which employed (or employer). Same

9. BIRTHPLACE Illinois
(State or Country)

10. NAME OF FATHER Luther Maxwell

11. BIRTHPLACE OF FATHER Illinois
(State or Country)

12. MAIDEN NAME OF MOTHER Do not know

13. BIRTHPLACE OF MOTHER Illinois
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Emmie M. Maxwell
(Address) Emmett, Idaho

15. Filed 7/11 1922 J. H. Reynolds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 9 22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 5, 1922 to July 9, 1922
that I last saw him alive on July 9, 1922
and that death occurred on the date stated above, at 8:30 a.m.

The CAUSE OF DEATH* was as follows:
Peritonitis due to gangrenous appendix
(Duration)Yrs.....mos.....ds.

Contributory (Secondary)
(Duration)yrs.....mos.....ds.
(Signed) R. J. Cunningham M. D.
7/11 1922 (Address) Emmett

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of deathyrs.....mos.....days. In the Stateyrs.....mos.....days

Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Emmett Idaho DATE OF BURIAL 7/11 1922

20. UNDERTAKER W. D. Bucknum ADDRESS Emmett Idaho

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33039

Registered No.

1. PLACE OF DEATH

County of *Gem* Registration District No. *1*
City of *Emmett* Registration District No. *1*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Walter Joshua Easton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

married

(Write the word.)

6. DATE OF BIRTH

Sept 28 1859
(Month) (Day) (Year)

7. AGE

62 Yrs. *9* Mos. *17* ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

Jeweler

9. BIRTHPLACE

(State or Country)

Wisconsin

10. NAME OF FATHER

Joshua Easton

11. BIRTHPLACE OF FATHER

(State or Country)

Mass.

12. MAIDEN NAME OF MOTHER

Mary Chaney

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. J. Easton

(Address)

Emmett Idaho

15.

Filed *July 16* 19 *22**J. D. Reynolds*
Local Registrar

NEW YORK CO. PRINTERS & BINDERS, NOISE 51088

MEDICAL CERTIFICATE OF DEATH

120

16. DATE OF DEATH

July 15 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 4 1920 to *July 15 1922*that I last saw him alive on *July 13 1922*and that death occurred on the date stated above, at *2:45* P.M.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *B. O. Clark* M. D.19. (Address) *Emmett Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Emmett Idaho

DATE OF BURIAL

7/16 1922

20. UNDERTAKER

C. D. Bucknum

ADDRESS

*Emmett**Idaho*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No.

Primary Registration District No.

St.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY That I attended deceased from

that I last saw him alive on

The CAUSE OF DEATH* was as follows:

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

19 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

1. PLACE OF DEATH

County of *Gooding*
City of *Bliss*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Frank Asbury Clampitt

CERTIFICATE OF DEATH

District No. *24*

Registration District No.

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *39041*

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married

(Write the word.)

6. DATE OF BIRTH

Oct 4 1866
(Month) (Day) (Year)

7. AGE

65 Yrs. *9* Mos. *10* ds.IF LESS than 1 day
how many hrs. or
..... min. 2)

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....*Farming*

9. BIRTHPLACE

(State or Country)

Ind.

10. NAME OF FATHER

Jake Clampitt

11. BIRTHPLACE OF FATHER

(State or Country)

Don't Know

12. MAIDEN NAME OF MOTHER

Don't Know

13. BIRTHPLACE OF MOTHER

(State or Country)

Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Harvey Clampitt (Son)*(Address) *Bliss, Idaho*

15.

Filed *7-14-* 191*11**J. J. Camp, M.D.*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 14 1911
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1911 to *1911*,
that I last saw him alive on *1911*and that death occurred on the date stated above, at *2 P. M.*

The CAUSE OF DEATH* was as follows:

*Cause given as Pulmonary
Tuberculosis of 30 years standing*

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *No Doctor in attendance* M. D.

19..... (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Swiss Falls, Ida

DATE OF BURIAL

7/15 1911

20. UNDERTAKER

A. E. Thompson

ADDRESS

Gooding, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11 SEP 1 1922

1. PLACE OF DEATH *Gooding* Registration District No. *24*
County of *Gooding* Primary Registration District No. *24*
City of *Gooding* (No. *24* St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *William Benson Kelly*

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. *39042*

Registered No. *17*
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*

6. DATE OF BIRTH *Dec 7 1868*
(Month) (Day) (Year)

7. AGE *56* yrs. *7* mos. *12* ds. IF LESS than 1 day how many *hrs.* or *min.*

8. OCCUPATION *Farming*
(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE *Union Utah*
(State or Country)

10. NAME OF FATHER *Wm B Kelly*

11. BIRTHPLACE OF FATHER *Illinois*
(State or Country)

12. MAIDEN NAME OF MOTHER *Caliza J Turpin*

13. BIRTHPLACE OF MOTHER *Virginia*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *Nina Kelly*

(Address) *Gooding Ida*

15. Filed *8-12* 191*2* *J H Gaym*

Local Registrar

MEDICAL CERTIFICATE OF DEATH *120*

16. DATE OF DEATH *July 19- 1922*
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from *Aug - 1919*, to *July 19- 1922* that I last saw him alive on *July 18- 1922* and that death occurred on the date stated above, at *10 A.M.*
The CAUSE OF DEATH* was as follows:
Chronic Brights Disease

(Duration) *3* yrs. *0* mos. *0* ds.
Contributory (Secondary)

(Duration) *14* yrs. *0* mos. *0* ds.
(Signed) *J H Crowell* M. D.
7/22/22 (Address) *Gooding*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death *0* yrs. *0* mos. *0* ds. State *0* yrs. *0* mos. *0* ds.
Where was disease contracted,
If not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL *Gooding Cemetery* DATE OF BURIAL *July 22 1922*
20. UNDERTAKER *A E Thompson* ADDRESS *Gooding*

1. PLACE OF DEATH

County of Idaho Registration District No. 105
 City of Cottonwood Primary Registration District No. 2183 St.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Eulalia R. Cremer

39044

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 17Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
 (Write the word.)

6. DATE OF BIRTH

April 2 1894
 (Month) (Day) (Year)

7. AGE

28 Yrs. 2 Mos. 1 ds.

If LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Housewife

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Henry A. Bruegman

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Anna Berger

13. BIRTHPLACE OF MOTHER

(State or Country)

Ind

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henry A. Bruegman
 (Address)

15.

Filled July 31 1922

W. F. Orr
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 3 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 27 1922, to June 3 1922 that I last saw her alive on June 3 1922 and that death occurred on the date stated above, at 5 A. M.

The CAUSE OF DEATH* was as follows:

Puerperal Septicemia

(Duration) Yrs. mos. 3 ds.

Contributory (Secondary) Influenza

(Duration) yrs. mos. 10 ds.

(Signed) J. D. Schirneck M. D.

(Address) Cottonwood Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cottonwood Id 6-7 1922

20. UNDERTAKER

ADDRESS

W. F. Orr Cottonwood Id

1. PLACE OF DEATH AUG 17 1922
 County of Myer Registration District No. 105
 City of Melrose Primary Registration District No. 2183
 (No. 16 St.)

File No. 16
 Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Margaret F. Rogers

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widower
 (Write the word.)

6. DATE OF BIRTH

June 4 1849
 (Month) (Day) (Year)

7. AGE

73 Yrs. 1 Mos. 27 ds.

IF LESS than 1 day
 how many _____ hrs.
 or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

Farmer

9. BIRTHPLACE

(State or Country)

Mo

10. NAME OF FATHER

Alexander A Rogers

11. BIRTHPLACE OF FATHER

(State or Country)

Mo

12. MAIDEN NAME OF MOTHER

Betinda Wallace

13. BIRTHPLACE OF MOTHER

(State or Country)

Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W B Williams
Lewiston

(Address)

15.

Filed

July 31 1922

W F Orr
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 31 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____ 19____, to _____ 19____,
 that I last saw him _____ alive on _____ 19____,
 and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Burned to death in garage fire at Melrose Idaho
Accidental

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
 (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W B Williams Coroner M. D.

Aug 1, 1922 (Address) Lewiston Idaho

State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Yapewell Cemetery Vinona Aug 2 1922

20. UNDERTAKER

ADDRESS

A N Van Collawood

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No.

Principal Registration District No.

(No.

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word)

6. DATE OF BIRTH

(Month)

(Day)

(Year)

7. AGE

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Aug, 1922

98

Stockton

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

1922

17. I HEREBY CERTIFY, That I attended deceased from

19..... to 19.....

that I last saw alive on 19.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Contributory (Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

(Duration)

yrs.

mos.

ds.

7/12/22 Address) Surgeon

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death..... yrs..... mos..... days.

In the

State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

1. PLACE OF DEATH. **Idaho**
County of **Idaho** Registration District No. **103**
City of **Grangerville** Primary Registration District No. **2181**
St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Clarence Kerr**

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. **39047**

Registered No. **17**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **M** 4. COLOR OR RACE **W** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **single**
(Write the word.)

6. DATE OF BIRTH. **don't know**
(Month) (Day) (Year)

7. AGE **35** Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.

8. OCCUPATION

(a) Trade, profession or particular kind of work... **Laborer**
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) **Missouri**

10. NAME OF FATHER **Joseph Kerr**

11. BIRTHPLACE OF FATHER (State or Country) **?**

12. MAIDEN NAME OF MOTHER **?**

13. BIRTHPLACE OF MOTHER (State or Country) **?**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) **Esthanerck**
(Address) **Grangerville Idaho**

15. Filed **Aug 1** 1922 **98 Stock**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **July 10** 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **191** to **191**
that I last saw h. alive on **191**
and that death occurred on the date stated above, at **11 A.M.**
The CAUSE OF DEATH* was as follows:

killed in runaway

(Duration) Yrs. mos. ds.
Contributory (Secondary)

(Duration) Yrs. mos. ds.
(Signed) **98 Stock** M. D.
7/12/1922 (Address) **Grangerville Idaho**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death...yrs...mos...days In the State...yrs...mos...days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **Republie, Mo** DATE OF BURIAL **191**

20. UNDERTAKER **Esthanerck Grangerville** ADDRESS

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Idaho*City of *Grangerville*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No. *103*Primary Registration District No. *1001*

(No.)

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widow
(Write the word.)

6. DATE OF BIRTH

Dec (Month) *29* (Day) *1892* (Year)

7. AGE

79 Yrs. *8* Mos. *25* ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Housewife

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

?

11. BIRTHPLACE OF FATHER

(State or Country)

?

12. MAIDEN NAME OF MOTHER

Wolsie

13. BIRTHPLACE OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Sept 1 19*22* *G. B. Strickton*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 23 19*22*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 21 19*22* to *Aug 23* 19*22*
that I last saw him alive on *Aug 21* 19*22*
and that death occurred on the date stated above, at *10* M.
The CAUSE OF DEATH* was as follows:*Cerebral Hemorrhage*

(Duration) Yrs. mos. ds.

Contributory (Secondary)

arteriosclerosis

(Duration) yrs. mos. ds.

(Signed)

G. B. Strickton

M. D.

Aug 24 19*22* (Address) *Grangerville Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Prairie View *8/24* 19*22*

20. UNDERTAKER

ADDRESS

Esthanclock *Grangerville*

1. PLACE OF DEATH

County of IdahoCity of Grangeville

If death occurs away from usual residence, give facts called for under special information.

RECEIVED

CERTIFICATE OF DEATH

SEP 6 1922

Registration District No. 103Primary Registration District No. 1001State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 33049Registered No. 21

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

John Coram

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W hite

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

Aug. 1 1841
(Month) (Day) (Year)

7. AGE

81 Yrs.7 Mos.ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

Retired farmer

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

William Coram

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs Mary Coram

(Address)

Grangeville Ida

15.

Filed

Sept 1 19221922H B Stockton

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 8 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 1922 to Aug 8 1922that I last saw him alive on Aug 8 1922and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Valvular lesion of heart

(Duration) Yrs. mos. ds.

Contributory (Secondary)

Chronic Brights

(Duration) yrs. mos. ds.

(Signed)

H B Stockton

M. D.

Aug 9 1922 (Address) Grangeville

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Prairie View

DATE OF BURIAL

Aug 10 1922

20. UNDERTAKER

J. Maugg

ADDRESS

Grangeville

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39050**
Registered No. **20**

1. PLACE OF DEATH **Idaho** Registration District No. **103**
County of **Idaho** Primary Registration District No. **1001**
City of **Grangeville** (State) _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William L Miller

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX **M** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Single**
(Write the word.)

16. DATE OF DEATH

Aug 22 19**22**
(Month) (Day) (Year)

6. DATE OF BIRTH

July 6 18**86**
(Month) (Day) (Year)

7. AGE

66 Yrs. **1** Mos. **16** ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

17. I HEREBY CERTIFY, That I attended deceased from **July 21** 19**22** to **Aug 22** 19**22**
that I last saw him alive on **Aug 22** 19**22**
and that death occurred on the date stated above, at **12 M.**

The CAUSE OF DEATH* was as follows:

Septic Peritonitis following operation for ruptured bowel occasioned by accidental injury

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) **G S Stockton**

Aug 22 19**22** (Address) **Grangeville Ida**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Pacific View

Aug 25 19**22**

20. UNDERTAKER

ADDRESS

A J Mangy

City

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Mrs E L Sweet**

(Address) **Grangeville**

15. Filed **Sept 1** 19**22** **G S Stockton**

Local Registrar

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Idaho Registration District No. 103
 City of Grangeville Primary Registration District No. 1001
 (No. of Local Registrar)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

George W Reed

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33051

Registered No. 19

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
 (Write the word.)

6. DATE OF BIRTH

July 5 1863
 (Month) (Day) (Year)

7. AGE

59 Yrs. 1 Mos. 12 ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

Real Estate & Loans

9. BIRTHPLACE

(State or Country)

Illinois

10. NAME OF FATHER

Samuel R Reed

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Jenny G. Blouin

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

A. J. Maugy
Grangeville

15. Filed Sept 1 1922 G. B. Stockton
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 27 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 27, 1922 to 1922
 that I last saw him alive on 1922
 and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

died at wheel on his Ford —
Probably some form of
heart trouble.

(Duration) Yrs. mos. ds.

Contributory
 (Secondary)

(Duration) yrs. mos. ds.

(Signed)

G. B. Stockton M. D.

Aug 27, 1922 (Address) Grangeville, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
 if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Monticello, Ill.

DATE OF BURIAL

Aug 28, 1922

20. UNDERTAKER

A. J. Maugy

ADDRESS

Grangeville

RECEIVED
AUG 21 1922
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

39052

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Adron Clark Gray

Registration District No.

Primary Registration District No.

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15. Filled

Aug 10 1922

Ray H. Fisher
Local Registrar

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

Infantile Convulsion

Contributory (Secondary)

(Signed)

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED
1922
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33053
Registered No. 42

1. PLACE OF DEATH
County of Jefferson
City of Rigby, R.D. #3
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 93
Primary Registration District No. 21-6

2. FULL NAME

Richard Tryfe

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH
Month 8 Day 2 Year 1922

7. AGE
Yrs. Mos. 9 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Rigby R.D. #3

10. NAME OF FATHER

William Tryfe

11. BIRTHPLACE OF FATHER

(State or Country) Utah

12. MAIDEN NAME OF MOTHER

Rachel E. Connell

13. BIRTHPLACE OF MOTHER

(State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William Tryfe
(Address) Rigby R.D. #3

15. Filed Sept 10 1922
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug. 11 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY That I attended deceased from Aug 4 1922 to Aug 11 1922 that I last saw him alive on Aug 11 1922 and that death occurred on the date stated above, at M. The CAUSE OF DEATH* was as follows:

Immature birth

(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) Saml. Price M. D.
19 (Address) Rigby, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Rigby, Idaho 8-12-1922

20. UNDERTAKER ADDRESS
Edw. Sullivan Rigby

RECEIVED
AUG 21 1922

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 39055
Registered No. 86

1. PLACE OF DEATH

County of Jefferson

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No. 98

Primary Registration District No. 2176

Sex

St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many.....hrs.
or.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw her alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Signed) M. D.

19. (Address)

*State the Disease Causing Death; or in death from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

RECEIVED
AUG 1 1922

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **35036**
Registered No. **45**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of JeffersonRegistration District No. 98City of RayPrimary Registration District No. 2176

(No. _____)

St. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Nickberg

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male4. COLOR OR RACE White5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)6. DATE OF BIRTH March 19 1959
(Month) (Day) (Year)7. AGE 63 3 18
Yrs. Mos. ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?8. OCCUPATION Farmer(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)9. BIRTHPLACE Sweden
(State or Country)10. NAME OF FATHER Louis Nickberg11. BIRTHPLACE OF FATHER Sweden
(State or Country)12. MAIDEN NAME OF MOTHER Don't know13. BIRTHPLACE OF MOTHER Sweden
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. John Nickberg(Address) Idaho15. Aug 10 1922 Ray H Fisher
Filed _____

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 5 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY That I attended deceased from July 3 1922 to July 5 1922
that I last saw him alive on July 5 1922
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Accident (Auto)
Run over by auto.

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Samuel P. Fisher M. D.19. (Address) Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL SheltonDATE OF BURIAL July 6 192220. UNDERTAKER E. A. GiltnerADDRESS Idaho

1. PLACE OF DEATH

County of Jefferson
City of Regby

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Phil B. HarmonRegistration District No. 98Primary Registration District No. 2176

(No. St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 39057Registered No. 45

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

June 29 1921
(Month) (Day) (Year)

7. AGE

1 Yrs. 1 Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country)

Regby, Idaho.

10. NAME OF FATHER

Allen I. Harmon

11. BIRTHPLACE OF FATHER

(State or Country)

Lewisville, Idaho

12. MAIDEN NAME OF MOTHER

Ada Baxter

13. BIRTHPLACE OF MOTHER

(State or Country)

Tulsa, Okla.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Allen I. Harmon

(Address)

Regby, Idaho.

15.

Filed

Aug 10 1922Ray H. Fisher
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 29 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 29 1922 to July 29 1922
that I last saw him alive on July 29 1922
and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis(Duration) Yrs. mos. 4 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) R. C. Call M. D.

.....19..... (Address).....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Regby, Ida7-31-1922

20. UNDERTAKER

ADDRESS

D. D. LintonRegby, Ida

1. PLACE OF DEATH

County of *Jefferson*City of *Regis*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No. *98*Primary Registration District No. *2176*(No. *15504*)

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. *39058*
Registered No. *43*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country) *Thayne, Wyo.*

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country) *Vernil, Utah*

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country) *Utah*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Geo W Marks*(Address) *Regis P.O. #1*

15.

Filed *Aug 10 1922**Ray H Fisher*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 31 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19....., to 19.....

that I last saw h..... alive on.....19.....

and that death occurred on the date stated above, at *10 A.M.*

The CAUSE OF DEATH* was as follows:

Accidental drowning.

(Duration) Yrs..... mos..... ds.

Contributory
(Secondary)

(Duration) yrs..... mos..... ds.

(Signed) *A.M. Palmer*

M. D.

7/31 1922 (Address) *Regis, Idaho.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Salt Lake, Utah *8-2 1922*

20. UNDERTAKER

ADDRESS

Edw. E. Egan *Regis*

1. PLACE OF DEATH

County of JeffersonCity of Payson

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many.....hrs.
or.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

RECEIVED

AUG 1 1922

CERTIFICATE OF DEATH

Registration District No. 98Registration District No. 2076

STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 39059Registered No. 41

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from Aug 13 1922, to Aug 13 1922that I last saw him alive on Aug 13 1922
and that death occurred on the date stated above, at 6 AM.

The CAUSE OF DEATH* was as follows:

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Wm. H. Fisher M. D.1922 (Address) Payson, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

(No. 1209)

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

39060

Registered No.

1095

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Signed)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... / days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

Form V. S. No. 5 20M.1-16-12

AUG 17 1922

CERTIFICATE OF DEATH

1. PLACE OF DEATH.

Registration District No.

County of

Primary Registration District No.

City of

(No.

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39061**
Registered No. **1094**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female

White

married
(Write the word.)

6. DATE OF BIRTH

Dec - 20th 1888
(Month) (Day) (Year)

7. AGE

22 yrs. 6 mos. 12 ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Domestic House-Work

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

Robert Seidler

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Anna Fombauer

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

August Seidel

(Address)

Hosley, Idaho, R. 1.

15.

Filed

Aug. 3 1922

1922

A. G. Gunnar
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July - 2nd 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 1921, to July 2nd 1922.

that I last saw her alive on July 2nd 1922.

and that death occurred on the date stated above, at 8:15 P. M.

The CAUSE OF DEATH was as follows:

Chronic Endocarditis

(Duration) 2 yrs. 5 mos. 4 ds.

Contributory Cerebral Hemorrhage.
(Secondary) only a few minutes

(Duration) 1 yrs. 5 mos. 4 ds.

(Signed) J. J. Hemmingson M. D.

19 (Address) Hosley, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hosley, Idaho July 2nd 1922

20. UNDERTAKER

ADDRESS

H. J. Gunnar Plummer

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

RECEIVED
AUG 17 1922

CERTIFICATE OF DEATH

39063

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Bureau Registration District No. 30
County of Notenai Primary Registration District No. 1051
City of Post Falls, P. F. D. No. Post, Falls, Ida. RFD St.

File No.

Registered No. 1097

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Samuel Coumbe

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH July 27 1865
(Month) (Day) (Year)

7. AGE 56 yrs. 11 mos. 21 ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) England

10. NAME OF FATHER John Martin Coumbe

11. BIRTHPLACE OF FATHER
(State or Country) England

12. MAIDEN NAME OF MOTHER Mary Shepherd

13. BIRTHPLACE OF MOTHER
(State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thos. Strick
(Address) Spokane, Wash

15. Filed 7/6 1922 L. H. Hennings
Alta T. Hennings Local Registrar
Rep. D. B.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 19 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 19 1922 to July 19 1922
that I last saw him before alive on July 19 1922
and that death occurred on the date stated above, at 6:55 M.

The CAUSE OF DEATH* was as follows:

Hemorrhage of Lungs
as result of Tuberculosis
of Lung
(Duration) yrs. mos. ds.
Contributory Tuberculosis
(Secondary)
(Duration) yrs. mos. ds.
(Signed) Post Falls, Ida. M. D.
July 20 1922 (Address) L. L. McCauley

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. 7 yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Spokane, Wash DATE OF BURIAL July 24 1922

20. UNDERTAKER Smith & Company ADDRESS Spokane, Wn.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH **RECEIVED**
 County of Boone Registration District No. 30
 Primary Registration District No. 1051
 City of Pocahontas (No. Fernan Lake St.)

File No. 39064
 Registered No. 1098

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Casper Borsum

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widower
 (Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

72

Yrs. Mos. ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

Retired

9. BIRTHPLACE

(State or Country)

Norway

10. NAME OF FATHER

Peter Borsum

11. BIRTHPLACE OF FATHER

(State or Country)

Norway

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Antony T. Torgue

(Address)

Pocahontas 2nd

15.

Filed 8/6

1922

D. O. Orenman

Local Registrar

16. DATE OF DEATH

July221922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19

to

19that I last saw him alive on 19and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Suicide by Drowning

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

R. B. Orenman7/24/1922

(Address)

Pocahontas 2nd

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. In the
 yrs. mos. days. State. yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

2001 Lakeside

19. PLACE OF BURIAL OR REMOVAL

Forest Cemetery

DATE OF BURIAL

7/24/1922

20. UNDERTAKER

ADDRESS

R. B. Orenman Pocahontas

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39065**

Registered No. **1099**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH **RECEIVED**
County of **Boone** Registration District No. **30**
City of **Corundale** Primary Registration District No. **1051**
(No. _____) (St.) _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **John Ruble**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **M** 4. COLOR OR RACE **W** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Widower**
(Write the word.)

6. DATE OF BIRTH

(Month) **7** (Day) **4** (Year) **1899**

7. AGE **63** Yrs. **0** Mos. **20** ds. IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Mill worker

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Miss Margaret Ruble**
(Address) **Corundale, Idaho**

15. Filed **8/6** 19**22** **D. O. Brennan**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

7 **24** **1922**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 19____, to _____ 19____, that I last saw h. _____ alive on _____ 19____, and that death occurred on the date stated above, at _____ M. The CAUSE OF DEATH* was as follows:

Heart trouble

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) **D. O. Brennan** M. D.

7/26 19**22** (Address) **Corundale, Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

St. Thomas Cemetery **7/27** 19**22**

20. UNDERTAKER

ADDRESS

C. O. Brennan **Corundale, Idaho**

39066

RECEIVED Idaho
 PLACE OF DEATH Washington State Board of Health

County of Rocky Mountain BUREAU OF VITAL STATISTICSCity or Town of For CERTIFICATE OF DEATH

Record No.

Registered No. 1190Registration Dist. No. 1021 No.
 (If death occurred in a hospital or institution, give its NAME instead of street and number)2. FULL NAME Gyonne Mann

(a) Residence No. St.;

(Usual place of abode)

(b) If non-resident, give city or town, and state Spokane Wn

(c) How long in

Registration Dist. yrs. mos. 4 ds.; how long in U. S. if of foreign birth yrs. mos. ds.

Personal and Statistical Particulars

3. Sex Female 4. Color or Race White 5. Single, Married, Widowed or Divorced (Write the word) Single

5. (a) If married, widowed or divorced:

Husband of

or

Wife of

6. Date of birth

Mar301919

(Month)

(Day)

(Year)

7. Age

3yrs. 3 mos.26 ds.

If less than one day

hrs. or min.

8. Occupation of deceased:

(a) Trade, profession, or

particular kind of work

(b) General nature of industry,

business, or establishment in

which employed (or employer)

(c) Name of employer

9. Birthplace (City or town) Chavella(State or country) Wn

10. Name of

Father John Mann

11. Birthplace of Father

(City or town) Wn(State or Country) Wn

12. Maiden name of

Mother Elatilda Poirier

13. Birthplace of Mother

(City or town) Oregon(State or Country) Oregon14. Informant John MannAddress Spokane Wn15. Filed 16

1922

DD Pinner

Registrar.

Medical Certificate of Death

16. Date of death

July26

1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased

from July 24, 1922, to July 26, 1922that I last saw him alive on July 26, 1922and that death occurred on the date stated above, at 11 a.m.

(State the disease causing death, or, in deaths from violent

causes, state: (1) Means and nature of injury; and (2)

whether ACCIDENTAL, SUICIDAL, or HOMICIDAL).

The CAUSE OF DEATH was as follows:

(Primary) Intestinal Toxemia

(Duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(Duration) yrs. mos. ds.

18. Where was disease contracted

if not at the place of death? Spokane(a) Did an operation precede death? No Date of(b) Was there an autopsy? No

(c) What test confirmed diagnosis?

(Signed) D. Clayton M. D.1922 Address Rockford Wn

19. Place of Burial, Cremation or

Removal

Spokane Wn

Date of Burial

July 29, 1922

20. Undertaker

Hennessey & Co.

Address

Spokane

I HEREBY CERTIFY, upon honor, That I have made the effort but was unable to secure answers to questions.

(Insert numbers of unanswered questions)

(Signature of Undertaker)

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED
AUG 1 1922

CERTIFICATE OF DEATH

39067

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Booleman Registration District No. 3
City of Council Bluffs Primary Registration District No. 1057
(No. 1728 3rd St.)

File No. _____
Registered No. 1111

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Martha L. Evans

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH 5 27 1851
(Month) (Day) (Year)

7. AGE 71 Yrs. 2 Mos. 3 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. House wife
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE
(State or Country) England.

10. NAME OF FATHER Wm. Laughner.

11. BIRTHPLACE OF FATHER
(State or Country) England.

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country) England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Mary J. Hill
(Address) Council Bluffs, Ia.

15. Filed 876 1922 W. D. Brennan
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 30 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 29 1922 to July 30 1922
that I last saw h. lv alive on July 28 1922
and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Endocarditis

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) W. D. Brennan M. D.
(Address) Council Bluffs, Ia.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Forest Cem. Est. DATE OF BURIAL Aug 1 1922

20. UNDERTAKER C. L. Sledge ADDRESS Council Bluffs

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Latah*
City of *Moscow*Registration District No. *61*Primary Registration District No. *1011*

(No. _____)

(St. _____)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Delia Hunter*State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *39068*Registered No. *47*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female White Married
(Write the word.)

6. DATE OF BIRTH

Nov 25 1887
(Month) (Day) (Year)

7. AGE

34 8 7
Yrs. Mos. ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

Housewife

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

John Philip Daubentorger
Germany

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Martha Walsh
Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Earl Hunter
Moscow Idaho

15. Filed

Aug 21 1922 W. H. Caruthers
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

August 2 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 27 1922 to Aug 2 1922
that I last saw him alive on *Aug 2 1922*
and that death occurred on the date stated above, at *2:40 P.M.*

The CAUSE OF DEATH* was as follows:

Purpural Septicemia

(Duration) Yrs. mos. 4 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Virgil M. Lechris M. D.(Address) *Moscow Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Moscow Idaho Aug 7 1922

20. UNDERTAKER

ADDRESS

Glenn Grice
Moscow Idaho

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

19

Local Registrar

CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

(City)

(St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Signed)

7/11/1922 (Address) 702 South Main

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs mos days In the State yrs mos days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics1. PLACE OF DEATH
Katah In District No. 61
County of Moo Can AUG 10 1922
City of (St.)
BUREAU OF VITAL STATISTICS

File No. 39070

Registered No. 44

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Beliss Roy King

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single

6. DATE OF BIRTH

June 30 1903
(Month) (Day) (Year)

7. AGE

19 Yrs. 10 Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

Student

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

William R. King

11. BIRTHPLACE OF FATHER

(State or Country)

Missouri

12. MAIDEN NAME OF MOTHER

Millie J. Crowell

13. BIRTHPLACE OF MOTHER

(State or Country)

Arkansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. R. King
Moo Can

(Address)

15.

Filed 7/11 1922

W. H. Baughman
Local Registrar

16. DATE OF DEATH

July 10 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 29 1922 to July 10 1922 that I last saw him alive on July 10 1922 and that death occurred on the date stated above, at 8:30 P. M.

The CAUSE OF DEATH* was as follows:

Acute nephritis.

about 15 Yrs. 1 Mos. 15 ds.

Contributory (Secondary)

(Duration) Yrs. Mos. ds.

(Signed)

J. H. Engholm M. D.
7/11 1922 (Address) Moscow, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Moo Can 7/12 1922
G. L. Grier Moo Can

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics1. PLACE OF DEATH *Idaho* (Registration District No. *61*)
County of *Blaine* Primary Registration District No. *1011*
City of *Moscow* (No. *1011*)File No. *33071*
Registered No. *43*

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME *Judy S Costigan*

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *F* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*
(Write the word)6. DATE OF BIRTH *Oct 22 1871*
(Month) (Day) (Year)7. AGE *50* 8. 27 *8* 27 *27*
Yrs. Mos. da. IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)*House wife*
Shoe making

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

William F McEntire

11. BIRTHPLACE OF FATHER

(State or Country)

New York

12. MAIDEN NAME OF MOTHER

Sarah C. Barnes

13. BIRTHPLACE OF MOTHER

(State or Country)

Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

William Costigan

(Address)

*Moscow*15. *7/20* 19 *22* *M. H. Baughman*
Filed Local Registrar16. DATE OF DEATH *July 19 1922*
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *May 25* 19 *22* to *July 19* 19 *22*
that I last saw her alive on *July 19* 19 *22*
and that death occurred on the date stated above, at *7 P. M.*
The CAUSE OF DEATH* was as follows:*Acute nephritis*

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Charles L. Gritman M. D.(Address) *Moscow Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Moscow *7/22 1922*

20. UNDERTAKER

ADDRESS

Edw. Guice *Moscow*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39072**
Registered No. **41**

1. PLACE OF DEATH. Registration District No. **61**
County of **Katahdan** Primary Registration District No. **1011**
City of **Moscow** (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Andrew Emtmann**

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Single**

6. DATE OF BIRTH **June 2 1860**
(Month) (Day) (Year)

7. AGE **63** yrs. **1** mos. **1** ds. IF LESS than 1 day
how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Merchant

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

John Emtmann

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Margaret Bergerline

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John Emtmann

(Address)

Sharon Nash

15.

Filed **July 3 1912** **W. H. Barithers**
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July 3

(Month) (Day) (Year) **1912**

17. I HEREBY CERTIFY, That I attended deceased from

June 10 1912, to **July 3 1912**

that I last saw him alive on **July 3 1912**

and that death occurred on the date stated above, at **11 30 A.M.**

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) **W. H. Barithers** M. D.

7/3 1912 (Address) **Moscow Ida**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____

of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Sharon Nash**1**

20. UNDERTAKER

ADDRESS

Glen Grace**Moscow**

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39073**
Registered No. **41**

1. PLACE OF DEATH **Idaho** Registration District No. **61**
County **Moscow** Primary Registration District No. **1011**
City **Moscow** (No. _____ St.)
If death occurs away from usual residence, give facts called for under special information.
BUREAU OF VITAL STATISTICS
2. FULL NAME **Mary Peterson**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX **F** 4. COLOR OR RACE **W** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **married**
(Write the word.)

6. DATE OF BIRTH **July 19 1866**
(Month) (Day) (Year)

7. AGE **55** Yrs. **11** Mos. **12** ds. IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION **House wife**
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE **Den mark**
(State or Country)

10. NAME OF FATHER **Joseph J. Jensen**

11. BIRTHPLACE OF FATHER **Den mark**
(State or Country)

12. MAIDEN NAME OF MOTHER **Not known here**

13. BIRTHPLACE OF MOTHER **Den mark**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) **Peter Peterson**
(Address) **Moscow**

15. Filed **July 1 1922** **M. H. Barthers**
Local Registrar

16. DATE OF DEATH **July 1st 1922**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **June 10 1922** to **July 1 1922**
that I last saw him alive on **July 1 1922**
and that death occurred on the date stated above, at **1:30 P.M.**

The CAUSE OF DEATH* was as follows:
**Chronic Intestinal
Aphasia**

about 20 Yrs. mos. ds.
(Duration)

Contributory **General debility**
(Secondary)

about 20 Yrs. mos. ds.
(Duration)

(Signed) **John E. Eihong** M. D.

7/1 1922 (Address) **Moscow, Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL **Moscow** DATE OF BURIAL **7/3 1922**

20. UNDERTAKER **Glen Guice** ADDRESS **Moscow**

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Salak, Idaho

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No.

Primary Registration District No.

St.

File No. 39074

Registered No. 46

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

19

22

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

June 4, 1922 to July 19, 1922
that I last saw him alive on July 19, 1922
and that death occurred on the date stated above, at 7:30 P.M.
The CAUSE OF DEATH* was as follows:Contributory
(Secondary)

(Signed)

7/21/1922 (Address) Moscow, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

ADDRESS

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

39075

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of **Power**City of **American Falls**

Registration District No.

Primary Registration District No. **2072**

File No.

Registered No. **164**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Richard Allen**Wennstrom**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.**Single**

(Write the word.)

6. DATE OF BIRTH.

January**26****1922**

(Month)

(Day)

(Year)

7. AGE

Yrs. **4** Mos. **9** ds.IF LESS than 1 day
how many.....hrs. or
.....min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work...
(b) General nature of in-
dustry, business, or estab-
lishment in which employ-
ed (or employer).....**None**

9. BIRTHPLACE

(State or Country)

Power**Idaho.**10. NAME OF
FATHER**Guss Wennstrom**11. BIRTHPLACE
OF FATHER

(State or Country)

Sweeden12. MAIDEN NAME
OF MOTHER**Bernice Hughes**13. BIRTHPLACE
OF MOTHER

(State or Country)

Wis

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

American Falls, Idaho

15.

Filed **8-7-1922****R. J. Roth**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July**5****22**

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191**191**that I last saw him alive on **191**and that death occurred on the date stated above, at **M.**

The CAUSE OF DEATH* was as follows:

**Burned to death in fire
of dwelling house,**

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) **Arthur J. Davis** Coroner**6/6/1922** (Address) **American Falls, Idaho**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

American Falls,**7/7-1922**

20. UNDERTAKER

ADDRESS

**AM Falls
Idaho**

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

AUG 17 1922

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Latah
City of PotlatchRegistration District No. 65Primary Registration District No. 2145

(No.)

St.)

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Arthur W. Shaffer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDSingle
(Write the word.)

6. DATE OF BIRTH

March 6 1922
(Month) (Day) (Year)

7. AGE

4 Yrs. 5 Mos. 1 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Farmer

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Montana

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

L. T. Shaffer
Potlatch Ida.

15.

Filed

8/4 1922W. H. Thompson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 4 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19..... to 19.....

that I last saw him..... alive on..... 19.....

and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Killed by Bull.

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

Duration..... yrs. mos. ds.

(Signed)

1922 (Address) Moscow Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days.

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Potlatch IdaAug 6 1922

20. UNDERTAKER

ADDRESS

W. H. ThompsonPalouse

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery, and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women, at home, who are engaged in the duties of the household, only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as **PUERPERAL septicemia,** "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL** or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoning by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *tetanus*) may be stated under the head of "Contributory."

2
#7

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-~~RECEIVED~~ CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39077**
Registered No. _____

1. PLACE OF DEATH. **AUG 17 1922** Registration District No. **65**
County of **Latah** Primary Registration District No. **2145**
City of **Potlatch** (No. _____, St. _____)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Anna Constance Danielson**

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Single**
(Write the word.)

6. DATE OF BIRTH **July 15 1905**
(Month) (Day) (Year)

7. AGE **16 yrs. 11 mos. 22 ds.** IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work. **School Girl**
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) **Idaho**10. NAME OF FATHER **Ernest Danielson**

11. BIRTHPLACE OF FATHER

(State or Country) **Norway**12. MAIDEN NAME OF MOTHER **Amalie Annan**

13. BIRTHPLACE OF MOTHER

(State or Country) **Norway**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Mary Bass**
(Address) **Potlatch, Ida.**

15. **July 9 1922**
Filed **Dr. W. Thompson**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **July 8 1922**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **July 7 1922**, to **July 8 1922**
that I last saw her alive on **July 8 1922**
and that death occurred on the date stated above, at **P.M.**
The CAUSE OF DEATH* was as follows:

Cerebro-Spinal Meningitis

(Duration) yrs. mos. **6** ds.

Contributory **Acute suppurative condition in**
(Secondary) **left lung.**

(Duration) yrs. mos. **6** ds.

(Signed) **W. S. Dart** M. D.

July 9 1922 (Address) **Palouse W.**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Palouse wash. July 9 1922

20. UNDERTAKER ADDRESS

C. H. Lewis Palouse wash.

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 106
County of Idaho Primary Registration District No. 2184
City of Kooskia (No. _____ St.)File No. 39079
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Robert Edwin Flynn

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH.

Sept-26
(Month)1919
(Day)1919
(Year)

7. AGE

2 Yrs.9 Mos.13 ds.IF LESS than 1 day
how many hrs. or
..... min. >]

8. OCCUPATION

(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....Child

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Caral Flynn

11. BIRTHPLACE OF FATHER

(State or Country)

Wisconsin

12. MAIDEN NAME OF MOTHER

May Palmer

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Caral Flynn

(Address)

Kooskia Idaho

15.

Filed

Aug 11922J.M. Verberkhus
Local Registrar

16. DATE OF DEATH

July
(Month)8
(Day)1922
(Year)17. I HEREBY CERTIFY, That I attended deceased from July 8 1922 to July 8 1922, that I last saw him alive on July 8 1922, and that death occurred on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Infantile Paralysis

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) J.M. Verberkhus M. D.July 9, 1922 (Address) Kooskia Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....Yrs.....mos.....days In the State.....Yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lorena CemeteryJuly 10 1922

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39080**Registered No. **726**If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

1. PLACE OF DEATH.

Registration District No. **106**County of **Idaho** Primary Registration District No. **2184**City of **Ruscha** (No. **106**) St.)If death occurs away from
usual residence, give facts
called for under special
information.

2. FULL NAME

William R. Herrington

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.**Divorced**

(Write the word.)

6. DATE OF BIRTH.

December

(Month)

1833

(Day)

(Year)

7. AGE

88

Yrs.

5

Mos.

ds.

IF LESS than 1 day
how many.....hrs. or
.....min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work...
(b) General nature of in-
dustry, business, or estab-
lishment in which employ-
ed (or employer).....

9. BIRTHPLACE

(State or Country)

Iowa10. NAME OF
FATHER**Do not know**11. BIRTHPLACE
OF FATHER

(State or Country)

Do not know12. MAIDEN NAME
OF MOTHER**Do not know**13. BIRTHPLACE
OF MOTHER

(State or Country)

Do not know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Lawis Herrington

(Address)

Ruscha

15.

Filed **Aug 1****1922****J. M. Winkler**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May

(Month)

24

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191

to

191that I last saw him alive on **October** **1921**and that death occurred on the date stated above, at **12** M.

The CAUSE OF DEATH* was as follows:

**Heart failure from senile
debility.**

(Duration)

Yrs.

7

mos.

ds.

Contributory
(Secondary)**Old age**

(Duration)

Yrs.

mos.

ds.

(Signed)

A. F. Wollenberg, M. D.**5/25/1922** (Address)**Ruscha, Idaho***State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place

of death.....yrs.....mos.....days

In the

State.....yrs.....mos.....days

Where was disease contracted
if not at place of death?Former or
usual residence**Council, Idaho**

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

191

20. UNDERTAKER

E. E. Bobo

ADDRESS

Profino

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of *Latah*City of *Troy*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Eda Weaver Hoffman

CERTIFICATE OF DEATH

Registration District No. *64*Registration District No. *9, 44*(No. *64*)

(St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39081**

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Divorced
(Write the word.)

6. DATE OF BIRTH

June
(Month)*8th*
(Day)*1868*
(Year)

7. AGE

54 Yrs. *2* Mos. *15* ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).*Housewife*

9. BIRTHPLACE

(State or Country)

New York

10. NAME OF FATHER

S. C. Weaver

11. BIRTHPLACE OF FATHER

(State or Country)

New York

12. MAIDEN NAME OF MOTHER

Phoebe LaRock

13. BIRTHPLACE OF MOTHER

(State or Country)

New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

S. C. Weaver

(Address)

Troy, Idaho

15.

Filed *Aug 31* 192*2**Lucy M. Pickard*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

August
(Month)*23*
(Day)*22*
(Year)17. I HEREBY CERTIFY, That I attended deceased from *July 13* 19*22* to *Aug 23* 19*22*that I last saw him alive on *Aug 15* 19*22*and that death occurred on the date stated above, at *3 A.M.*

The CAUSE OF DEATH* was as follows:

Renal Sclerosis(Duration) *Unknown* yrs. mos. ds.Contributory
(Secondary)(Duration) *Unknown* yrs. mos. ds.(Signed) *W. Wilson* M. D.

19..... (Address).....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Moscow Ida

DATE OF BURIAL

Aug 23 1922

20. UNDERTAKER

John J. Pickard

ADDRESS

Troy Ida

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39082**

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of *Blaine* Registration District No. *41*
City of *Basler* Registration District No. *2116* St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John R. Cheney

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*
(Write the word.)

6. DATE OF BIRTH

October 17 1846
(Month) (Day) (Year)

7. AGE

75 Yrs. *8* Mos. *25* ds.IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....*Rancher*

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

Lorenzo Cheney

11. BIRTHPLACE OF FATHER

(State or Country)

Virginia

12. MAIDEN NAME OF MOTHER

Not known

13. BIRTHPLACE OF MOTHER

(State or Country)

Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Frank P. Cheney
Basler, Idaho

(Address)

15.

Filed

*7/10 - 1922**Chas. Bell*
Abp.

Local Registrar

16. DATE OF DEATH

July 12 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *July 12 1922* to *July 12 1922*
that I last saw him alive on *July 12 1922*
and that death occurred on the date stated above, at *4:15 A.M.*

The CAUSE OF DEATH* was as follows:

Dilatation of heart(Duration) Yrs. mos. *4* ds.Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) *P. S. Patton* M. D.
7/10 (Address) *Salmon, Idaho*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Salmon, Idaho

DATE OF BURIAL

7/14 1922

20. UNDERTAKER

W. C. Doehler

ADDRESS

Salmon, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED
SEP 1 1922
BUREAU OF VITAL STATISTICS

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39083**
Registered No. _____

1. PLACE OF DEATH _____
County of **Lewiston** Registration District No. **41**
City of **Lewiston** Secondary Registration District No. **2116**
(No. _____) (St. _____)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John R. McFrederick

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **widowed**
(Write the word.)

6. DATE OF BIRTH **Not known**
(Month) (Day) (Year)

7. AGE **about 55** IF LESS than 1 day how many _____ hrs. or _____ min. ?
Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work. **Garage Business**
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE **Maine**
(State or Country)

10. NAME OF FATHER **James McFrederick**

11. BIRTHPLACE OF FATHER **Ireland**
(State or Country)

12. MAIDEN NAME OF MOTHER **Mary Knowles**

13. BIRTHPLACE OF MOTHER **N.B. Canada**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) **Lillian Isley**
(Address) **Corwen Ida**

15. **July-10** 19**22** **Chas Bellomy**
Filed _____ Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **July 1st** 19**22**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 19____ to _____ 19____
that I last saw him _____ alive on _____ 19____
and that death occurred on the date stated above, at **6-30 A.M.**
The CAUSE OF DEATH* was as follows:

Accidently
drawered was pinned under
The vehicle (auto) in a depth of four feet
water in Salmon River.
(Duration) _____ Yrs. _____ mos. _____ ds.
Contributory
(Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) **W.C. Jaebler, Corwen**
7/1st 1922 (Address) **Salmon Ida**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ days. State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL **Salmon Cemetery** DATE OF BURIAL **7-21 1922**

20. UNDERTAKER **W.C. Jaebler** ADDRESS **Salmon Ida**

1. PLACE OF DEATH.

County of Lewis
City of Nezperce

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Evelyn Sarah Francis

CERTIFICATE OF DEATH.

Registration District No. 47Registration District No. 47

St.)

Registered No. 82State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 39084

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH.

January, Tuesday 1919
(Month) (Day) (Year)

7. AGE

7 Yrs. 7 Mos. 12 ds.IF LESS than 1 day
how many hrs. or
min. 2

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....chief

9. BIRTHPLACE

(State or Country)

* Idaho

10. NAME OF FATHER

* Ale Thompson

11. BIRTHPLACE OF FATHER

(State or Country)

* Idaho

12. MAIDEN NAME OF MOTHER

* Vera Osterhout

13. BIRTHPLACE OF MOTHER

(State or Country)

* Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

* Mrs. Ale Thompson
(Address) Nezperce, Idaho

15.

Filed Aug 26 1922Albert Huff
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 19 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Aug 18 1922 to Aug 19 1922, that I last saw him alive on Aug 17 1922 and that death occurred on the date stated above, at 6:30 A.M.

The CAUSE OF DEATH* was as follows:

Enterocolitis(Duration) Yrs. mos. 1 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) R. E. Edmunds M. D.1922 (Address) Nezperce, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Nezperce, Idaho8-20 1922

20. UNDERTAKER

ADDRESS

Albert HuffNezperce, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

RECEIVED
AUG 29 1922
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1. PLACE OF DEATH. _____ District No. 47
County of Lewis Registration District No. _____
City of Mayfield (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Marion Vivian Hutchins

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 39085
Registered No. E 4

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Child
(Write the word.)

6. DATE OF BIRTH Feb 5 1920
(Month) (Day) (Year)

7. AGE 2 yrs. 6 mos. 2 ds. IF LESS than 1 day how many..... hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Mayfield

10. NAME OF FATHER

Charles Hutchins

11. BIRTHPLACE OF FATHER

(State or Country)

Mich.

12. MAIDEN NAME OF MOTHER

Virginia Picart

13. BIRTHPLACE OF MOTHER

(State or Country)

Belgium

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Virginia Hutchins
Mayfield Idaho

15.

Filed 8-26-22 Albert Huff
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug 21 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 21 1922, to Aug 21 1922 that I last saw him alive on Aug 21 1920 and that death occurred on the date stated above, at 8:30 P. M.

The CAUSE OF DEATH* was as follows:

Enterocolitis

(Duration) yrs. mos. 1 1/2 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) R. E. Dineen M.D.
8/21 1922 (Address) Mayfield Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death..... yrs. mos. ds. State..... yrs. mos. ds.

Where was disease contracted,
If not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Mayfield Cemetery

8-22-22 191 22

20. UNDERTAKER

ADDRESS

Albert Huff

Mayfield Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

RECEIVED
AUG 29 1922
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1. PLACE OF DEATH. _____
County of Lewis District No. 47
City of Nezperce Idaho (No. _____) St. _____
Route 2

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elton Hutchins

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 39086
Registered No. 83

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Child
(Write the word.)

6. DATE OF BIRTH Aug 12 1917
(Month) (Day) (Year)

7. AGE 5 yrs. 11 mos. 11 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. _____
(b) General nature of industry business or establishment in which employed (or employer) _____

9. BIRTHPLACE (State or Country) Chene Wash.

10. NAME OF FATHER Charles Hutchins

11. BIRTHPLACE OF FATHER (State or Country) Mich.

12. MAIDEN NAME OF MOTHER Virginia Picant

13. BIRTHPLACE OF MOTHER (State or Country) Belgian

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Virginia Hutchins
(Address) Nezperce Idaho

15. _____
Filed 8-26 1922 Albert Huff
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Aug 22 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 21 1922 to Aug 22 1922 that I last saw him alive on Aug 22 1922 and that death occurred on the date stated above, at 10:30 M. The CAUSE OF DEATH* was as follows:

Euler's colitis
(Duration) _____ yrs. _____ mos. 2 ds.

Contributory (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) R. E. Duvall M. D.
823 1922 (Address) Croquet St

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or _____
usual residence _____

19. PLACE OF BURIAL OR REMOVAL Nezperce Cemetery DATE OF BURIAL 8-23 1922

20. UNDERTAKER Albert Huff ADDRESS Nezperce Idaho

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

St.)

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male

White

Single

(Write the word.)

6. DATE OF BIRTH

March 20th 1910
(Month) (Day) (Year)

7. AGE

12 Yrs. 6 Mos. 5 ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

child.

(b) General nature of industry, business or establishment in which employed (or employer).

minor.

9. BIRTHPLACE

(State or Country)

Woody - Madison Co Idaho,

10. NAME OF FATHER

John W Huskisson

11. BIRTHPLACE OF FATHER

(State or Country)

Salt Lake City, Utah

12. MAIDEN NAME OF MOTHER

Mary E Bush

13. BIRTHPLACE OF MOTHER

(State or Country)

Pleasant Grove, Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

John W. Huskisson
Super City Bldg. 71. Idaho.

15.

Filed

28 1922
R. Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

August 27 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 1922, to Aug - 25 1922

that I last saw him alive on Aug - 25 1922

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) Yrs. 5 mos. ds.

Contributory
(Secondary)

Rheumatic fever

(Duration) Yrs. 1 mos. 15 ds.

(Signed) Lorin F. Rich M. D.

8/28 1922 (Address) Rexburg Idaho,

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Teton

8/28 1922

20. UNDERTAKER

ADDRESS

Hansen

Shimberg

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED CERTIFICATE OF DEATH.

1. PLACE OF DEATH.

County of Madison Registration District No. 100
City of Sugar Primary Registration District No. 2178
St. Idaho

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Markler

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

39088

Registered No.

12

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Infant
(Write the word.)

6. DATE OF BIRTH.

Aug 24 1922
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

NoneNone

9. BIRTHPLACE

(State or Country)

Sugar City Idaho

10. NAME OF FATHER

William Allen Markler

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Mary Jane King

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

W. A. Markler

(Address)

Sugar

15.

Filed

8/30

191

22Pyong

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 25 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 24 1922, to Aug 25 1922, that I last saw her alive on Aug 25 1922, and that death occurred on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:

Premature Birth (7 mos.).

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. A. Markler M. D.

Aug 30 1922 (Address) Sugar City Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Sugar City

DATE OF BURIAL

7/26 1922

20. UNDERTAKER

No Undertaker

ADDRESS

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Minidoka Registration District No. 19
 City of Rupert Primary Registration District No. 2018
 St. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William E. Ballard

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 39030Registered No. 35

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male White Married

6. DATE OF BIRTH

Sept 15 1888
 (Month) (Day) (Year)

7. AGE

33 Yrs. 9 Mos. 5 ds.
 IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Iowa

10. NAME OF FATHER

Juris Ballard

11. BIRTHPLACE OF FATHER

(State or Country) Iowa

12. MAIDEN NAME OF MOTHER

May Wickersham

13. BIRTHPLACE OF MOTHER

(State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Gladys Ballard

(Address) Rupert Idaho

15. Sept. 2 1922 Ed O'Leary

Filed Sept. 2 1922 Ed O'Leary
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 20 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 9 1922, to July 20 1922 that I last saw him alive on July 20 1922 and that death occurred on the date stated above, at 3:40 M.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar, Right

(Duration) Yrs. mos. 11 ds.

Contributory As a result of heart
 (Secondary)

(Duration) yrs. mos. 5 ds.

(Signed) Leland Freyer M. D.

19. (Address) Rupert Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

1005 Cemetery July 24 1922

20. UNDERTAKER

W. G. Goodman Rupert

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Minadoka Registration District No. 19
City of Heyburn Primary Registration District No. 2015
STAT. (No. _____) (St.) _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Orvin Warner

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 39091Registered No. 36

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH

July 2 1922
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day
how many _____ hrs.
or 45 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country) Heyburn Idaho

10. NAME OF FATHER

Wilson Adolph Warner

11. BIRTHPLACE OF FATHER

(State or Country) Coyote Utah

12. MAIDEN NAME OF MOTHER

Mable Ann Johansen

13. BIRTHPLACE OF MOTHER

(State or Country) Farwell Neb.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs W. A. Warner(Address) Heyburn Ida

15.

Filed Sept 2 1922 Ed E. Elmer

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 2 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 2, 1922, for 45 minutes after birth
that I last saw him alive on July 2, 1922,
and that death occurred on the date stated above, at 7:45 P.M.

The CAUSE OF DEATH* was as follows:

Premature (Asphyxia leuda)

(Duration) _____ Yrs. _____ mos. 45 minute ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

C. A. Rich M. D.

7-2-1922 (Address) Burley Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Heyburn

DATE OF BURIAL

July 3, 1922

20. UNDERTAKER

None

ADDRESS

1. PLACE OF DEATH

County of MundanaCity of Reupert

If death occurs away from usual residence, give facts called for under special information.

RECEIVED

CERTIFICATE OF DEATH

Registration District No. 19Primary Registration District No. 2015

STATE

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 33092Registered No. 37

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

FULL NAME Ethna Manner

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

Apr. 27

(Month)

(Day)

1920
(Year)

7. AGE

2

Yrs.

Mos.

ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Reupert

10. NAME OF FATHER

Loren Albert Manner

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Ruth Stewart

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

L. A. Manner

(Address)

15.

Filed

Aug. 22 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

August

(Month)

14

(Day)

1922
(Year)17. I HEREBY CERTIFY, That I attended deceased from July 19 1922, to Aug 14 1922 that I last saw her alive on Aug 14 1922 and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Sho-Colitis, Acute(Duration) Yrs. mos. 20 ds.

Contributory (Secondary)

Ulcerative Stomatitis(Duration) yrs. mos. 12 ds.

(Signed)

Loren Frazier

M. D.

8/16 1922(Address) Reupert, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Reupert CemeteryAug 15 1922

20. UNDERTAKER

ADDRESS

Loren Frazier

FORM V. S. No. 5-25 M. 1-19.

RECEIVED CERTIFICATE OF DEATH

39093

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Myersee*City of *Lewiston*If death occurs away from usual residence, give facts called for under special information. *1916-8th Ave.*Registration District No. *96.*Primary Registration District No. *1009*File No. *130*

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Frank McClain

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

m

4. COLOR OR RACE

*white*5. SINGLE, MARRIED, WID-
OWED OR DIVORCED*child*

(Write the word.)

6. DATE OF BIRTH

7 *15* - *1922*
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many *7* hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

child

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Lewiston Ida.

10. NAME OF FATHER

Harold C. McClain

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Marjorie Cosgrove

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ellis Branson

(Address)

0137-26 street

15.

Filed

*8/9/1922**F. T. Harris, M.D.*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

7 - *15* - *1922*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

7-15-1922 to *same* *1922*that I last saw him alive on *7-15-1922*and that death occurred on the date stated above, at *10 A.M.*

The CAUSE OF DEATH* was as follows:

Infant(Duration) *7 hrs.* Yrs. Mos. ds.Contributory *Premature*
(Secondary)

(Duration) yrs. Mos. ds.

(Signed) *W. F. McQuahaw, D.**7-15-1922* (Address) *Lewiston, Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. Mos. days. In the State yrs. Mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lewiston Idaho *7/15/1922*

20. UNDERTAKER

ADDRESS

Barrett & Co *Lewiston*

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. **39094**
 Registered No. **138**

1. PLACE OF DEATH

Registration District No. **96**
 County of **Boise** Primary Registration District No. **1009**
 City of **Lewiston** (City or Town) St.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Bertina Wold

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
 (Write the word.)

6. DATE OF BIRTH

Oct 20 1893
 (Month) (Day) (Year)

7. AGE

28 Yrs. **9** Mos. **9** ds.

IF LESS than 1 day
 how many..... hrs.
 or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

S. P. Lee

11. BIRTHPLACE OF FATHER

(State or Country)

Norway

12. MAIDEN NAME OF MOTHER

Isabell Nedros

13. BIRTHPLACE OF MOTHER

(State or Country)

Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

John Lee
Spout Lake, Idaho

15.

Filed

8/9/ 1922

F. T. Harris, M.D.
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 29 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 23 1920 to July 29 1922
 that I last saw her alive on **July 29 1922**
 and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia Right Lung
 (Duration) Yrs. mos. **7** ds.

Contributory
 (Secondary)

Empyema Left

(Duration) yrs. **3** mos. ds.

(Signed)

J. E. Carson M. D.

19..... (Address) **Lewiston, Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Lewiston, Idaho

DATE OF BURIAL

7/31 1922

20. UNDERTAKER

ADDRESS

Lewiston, Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics1. PLACE OF DEATH
County of *Neperus*
City of *Leiston*Registration District No. *96*
Primary Registration District No. *1009*
(No. _____ St.)File No. *39095*
Registered No. *136*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Eliza Devins

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*
(Write the word.)

6. DATE OF BIRTH

Aug 7 1863
(Month) (Day) (Year)

7. AGE

39 Yrs. *11* Mos. *18* ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)*House-Wife*

9. BIRTHPLACE

(State or Country)

Ark.

10. NAME OF FATHER

Mr. Holmes

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Mr. Hopper

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. A. Devins
Leiston Wash.

(Address)

15.

Filed

*8/9/1922**F. T. Harris, M.D.*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 26 1922
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from *July 15 1922* to *July 26 1922*
that I last saw her alive on *July 26 1922*
and that death occurred on the date stated above, at *3:45 P.M.*

The CAUSE OF DEATH* was as follows:

Carcinoma of breasts intestine & ovaries.

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory (Secondary)

Same

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

E. L. White M. D.
Leiston 2da

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Flora Oregon *7/28 1922*
H. R. Merchant *Leiston*

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **33096**
Registered No. **135**

1. PLACE OF DEATH **AUG**
Registration District No. **96**
County of **Payette** Primary Registration District No. **1009**
City of **Lewiston** (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Franklin Strickland

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Single**
(Write the word.)

6. DATE OF BIRTH **Jan 26 1911**
(Month) (Day) (Year)

7. AGE **11** Yrs. **5** Mos. **29** ds.
IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

School boy.

9. BIRTHPLACE

(State or Country)

Colorado

10. NAME OF FATHER

J. B. Strickland

11. BIRTHPLACE OF FATHER

(State or Country)

W. B.

12. MAIDEN NAME OF MOTHER

Flora Hosier

13. BIRTHPLACE OF MOTHER

(State or Country)

Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Rosie Grasser**
(Address) **Lewiston, Ida.**

15. Filled **8/9/ 19 22** **F. T. Harris, M.D.**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **July 25th 1922**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **July 25th 1922**, to **July 25th 1922**
that I last saw him alive on **July 25th 1922**
and that death occurred on the date stated above, at **9:00** P. M.
The CAUSE OF DEATH* was as follows:

strychnine poisoning
***acid.**

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) **H. B. Fouse** M. D.

19 (Address) **Lewiston, Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **Lewiston, Ida.** DATE OF BURIAL **7/28/1922**

20. UNDERTAKER **Bassar and Co.** ADDRESS **Lewiston**

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of BoyerCity of LeviRegistration District No. 96Primary Registration District No. 1009

(No. _____ St.)

File No. 39097Registered No. 134

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Viola M. McAllister

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDSingle
(Write the words)

6. DATE OF BIRTH

June 16 1 900
(Month) (Day) (Year)

7. AGE

22 Yrs. 1 Mos. 9 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

School Teacher

(b) General nature of industry, business or establishment in which employed (or employer).

Grade School

9. BIRTHPLACE

(State or Country)

Nebr.

10. NAME OF FATHER

S. A. McAllister

11. BIRTHPLACE OF FATHER

(State or Country)

Pa.

12. MAIDEN NAME OF MOTHER

Ida I. Smith

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

S. A. McAllister

(Address)

Rendrick Idaho

15.

Filed 8/9/1922F. T. Harris, M.D.

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 25 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 21st 1922 to July 25th 1922
that I last saw him alive on July 25th 1922
and that death occurred on the date stated above, at 3:54 P.M.

The CAUSE OF DEATH* was as follows:

Sepsis(Duration) _____ Yrs. _____ mos. 9 ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

J. H. Pouse M.D.
19 _____ (Address) Levi, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rendrick Idaho 19 _____

20. UNDERTAKER

ADDRESS

Vassar Undertaking Co. Levi, Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Wayne Registration District No. 96
 City of Lewiston Primary Registration District No. 1009
 (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Edward W. Denham

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 35098
 Registered No. 133

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
 (Write the word.)

6. DATE OF BIRTH

June 29 1986
 (Month) (Day) (Year)

7. AGE

54 Yrs. 0 Mos. 18 ds.

IF LESS than 1 day
 how many _____ hrs.
 or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Farmer
 (b) General nature of industry, business or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country) Ky.

10. NAME OF FATHER

Thos. J. Denham

11. BIRTHPLACE OF FATHER

(State or Country) Texas

12. MAIDEN NAME OF MOTHER

Lucy Sanders

13. BIRTHPLACE OF MOTHER

(State or Country) Ky.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Rose Wright
 (Address) Lewiston, Id.

15.

Filed 8/9/ 1922 F. T. Harris, M.D.
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 17th 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 5 1922, to July 17 1922,
 that I last saw him alive on July 12 1922,
 and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Laurel of Liver

(Duration) 2 Yrs. _____ mos. _____ ds.

Contributory (Secondary) with pneumonia

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) July 18 Alley M. D.

19. (Address) Lewiston

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Caldesac, Idaho

DATE OF BURIAL

19 _____

20. UNDERTAKER

ADDRESS Lewiston, Id.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

AUG 17

CERTIFICATE OF DEATH

1. PLACE OF DEATH

Registration District No. 96
 County of Jefferson Primary Registration District No. 1009
 City of Leicester (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ellen Shidlar

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 33009
 Registered No. 132

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widow
(Write the word.)

6. DATE OF BIRTH

unknown (Month) _____ (Day) _____ 1 (Year) _____

7. AGE

57 Yrs. _____ Mos. _____ ds.

IF LESS than 1 day
 how many _____ hrs.
 or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Ill.

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ray Garrison

(Address)

Leicester, Ill.

15.

Filed

8/9/ 19 22

F. T. Harris, M.D.
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 16 19 22
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 23 19 22, to July 16 19 22

that I last saw him alive on July 15 19 22
 and that death occurred on the date stated above, at 1 A.M.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis - Pneumonia
Unusual Branches - Pneumonia

(Duration) unknown yrs. _____ mos. _____ ds.

Contributory
 (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

W. O. Clark

M. D.

7/12 19 22 (Address) Leicester, Mo.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Prof. Ahlsbaker

19

20. UNDERTAKER

ADDRESS

Vassar and Leicester, Ill.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Nez Perce
City of LeavistonRegistration District No. 96Primary Registration District No. 1009

(No. _____)

(St. _____)

File No. 39100Registered No. 131

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Josephine Leachman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widow
(Write the word.)

6. DATE OF BIRTH

May 12th 1844
(Month) (Day) (Year)

7. AGE

78 Yrs. 2 Mos. 3 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

at home

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ida

10. NAME OF FATHER

W. Leachman

11. BIRTHPLACE OF FATHER

(State or Country)

Ida

12. MAIDEN NAME OF MOTHER

Phoebe Whitman

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Don Leachman
Leaviston, Idaho

15.

Filed 8/9/ 1922F.T. Harris, M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 15 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19that I last saw him alive on 19and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia(Duration) _____ Yrs. 3 mos. 3 ds.Contributory (Secondary) Fracture of head of femur
left leg.(Duration) _____ Yrs. 40 mos. 40 ds.(Signed) Edgar L. White M. D.July 17, 1922 (Address) Leaviston, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ Yrs. _____ mos. _____ days. In the State _____ Yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Leaviston Ida 7/17/1922

20. UNDERTAKER

ADDRESS

Boassar and Co. Leaviston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH
 County of Levy
 City of Levinston
 Registration District No. 96
 Primary Registration District No. 1009
 (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Joe Gentry

39101

State of _____
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 129

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
 (Write the word.)

6. DATE OF BIRTH

Feb. 22 1899
 (Month) (Day) (Year)

7. AGE

23 Yrs. 5 Mos. 18 ds.

IF LESS than 1 day
 how many _____ hrs.
 or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer)

Contractor
Rock Crusher

9. BIRTHPLACE

(State or Country)

N. Car.

10. NAME OF FATHER

John E. Gentry

11. BIRTHPLACE OF FATHER

(State or Country)

N. Car.

12. MAIDEN NAME OF MOTHER

Celia E. Green

13. BIRTHPLACE OF MOTHER

(State or Country)

N. Car.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Wm. J. Gentry
Cottonwood Idaho

15.

Filed 8/9/1922

F.T. Harris, M.D.

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 10 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 4 1922, to July 10 1922
 that I last saw him alive on July 10 1922
 and that death occurred on the date stated above, at 3:30 P.M.

The CAUSE OF DEATH* was as follows:

Peritonitis & General
Depress

(Duration) Yrs. 0 mos. 0 ds.

Contributory (Secondary)

(Duration) Yrs. 0 mos. 0 ds.

(Signed)

Elmer G. Bradley M.D.
July 11, 1922 (Address) Levinston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cottonwood Idaho 19

20. UNDERTAKER

ADDRESS

Gentry Place

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

39102

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 96
County of Payson Primary Registration District No. 1009
City of Payson (No. 1009) St. Idaho

File No. 128

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John J. Johnson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH

Apr 15 1922
(Month) (Day) (Year)

7. AGE

65 Yrs. 2 Mos. 24 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Farmer

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

unknown

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Caroline Johnson
(Address) 423 8th St. Clarkston, Id.

15.

Filed 8/9/1922 F. T. Harris, M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 9 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from June 21 1922 to July 3 1922
that I last saw him alive on July 3 1922
and that death occurred on the date stated above, at 10 am.

The CAUSE OF DEATH* was as follows:

Cardiac Dropsy

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) E. F. Gorman M. D.19. (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Lewiston Ida.

DATE OF BURIAL

July 13 1922

20. UNDERTAKER

Sassar and Co.

ADDRESS

Lewiston Ida.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 96
County of Myers Primary Registration District No. 1009
City of Twister (No. 1009 St.)File No. 39103
Registered No. 129

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Margery Lucille Anderson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH

July (Month) 5th (Day) 1922 (Year)

7. AGE

3 Yrs. 3 Mos. 3 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Infant

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Manfred Anderson

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Grace Smeltzer

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Manfred Anderson

(Address)

Twister Idaho

15.

Filed

8/9/22 F. J. Harris
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July (Month) 8th (Day) 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 2 1922 to July 8 1922
that I last saw him alive on July 8 1922
and that death occurred on the date stated above, at 7:30 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary atelectasis

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) W. O. Clark M. D.1922 (Address) Twister Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Twister Idaho July 9 1922

20. UNDERTAKER

ADDRESS

Twister Idaho

2. FULL NAME

MEDICAL CERTIFICATE OF DEATH

Local Registrar

DATE OF BURIAL.

ADDRESS

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 96
County of Blaine AUG 10 1922
Primary Registration District No. 1009
City of Lewiston (State) Idaho

If death occurs away from usual residence, give facts called for under special information.

File No. 39105
Registered No. 122

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Leslie Kinsella

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word)

6. DATE OF BIRTH

Apr 5 1910
(Month) (Day) (Year)

7. AGE

12 Yrs. 3 Mos. — ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)School Boy

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

J. J. Kinsella

11. BIRTHPLACE OF FATHER

(State or Country)

Iowa

12. MAIDEN NAME OF MOTHER

Reta Hurley

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. J. Kinsella

(Address)

Godwin Street, 326 - 8th St.

15.

Filed

8/9/22 F. J. Harris
Local Registrar

16. DATE OF DEATH

July 5 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from July 5 - 1922 to July 5 - 1922 that I last saw him alive on July 5, 1922 and that death occurred on the date stated above, at 6:15 P.M.

The CAUSE OF DEATH* was as follows:

Fracture of skull extending into brain.

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) A. H. Hays M. D.7/6 1922 (Address) Lewiston, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lewiston, Ida 7/7 1922

20. UNDERTAKER

ADDRESS

Bassar and Co. Lewiston, Ida

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39106**
Registered No. **123**

1. PLACE OF DEATH

Registration District No. **96**
County of **They were REC V33** Primary Registration District No. **1009**
City of **Levinston AUG 1 1922** (No. **1002** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Innesdale

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Single**
(Write the word.)

6. DATE OF BIRTH

June 4 1853
(Month) (Day) (Year)

7. AGE

69 Yrs. **1** Mos. **1** ds.IF LESS than 1 day
how many..... hrs
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).**retired**
Farmer.

9. BIRTHPLACE

(State or Country)

West Sterling Ill

10. NAME OF FATHER

Jesse Innesdale

11. BIRTHPLACE OF FATHER

(State or Country)

Ky.

12. MAIDEN NAME OF MOTHER

Martha Briscoe

13. BIRTHPLACE OF MOTHER

(State or Country)

Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. B. Vane
Levinston Idaho

15.

Filed

8/9/22 **F. T. Hawn**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 5 1922
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from **June 1922**, to **July 1922**
that I last saw him alive on **July 4 1922**
and that death occurred on the date stated above, at **1 A.M.**

The CAUSE OF DEATH* was as follows:

Senile Phlegm(Duration) Yrs. **6** mos. **6** ds.
Contributory (Secondary) **High blood pressure**(Duration) **5** yrs. **5** mos. **5** ds.
(Signed) **L. H. H. M. D.****19** (Address) **Levinston**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Levinston Idaho

DATE OF BURIAL

7-7 1922

20. UNDERTAKER

ADDRESS

Levinston Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 96
County of Myra Primary Registration District No. 1009
City of Lewiston St. _____File No. _____
Registered No. 124

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

clara
James

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE Indian 5. SINGLE, MARRIED, WIDOWED OR DIVORCED single
(Write the word.)

6. DATE OF BIRTH

Nov 9 1921
(Month) (Day) (Year)

7. AGE

✓ Yrs. 9 Mos. _____ ds. IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Infant
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Sweetwater Idaho

10. NAME OF FATHER

Louis James

11. BIRTHPLACE OF FATHER

(State or Country) Idaho

12. MAIDEN NAME OF MOTHER

Theresa Black Elk

13. BIRTHPLACE OF MOTHER

(State or Country) Montana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Theresa Black Elk
(Address) Sweetwater Idaho

15.

Filed 8/9/22 P. T. Harris
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 6 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from July 5 1922, to July 6 1922
that I last saw her alive on July 6 1922
and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia(Duration) about 5 days
Yrs. _____ mos. _____ ds.Contributory
(Secondary)

(Duration) Yrs. _____ mos. _____ ds.

(Signed) Paul W. Johnson M. D.7/6/1922 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. _____ mos. 2 days. In the home birth.
State Yrs. _____ mos. _____ daysWhere was disease contracted if not at place of death? Sweetwater IdahoFormer or usual residence Sweetwater Idaho

19. PLACE OF BURIAL OR REMOVAL

Sweetwater July 7 1922

20. UNDERTAKER

ADDRESS

Lewiston Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 96
County of Keyser Primary Registration District No. 1009
City of Sevierston (No. 1009 St.)File No. 33108
Registered No. 125

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(write the word.)

6. DATE OF BIRTH

Jan (Month) 10 (Day) 1922 (Year)

7. AGE

60 Yrs. 6 Mos. 6 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

at Home

9. BIRTHPLACE

(State or Country)

Oregon

10. NAME OF FATHER

James Miner

11. BIRTHPLACE OF FATHER

(State or Country)

Id

12. MAIDEN NAME OF MOTHER

Anna Bowman

13. BIRTHPLACE OF MOTHER

(State or Country)

Id

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Glenn Sampson
Sevierston Idaho

15.

Filed

8/9/22 FT Ham
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July (Month) 6 (Day) 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 3 1922 to July 6 1922
that I last saw him alive on July 6 1922
and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Intestinal Pyelitis(Duration) Yrs. 3 mos. ds.Contributory
(Secondary)Pneumonia

(Duration) Yrs. mos. ds.

(Signed)

W. O. Clark M. D.July 8, 1922 (Address) Sevierston Idaho

State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Sevierston Idaho

DATE OF BURIAL

7/7 1922

20. UNDERTAKER

ADDRESS

Sevierston Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

9^{PM} White
State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 39109
Registered No. 126

1. PLACE OF DEATH

County of

City of

Registration District No.

Primary Registration District No.

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Registration District No.

Primary Registration District No.

St.)

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

19..... to 19.....

that I last saw him..... alive on..... 19.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

FORM V, S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of *Myrtle*City of *Myrtle*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED CERTIFICATE OF DEATH

Registration District No. *97*Primary Registration District No. *5174*

BUREAU OF VITAL STATISTICS

39110

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *1*

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

Aug 19 1920
(Month) (Day) (Year)

7. AGE

1 Yrs. *11* Mos. *20* ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Myrtle - Ida.

10. NAME OF FATHER

Royden L. Hardman

11. BIRTHPLACE OF FATHER

(State or Country)

Oregon

12. MAIDEN NAME OF MOTHER

Mary - Galaher

13. BIRTHPLACE OF MOTHER

(State or Country)

Spokane Wash.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Royden L. Hardman

(Address)

Myrtle - Ida.

15. Filed

*Aug - 10 1922**Welf. an P. H. Stahl*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 9 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 8 1922 to *Aug 9 1922*that I last saw h.l.m. alive on *Aug 9 1922*and that death occurred on the date stated above, at *6 P. M.*

The CAUSE OF DEATH* was as follows:

Septic Endocarditis(Duration) Yrs. mos. *3* ds.

Contributory (Secondary)

Infectious Process(Duration) Yrs. mos. *5* ds.

(Signed)

Welf. an P. H. Stahl
Lapwai

M. D.

7/10 1922

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Myrtle

DATE OF BURIAL

Aug 10 1922

20. UNDERTAKER

Friends

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED

CERTIFICATE OF DEATH.

39111

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of My Perer Registration District No. 92
City of Summit Registration District No. 2170
St.)

File No. 7Registered No. 1

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Eva Laverna Beloit

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

single

(Write the word.)

6. DATE OF BIRTH.

Febr

(Month)

22

(Day)

1922

(Year)

7. AGE

1 Yrs. 5 Mos. 6 ds.

IF LESS than 1 day
how many.....hrs. or
.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

at home

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

James J. Beloit

11. BIRTHPLACE OF FATHER

(State or Country)

Montana

12. MAIDEN NAME OF MOTHER

Myra Stup

13. BIRTHPLACE OF MOTHER

(State or Country)

Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

J. J. Beloit

(Address)

Summit

15.

Filed

Aug 21922E. E. Watts

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug

(Month)

2

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 1 1922 to Aug 2 1922.that I last saw him alive on Aug 1 1922.and that death occurred on the date stated above, at 3 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral congestion(Duration) 1 Yrs. 2 mos. 2 ds.

Contributory (Secondary)

gastro enteritis(Duration) 1 yrs. 7 mos. 7 ds.

(Signed)

E. E. Watts

M. D.

8-2-1922 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Gifford Ida

DATE OF BURIAL

8-3-1922

20. UNDERTAKER

W. E. Stoddard

ADDRESS

Gifford

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

RECEIVED
SEP 24 1922

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Payette
City of Ranch

Registration District No.

Registration District No. 2009

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Azzie Syson Nesbitt

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 39113

Registered No. 5

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Aug 12 1922
(Month) (Day) (Year)

7. AGE

26 yrs. 8 mos. 20 ds.

IF LESS than 1 day
how many hrs. or mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

S. H. Syson

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Sarra Shaw

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. L. L. Ashley

(Address)

Murphy, Idaho

15.

Filed

8/13/1922

1922

Wm. T. Drysdale
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

August 12 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 12 1922 to Aug 12 1922
that I last saw her alive on Aug 12 1922

and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

General Gas bacillus
infection of abdominal origin
attending self attempted abortion
(Duration) yrs. mos. 1 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Wm. T. Drysdale

M. D.

8/13 1922 (Address) New Plymouth Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

Payette Ida

DATE OF BURIAL

8/14 1922

20. UNDERTAKER

J. H. Chair

ADDRESS

Payette, Ida

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of **TEDON**City of **FELT**

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
SEP 5 1922
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

(No. St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39114**

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME **JOSEPH VERLE LOOSLIE**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

MALE

4. COLOR OR RACE

WHITE5. SINGLE, MARRIED, WID-
OWED OR DIVORCED**SINGLE**
(Write the word.)

6. DATE OF BIRTH

MARCH

(Month)

3rd

(Day)

1908

(Year)

7. AGE

14

Yrs.

4

Mos.

35

ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

AT HOME

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

ASHTON IDAHO

10. NAME OF FATHER

J.F. LOOSLIE

11. BIRTHPLACE OF FATHER

(State or Country)

UTAH

12. MAIDEN NAME OF MOTHER

MINNIE CUNNINGHAM

13. BIRTHPLACE OF MOTHER

(State or Country)

UTAH

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **J.F. LOOSLIE**(Address) **FELT IDAHO**

15.

Filed **July 27 1922**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

JULY 28th 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from **July 27 1922** to **July 28 1922** that I last saw him alive on **July 28 1922** and that death occurred on the date stated above, at **8-A.M.**

The CAUSE OF DEATH was as follows:

**Chronic Valvular Heart Disease
(Chronic Endocarditis)**

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) **Chas. M. Smith** M. D.**July 27 1922** (Address) **Ashton, Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

ASHTON IDAHO

DATE OF BURIAL

7/29/ 1922

20. UNDERTAKER

LEWIS KISER

ADDRESS

ASHTON IDAHO

1. PLACE OF DEATH

County of **FREMONT**City of **ASHTON**

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
SEP 5 1922
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

103

Registration District No.

Primary Registration District No. **6**

(No. St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39115**

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME **OTTO KRAEMER**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

MALE

4. COLOR OR RACE

WHITE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

SINGLE
(Write the word.)

6. DATE OF BIRTH

OCTOBER 12TH 1903
(Month) (Day) (Year)

7. AGE

18 Yrs. 9 Mos. 19 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

AT WORK ON FARM

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

NEB

10. NAME OF FATHER

KARL KRAEMER

11. BIRTHPLACE OF FATHER

(State or Country)

GERMANY

12. MAIDEN NAME OF MOTHER

--- YEIGNER

13. BIRTHPLACE OF MOTHER

(State or Country)

GERMANY

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **E. CUNNINGHAM.**(Address) **ASHTON IDAHO**

15.

Filed **19**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

JULY 31st 1903
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended, deceased from

that I last saw him alive on

and that death occurred on the date stated above, at **8:30 P.M.**

THE CAUSE OF DEATH* was as follows:

Choked
(Duration) Yrs. mos. ds.Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) **J. P. Chargin** M. D.19 **22** (Address) **Ashton Idaho.**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

NORFOLK NEB

DATE OF BURIAL

19

20. UNDERTAKER

LEWIS KISER

ADDRESS

ASHTON IDAHO

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of **FREMONT** Registration District No. **103**
 City of **MARYSVILLE** Primary Registration District No. **6**
 (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **JAMES GEORGE WOOD**

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. **39116**

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **MALE** 4. COLOR OR RACE **WHITE** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED
WIDOWED
 (Write the word.)

6. DATE OF BIRTH
AUGUST 34th 1856
 (Month) (Day) (Year)

7. AGE **65** Yrs. **11** Mos. **18** ds.
 IF LESS than 1 day
 how many _____ hrs.
 or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. **RETIRED FARMER**
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) **ENGLAND**

10. NAME OF FATHER

GEORGE. WOOD

11. BIRTHPLACE OF FATHER

(State or Country) **ENGLAND**

12. MAIDEN NAME OF MOTHER

SARAH BARON

13. BIRTHPLACE OF MOTHER

(State or Country) **IRELAND**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **ALMA . D. WOOD**(Address) **MARYSVILLE IDAHO**

15. Filed **Aug 13 1922**
 Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51083

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

AUGUST 13th 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 10 1921 to **Aug 12 1922**
 that I last saw him alive on **Aug 12 1922**
 and that death occurred on the date stated above, at **9 A.M.**

The CAUSE OF DEATH* was as follows:

Paralysis(Duration) **2** Yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) **J. L. Chapman** M. D.

Aug 12 1922 (Address) **Ashton Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

ASHTON IDAHO

DATE OF BURIAL

8/13/22 1920. UNDERTAKER
LEWIS KISERADDRESS
ASHTON IDAHO

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH *Leton* Registration District No. *77*
 County of *Leton* Primary Registration District No. *2176*
 City of *Driggs* (No. _____) St.)

File No. *39118*Registered No. *16*

If death occurs away from
usual residence, give facts
called for under special in-
formation.

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

2. FULL NAME *Martha Austin*

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED *Married*
(Write the word.)

6. DATE OF BIRTH *May 25 1892*
(Month) (Day) (Year)

7. AGE *30* Yrs. *2* Mos. *15* ds. IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work *Housewife*
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country) *Reverburg, Ida*10. NAME OF FATHER *John B. Replinger*

11. BIRTHPLACE OF FATHER

(State or Country) *France*12. MAIDEN NAME OF MOTHER *Louise Butler*

13. BIRTHPLACE OF MOTHER

(State or Country) *Switzerland*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Henry Replinger*(Address) *Driggs Ida*

15.

Filed *Aug 30th 1922*

Martha Marker
Local Registrar

16. DATE OF DEATH *Aug 16 1922*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
July 16 1922 to *Aug 16 1922*
that I last saw him alive on *Aug 14 1922*
and that death occurred on the date stated above, at *12: M.*

The CAUSE OF DEATH* was as follows:

Embolus
Following operation for rupture of
arteries & child birth
(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) *Chas. Martin* M. D.(Address) *Driggs, Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted
if not at place of death?

Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bates Cemetery Aug 18 1922

20. UNDERTAKER

ADDRESS

W. H. King Driggs

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 39120
Registered No. 19

1. PLACE OF DEATH
County of Idaho Registration District No. 77
City of Idaho Falls Primary Registration District No. 2176
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME Marie E. Hathaway

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH 78

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)
6. DATE OF BIRTH March 26 1909
(Month) (Day) (Year)
7. AGE 13 Yrs. 5 Mos. 3 ds. IF LESS than 1 day how many hrs. or min.?
8. OCCUPATION Student
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer) School duties
9. BIRTHPLACE Utah
(State or Country)
10. NAME OF FATHER L. L. Hathaway
11. BIRTHPLACE OF FATHER Utah
(State or Country)
12. MAIDEN NAME OF MOTHER Katherine M. Lee
13. BIRTHPLACE OF MOTHER Idaho
(State or Country)
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. L. Hathaway
(Address) Idaho Falls
15. Filled Aug 30 1922 Martha Marker
Local Registrar

16. DATE OF DEATH August 29 1922
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Aug 19 1922 to Aug 29 1922
that I last saw her alive on Aug 28 1922
and that death occurred on the date stated above, at 3:45 A.
The CAUSE OF DEATH* was as follows:
Chronic Endocarditis
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) Chas. Martin M. D.
(Address) Idaho Falls
*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.
18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence
19. PLACE OF BURIAL OR REMOVAL Idaho Falls DATE OF BURIAL Aug 30 1922
20. UNDERTAKER Chas. Martin ADDRESS Idaho Falls

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH *Leton* **RECEIVED**
County of *Leton* **SEP 5 1922**
City of *sluggs* **BUREAU**
Registration District No. *77*
Primary Registration District No. *2176*
(No. _____, _____ St.)

File No. **39121**
Registered No. *98*

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME *Emiley Kimball*

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *Female* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *married*
(Write the word.)

16. DATE OF DEATH *Aug. 25-22*
(Month) (Day) (Year)

6. DATE OF BIRTH *Sept 13 1872*
(Month) (Day) (Year)

7. AGE *49* Yrs. *11* Mos. *23* ds. IF LESS than 1 day how many _____ hrs. or _____ min.?

17. I HEREBY CERTIFY, That I attended deceased from *June 25 1922* to *Aug 25 1922*, that I last saw her alive on *Aug 25 1922* and that death occurred on the date stated above, at *9:20 A.*

The CAUSE OF DEATH* was as follows:

Carcinoma of Bowel

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

Housewife
"

9. BIRTHPLACE

(State or Country)

Ill.

10. NAME OF FATHER

Edward Seymour

11. BIRTHPLACE OF FATHER

(State or Country)

New York

12. MAIDEN NAME OF MOTHER

Elyse Plumley

13. BIRTHPLACE OF MOTHER

(State or Country)

Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

R.C. Kimball

sluggs, Ida.

15.

Filed *Aug 30 1922*

Martha Marker
Local Registrar

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Chas. Martin M. D.

(Address) *sluggs, Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

sluggs Cemetery Aug 27 1922

20. UNDERTAKER

ADDRESS

sluggs

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 39123

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH **RECEIVED**
 County of Latah Registration District No. 39
 City of Buhl Registration District No. 2087 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Geo Lewis Wellman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married

6. DATE OF BIRTH Nov. 3 - 1876
 (Month) (Day) (Year)

7. AGE 45 Yrs. 8 Mos. 13 ds.
 IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Farmer
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Ida

10. NAME OF FATHER

Lewis Wellman

11. BIRTHPLACE OF FATHER

(State or Country) Not Known

12. MAIDEN NAME OF MOTHER

Joanna Hinds

13. BIRTHPLACE OF MOTHER

(State or Country) Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Oscar Hietter
 (Address) Buhl, Idaho.

15. Filed 7-16 1922

Local Registrar J. H. Murphy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

7-16 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7-15-1922 to 7-16-1922

that I last saw him alive on 7-16-1922
 and that death occurred on the date stated above, at 5 a. M.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Geo. J. Jennings M. D.7-16-1922 (Address) Buhl, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Buhl Cemetery July 16, 1922

20. UNDERTAKER

ADDRESS

Hewitt & Rugg Buhl, Ida.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Lincoln Registration District No. 39
City of Buhl Registration District No. 2087
STATISTICS (No.) _____ St.)File No. 33121
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

James Kyle Jr.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widowed

6. DATE OF BIRTH

Aug 25 1850
(Month) (Day) (Year)

7. AGE

71 Yrs. 11 Mos. - ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

James Kyle Sr.

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Mary Hitchcock

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H. W. Wulfsberg(Address) Buhl, Ida.

15.

Filed

7-271922J. H. Wulfsberg
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

7-25-22
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from 7-1-22 to 7-25-22 that I last saw him alive on 7-25-22 and that death occurred on the date stated above, at 6 A.M. The CAUSE OF DEATH* was as follows:Cancer of stomach

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

7-25-22(Address) Buhl, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

Howell Drugg - Buhl, Ida.

1. PLACE OF DEATH

County of Juin Jones District No. 59
City of Buho Primary Registration District No. 2087
STATISTIC

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Edward WoodruffState of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 39125

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH

May 25 1851
(Month) (Day) (Year)

7. AGE

71 Yrs. 2 Mos. 1 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Farmer

9. BIRTHPLACE

(State or Country)

Georgia

10. NAME OF FATHER

W. J. Woodruff

11. BIRTHPLACE OF FATHER

(State or Country)

Georgia

12. MAIDEN NAME OF MOTHER

Miss Jackson

13. BIRTHPLACE OF MOTHER

(State or Country)

Georgia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. C. Woodruff

(Address)

Buho

15.

Filed 7-27 1922J. H. Murphy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 26 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

7-4-1922 to 7-26-1922
that I last saw him alive on 7-26-1922and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Cancer of Lung

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Geo. Jennings M. D.7-26-1922 (Address) Buho Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Buho July 27 1922

20. UNDERTAKER

ADDRESS

J. Johnson Buho Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Twin FallsCity of " " BURSA

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby King.Registration District No. 37Primary Registration District No. 1080

(No.) (St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 39127
Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDSingle

(Write the word.)

6. DATE OF BIRTH

July31922

(Month)

(Day)

(Year)

7. AGE

Yrs. Mos. I ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Twin Falls, Ida.

10. NAME OF FATHER

Clay King.

11. BIRTHPLACE OF FATHER

(State or Country)

Mo.

12. MAIDEN NAME OF MOTHER

Ada Wooldridge.

13. BIRTHPLACE OF MOTHER

(State or Country)

Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W M Wooldridge.

(Address)

Twin Falls, Ida.

15.

Filed 7 10 1922John F. Coughlin
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 4 '22

(Month)

(Day)

19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 4, 1922, to July 4, 1922.

that I last saw him alive on July 4, 1922.

and that death occurred on the date stated above, at 8 PM M.

The CAUSE OF DEATH* was as follows:

Primature

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) W. F. Passer M. D.July 5, 1922 (Address) Twin Falls, Id.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Twin Falls

DATE OF BURIAL

7/5/22 19

20. UNDERTAKER

P J Grossman

ADDRESS

Twin FALLS, Ida

CERTIFICATE OF DEATH

1. PLACE OF DEATH *Twin Falls* Registration District No. *37*
County of *Twin Falls* Primary Registration District No. *1095*
City of *"* (No. *"* St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Thiemann

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. *39128*
Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*
(Write the word.)

6. DATE OF BIRTH *July 13 1922*
(Month) (Day) (Year)

7. AGE *6 mos.* IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Twin Falls

10. NAME OF FATHER

Tom Thiemann

11. BIRTHPLACE OF FATHER

(State or Country)

Kan.

12. MAIDEN NAME OF MOTHER

Sophia Johnson

13. BIRTHPLACE OF MOTHER

(State or Country)

Kan.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Tom Thiemann

(Address)

Twin Falls Id.

15. Filed *7 12 1922*

John F. Coe
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 13 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *July 13th 1922* to *July 13th 1922* that I last saw her alive on *July 13 1922* and that death occurred on the date stated above, at *6 p. M.* The CAUSE OF DEATH* was as follows:

Premature 7 mo.

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) *Samuel L. Alexander* M. D.

7/10 1922 (Address) *Twin Falls Id.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Twin Falls Id. *July 14 1922*

20. UNDERTAKER

ADDRESS

J. F. Grossman *Twin Falls Id.*

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH **RECEIVED**
 County of Idaho Registration District No. 37
 City of Idaho Falls Primary Registration District No. 1085
 (No. Idaho St.)

 File No. 39132
 Registered No. _____

 If death occurs away from
 usual residence, give facts
 called for under special in-
 formation.

2. FULL NAME

Moses Jones

 If death occurred in a hos-
 pital, institution or camp,
 give its NAME instead of
 street and number.

PERSONAL AND STATISTICAL PARTICULARS

 3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED Married

6. DATE OF BIRTH

Nov 7 1883
 (Month) (Day) (Year)

7. AGE

68 Yrs. 8 Mos. 17 ds.

 IF LESS than 1 day
 how many..... hrs.
 or..... min.?

8. OCCUPATION

 (a) Trade, profession or
 particular kind of work.
 (b) General nature of in-
 dustry, business or estab-
 lishment in which employ-
 ed (or employer).

Machanic
Mine Machinery

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

John Jones

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Elizabeth Jones

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs Moses Jones

(Address)

Idaho Falls, Ida

15.

 Filed Aug. 9 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 24 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

6/16/1922 to 7/24/1922
 that I last saw him alive on 7/21/1922
 and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach
(Duration) Yrs. 4 mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. D. Fisher M. D.

7/24/1922 (Address) Idaho Falls, Ida

 *State the Disease Causing Death; or in deaths from Violent Causes, state
 (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.
18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

 Where was disease contracted
 if not at place of death?
Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Idaho Falls

DATE OF BURIAL

7/26 1922

20. UNDERTAKER

P. J. Brown

ADDRESS

Idaho Falls

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *San J. Falls* Registration District No. *37*
City of *San J. Falls* (No. *1085*) St. *Idaho*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Edith May Phiffs*File No. *39133*
Registered No. *103*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*

6. DATE OF BIRTH

Sept 20 1921
(Month) (Day) (Year)

7. AGE

Yrs. *10* Mos. *8* ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)*Infant*

9. BIRTHPLACE

(State or Country) *Idaho*

10. NAME OF FATHER

James H. Phiffs

11. BIRTHPLACE OF FATHER

(State or Country) *Idaho*

12. MAIDEN NAME OF MOTHER

Katy Walster

13. BIRTHPLACE OF MOTHER

(State or Country) *France*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *James H. Phiffs*
(Address) *San J. Falls*

15.

Filed *Aug. 9-* 1922 *John J. Coughlin*
Local Registrar

16. DATE OF DEATH

July 29 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *July 28* 1922, to *July 28* 1922
that I last saw him alive on *July 28* 1922
and that death occurred on the date stated above, at *12* P.M.
The CAUSE OF DEATH* was as follows:*Acute Bacterial Enteritis*(Duration) Yrs. mos. *5* ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *H. J. Lister* M. D.*July 28 1922* (Address) *San J. Falls*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

San J. Falls *July 28* 1922

20. UNDERTAKER

ADDRESS

San J. Falls

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39134**

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of **Twin Falls** Registration District No. **37**
Primary Registration District No. **1085**
City of " " (No. **County Hospital**) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

May D Longtie

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female **White** **Married**
(Write the word.)

6. DATE OF BIRTH

May 12 1880
(Month) (Day) (Year)

7. AGE

42 Yrs. **2** Mos. **14** ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)**Housewife**

9. BIRTHPLACE

(State or Country)

Kas

10. NAME OF FATHER

George Darby

11. BIRTHPLACE OF FATHER

(State or Country)

Not known.

12. MAIDEN NAME OF MOTHER

" "

13. BIRTHPLACE OF MOTHER

(State or Country)

" "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Geo. C. Longtie
Twin Falls, Ida
143 - 71 - Elm

15.

Filed

Aug. 9 - 1922**John T. Longtie**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 26 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

7/24 1922 to **7/26 1922**
that I last saw **her** alive on **7/25 1922**and that death occurred on the date stated above, at **9 A.M.**

The CAUSE OF DEATH* was as follows:

hemorrhage into ovarian cyst(Duration) Yrs. mos. **4** ds.

Contributory (Secondary)

Laparotomy(Duration) yrs. mos. **2** ds.

(Signed)

W. G. Piper M. D.(Address) **Twin Falls, Ida**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Southwick, Ida **19**

20. UNDERTAKER

ADDRESS

P. J. Grossman, Twin Falls

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH **RECEIVED**
 County of **Sanford** Registration District No. **37**
 City of **Boise** Primary Registration District No. **1085**
 (No. St.)

 File No. **39135**
 Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Elebeth Danner

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

 3. SEX **female** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **single**

6. DATE OF BIRTH

march 13
 (Month) (Day) (Year)

7. AGE

8 Yrs. **4** Mos. **15** ds.
 IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

 (a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).
Infant

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Lildon Danner

11. BIRTHPLACE OF FATHER

(State or Country)

Linn

12. MAIDEN NAME OF MOTHER

Lewite Tidwell

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. A. Danner
345 Harrison

15.

Filed

Aug 9 19**22** **John Thompson**
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 31 19**22**
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 28 19**22**, to **July 30** 19**22**,
 that I last saw him alive on **July 30** 19**22**,
 and that death occurred on the date stated above, at **9 A.M.**

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia (Double)
Not known as I only attended
case 2 days. Yrs. mos. ds.
Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

P. A. Danner

M. D.

19

(Address)

Turn Falls, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Turn Falls

DATE OF BURIAL

8-1 19**22**

20. UNDERTAKER

L. E. Smith

ADDRESS

Turn Falls

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Turner Registration District No. 37
 City of Turner Primary Registration District No. 1085
 (No. _____) (St.) _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

James Barnes

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 39136

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male white Single
 (Write the word.)

6. DATE OF BIRTH

Sep 4 1904
 (Month) (Day) (Year)

7. AGE

17 Yrs. 11 Mos. 0 ds.

IF LESS than 1 day
 how many _____ hrs.
 or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

School Boys

9. BIRTHPLACE

(State or Country) Okla

10. NAME OF FATHER

S M Barnes

11. BIRTHPLACE OF FATHER

(State or Country) Kansas

12. MAIDEN NAME OF MOTHER

Lois Altemus

13. BIRTHPLACE OF MOTHER

(State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

James S. Barnes
Hansen Ida

15.

Filed

Aug. 9 1922 John Floughlin

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

8 - 4 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1st 1922 to Aug 4th 1922
 that I last saw him alive on Aug 4th 1922
 and that death occurred on the date stated above, at 8 PM.
 The CAUSE OF DEATH* was as follows:

Edocarditis Acute Streptococci

(Duration) _____ Yrs. _____ mos. 10 ds.

Contributory General Streptococci Infection
 (Secondary)

(Duration) _____ Yrs. _____ mos. 14 ds.

(Signed) Samuel L. H. + under M. D.

4 1922 (Address) Turner Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Turner Falls

8 - 5 - 1922

20. UNDERTAKER

ADDRESS

L. E. DeWitt

Turner Falls

1. PLACE OF DEATHY **Twinn Falls** **RECEIVED** Registration District No. **37**
 County of **Twinn Falls** Primary Registration District No. **1085**
 City of **"** (No. **"** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Dorothy Marie Dazley

Sawyer
 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. **39137**
 Registered No. **1526**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Single**
 (Write the word.)

6. DATE OF BIRTH

Apr 17 1922
 (Month) (Day) (Year)

7. AGE

3 3
 Yrs. Mos. ds.

IF LESS than 1 day
 how many..... hrs.
 or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

A. E. Dazley

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Clara Ann Taylor

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

A. E. Dazley
Twinn Falls, Id.

15.

Filed **Aug 9 - 1922**

John F. Leung
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 20 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 19 1922 to **June 20 1922**
 that I last saw **her** alive on **June 20 1922**
 and that death occurred on the date stated above, at **10:30 P.M.**

The CAUSE OF DEATH* was as follows:

Status Lymphaticus

(Duration) Yrs. **3** mos. **3** ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed)

A. E. Sawyer

M. D. O.

7-21-1922 (Address) **Twinn Falls, Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Twinn Falls

11/24 1922

20. UNDERTAKER

ADDRESS

J. F. Grossman

Twinn Falls, Idaho

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Twin FallsCity of Rogerson

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Robert HardyRegistration District No. 37Primary Registration District No. 2086-

(No. St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 39138

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Male

White

Single
(Write the word.)

6. DATE OF BIRTH

Mar 24 1882
(Month) (Day) (Year)

7. AGE

40 Yrs. 3 Mos. 7 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Farmer

(b) General nature of industry, business or establishment in which employed (or employer).

Stockman

9. BIRTHPLACE

(State or Country) Nev.

10. NAME OF FATHER

E C Hardy.

11. BIRTHPLACE OF FATHER

(State or Country) Mass.

12. MAIDEN NAME OF MOTHER

Mary H snook.

13. BIRTHPLACE OF MOTHER

(State or Country) Pa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dell Hardy(Address) Rogerson, Ida.

15.

Filed 4 10 1932Local Registrar John F. Goughlin

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 1st '22 19.....
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

..... 19..... to 19.....
that I last saw h..... alive on 19.....
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

ecrasy showed valvular heart disease & acute dilatation of heart.

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) John F. Goughlin M. D.7.3 1922 (Address) Twin Falls Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Twin Falls7/3/22 19.....

20. UNDERTAKER

ADDRESS

P J GrossmanTwin Falls

RECEIVED
BUREAU

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 39139
Registered No.1. PLACE OF DEATH
County of Twin Falls
City of Hansen
Registration District No. 39
Primary Registration District No. 2085
(No.) (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Walter W Lowery

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Male White Married

6. DATE OF BIRTH

Sept 17 1853
(Month) (Day) (Year)

7. AGE

68 Yrs 10 Mos - ds

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Farmer
Owner

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

Joseph W Lowery
Pa

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Mary Dimmons
Pa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J.E. Lowery
Hansen Ida

15.

Filed 4 20 1922

John H. Laughlin
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 17 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 3rd 1922 to July 17th 1922 that I last saw him alive on July 17 1922 and that death occurred on the date stated above, at M. The CAUSE OF DEATH* was as follows:

Acute Dilatation Heart

(Duration) Yrs. mos. ds.
Contributory Chronic Intestinal Disease
(Secondary) Mitral Regurgitation Nephritis
(Duration) 3 yrs. mos. ds.(Signed) Simeon L. Alexander
7/18 1922 (Address) Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Twin Falls 7/19 1922

20. UNDERTAKER

ADDRESS

R.J. Grossman
Twin Falls Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39140**
Registered No. _____

1. PLACE OF DEATH

County of **Twin Falls**

City of _____

Registration District No. **39**Primary Registration District No. **1085**

(No. _____)

(St.) _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Etta L Kopf**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widow

(Write the word.)

6. DATE OF BIRTH

Jan.**26****1875**

(Month)

(Day)

(Year)

7. AGE

46

Yrs.

9

Mos.

22

ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business or establishment in which employed (or employer)

Retired

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

Chas Flowerdew

11. BIRTHPLACE OF FATHER

(State or Country)

Eng.

12. MAIDEN NAME OF MOTHER

Carrie E Valintine

13. BIRTHPLACE OF MOTHER

(State or Country)

Pa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Chas Flowerdew

(Address)

Twin Falls, Ida

15.

Filed

7 20**1922****John F Coughlin**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July**18****'22****19**

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 18 1922 to July 18 1922
that I last saw him alive on **July 18 1922**
and that death occurred on the date stated above, at **10:00 PM**

The CAUSE OF DEATH* was as follows:

Strangulated Hernia (umbilical)(Duration) _____ Yrs. _____ mos. **4** ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Har Wilson M. D.(Address) **Twin Falls, Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Twin Falls**19**

20. UNDERTAKER

ADDRESS

P J Grossman

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Twin Falls Registration District No. 1080
City of " St. "

File No. 39141
Registered No. 63

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ward Dwyer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH Don't Know
(Month) (Day) (Year)

7. AGE About 35 IF LESS than 1 day
Yrs. Mos. ds. how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Laborer

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

LT

11. BIRTHPLACE OF FATHER

(State or Country)

Iowa

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) County Hospital Records
(Address) Twin Falls

15. Filed 7 18 1922 John F. Coe Idaho
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 12 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 16th 1922 to July 12 1922
that I last saw him alive on July 12 1922
and that death occurred on the date stated above, at 10 P.M.
The CAUSE OF DEATH* was as follows:

Sclerosis of Brain + cord
(Duration) 2 Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Samuel R. Alexander M. D.
7/15 1922 (Address) Twin Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Twin Falls DATE OF BURIAL 7-17 1922

20. UNDERTAKER R. J. Grossman ADDRESS Twin Falls

FORM V. S. No. 5-25 M. 1-16-13

1. PLACE OF DEATH.

County of *Lewis*City of *Mason Butte*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Angie Wapshile

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married

(Write the word.)

6. DATE OF BIRTH.

Dec. 21

(Month)

21

(Day)

1903

(Year)

7. AGE

18 Yrs. *7* Mos. *7* ds.IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

House keeper

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Chas. America

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Maattie Corbett

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Eugene F. Corbett

(Address)

Kamiah

15.

Filed

*1/24**1912**J. H. Hallberg*

Local Registrar

CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

St.

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *39142*

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July

(Month)

28

(Day)

1912

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 1912 to *about* *1912*that I last saw her alive on *July 24* *1912*and that death occurred on the date stated above, at *7* A. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(Duration) *1* Yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *E. H. Ryan* M. D.*81* (Address) *Kamiah, Id.*

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Ind. Cem No 1

DATE OF BURIAL

8/1 *1912*

20. UNDERTAKER

E. J. Johnson

ADDRESS

Kamiah

1. PLACE OF DEATH

County of *Lyon*City of *Buhl*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Rose E. Christall

CERTIFICATE OF DEATH

RECEIVED
S. P. M. 2
BUREAU OF
STATISTICS

Registration District No.

Registration District No. *2086*

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *39143*

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Sept. 27 1901
(Month) (Day) (Year)

7. AGE

21 Yrs. *21* Mos. *21* ds.IF LESS than 1 day
how many *21* hrs.
or *21* min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

None

(b) General nature of industry, business or establishment in which employed (or employer).

None

9. BIRTHPLACE

(State or Country)

Buhl

10. NAME OF FATHER

Nelson Christall

11. BIRTHPLACE OF FATHER

(State or Country)

Mo.

12. MAIDEN NAME OF MOTHER

Francis Briggs

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Dr. Jas. M. Moyer

(Address)

Buhl, Ida.

15. FILED

Aug 5 1922

19

A. G. Newberry

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 28 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *July 28 1922* to *July 28 1922*
that I last saw her alive on *July 28 1922*
and that death occurred on the date stated above, at *11 P.M.*
The CAUSE OF DEATH* was as follows:*Pneumonia*

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

James M. Moyer M. D.(Address) *Buhl, Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

at birth

Former or usual residence

Buhl, Ida.

19. PLACE OF BURIAL OR REMOVAL

St. Joseph's Cemetery

DATE OF BURIAL

July 29 1922

20. UNDERTAKER

J. C. Drake

ADDRESS

Buhl, Ida.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH

Bureau of Vital Statistics

File No. 39144

Registered No. _____
If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

1. PLACE OF DEATH
County of *Idaho Falls* Registration District No. *38*
City of *Filer* Primary Registration District No. *2086*
If death occurs away from
usual residence, give facts
called for under special
information.

2. FULL NAME *Francis Reese*

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED. *married*
(Write the word.)

6. DATE OF BIRTH *June 23 1854*
(Month) (Day) (Year)

7. AGE *78* Yrs. *2* Mos. *—* ds.
IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of in-
dustry, business, or estab-
lishment in which em-
ployed (or employer) *Jarner*

9. BIRTHPLACE

(State or Country)

10. NAME OF
FATHER *Jas. Reese*11. BIRTHPLACE
OF FATHER *Wales*

(State or Country)

12. MAIDEN NAME
OF MOTHER13. BIRTHPLACE
OF MOTHER *Wales*

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mrs. Nettie Barrow*
(Address) _____

15. *Aug 24 1911* *A. A. Newberry*
Filed _____ 1911 _____
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *Aug 23 1922*
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from
June 1 1911 to *Aug 23 1911*
that I last saw him alive on *Aug 21 1911*
and that death occurred on the date stated above, at *8 P.* M.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary) _____
(Duration) _____ Yrs. _____ mos. _____ ds.
(Signed) *A. A. Newberry* M. D.
Aug 24 1911 (Address) *Filer, Ida*

*State the Disease Causing Death; or in deaths from Violent
Causes, state (1) Means of Injury; and (2) whether Accidental,
Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place _____ In the
of death _____ yrs. _____ mos. _____ days, State _____ yrs. _____ mos. _____ days

Where was disease contracted
if not at place of death? _____

Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL *1007 Cornish* DATE OF BURIAL *Aug 25 1922*

20. UNDERTAKER *J. H. Drake* ADDRESS *Filer*

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS
should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement
of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39145**
Registered No. _____

1. PLACE OF DEATH
County of *Idaho* Registration District No. *37*
City of *Idaho Falls* Primary Registration District No. *1085*
If death occurs away from usual residence, give facts called for under special information.
Idaho Falls Community Hospital St.)
2. FULL NAME *Garrett Howard Ross*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*
(Write the word.)

6. DATE OF BIRTH *June 18* 19*99*
(Month) (Day) (Year)

7. AGE *3* Yrs. *25* Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE *Utah*
(State or Country)

10. NAME OF FATHER *J. J. Ross Jr.*

11. BIRTHPLACE OF FATHER *Va.*
(State or Country)

12. MAIDEN NAME OF MOTHER *Leah Marshall*

13. BIRTHPLACE OF MOTHER *Va.*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *J. J. Ross Jr.*
(Address) *Rupert, Ida.*

15. Filed *Sept. 1* 19*22* *John F. Longhien*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *Aug 13* 19*22*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Aug 11* 19*22* to *Aug 13* 19*22*
that I last saw him alive on *Aug 13* 19*22*
and that death occurred on the date stated above, at *10* M.

The CAUSE OF DEATH* was as follows:

Adhesions causing bowel obstruction

(Duration) Yrs. mos. *7* ds.
Contributory (Secondary) *acidosis*

(Duration) yrs. mos. *7* ds.
(Signed) *John F. Longhien* M. D.
8-13-22 (Address) *Idaho Falls*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Rupert* DATE OF BURIAL *19*

20. UNDERTAKER *R. J. Grossman* ADDRESS *Idaho Falls Ida.*

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Twin Falls* Registration District No. *1085*
City of *Twin Falls* (State)File No. *38146*

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant Lansberry

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

M *white* *Infant*
(Write the word.)

6. DATE OF BIRTH

aug 11 19*22*
(Month) (Day) (Year)

7. AGE

2 hr IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)*Infant*

9. BIRTHPLACE

(State or Country) *Idaho*

10. NAME OF FATHER

Charles Lansberry

11. BIRTHPLACE OF FATHER

(State or Country) *Nebr*

12. MAIDEN NAME OF MOTHER

Emily Jensen

13. BIRTHPLACE OF MOTHER

(State or Country) *Utah*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mrs. Alice Shiffer*

(Address) _____

15.

Filed *Sept 1 -* 19*22**John F. Langhlin*
Local Registrar

16. DATE OF DEATH

aug 11 19*22*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

On Aug 11 19*22*
that I last saw him alive on *8/11* 19*22*
and that death occurred on the date stated above, at *8:10 P.M.*

The CAUSE OF DEATH* was as follows:

Premature(Duration) _____ Yrs. _____ mos. _____ ds.
Contributory
(Secondary)(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) *E. D. Weaver* M. D.

19 _____ (Address) _____

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs _____ mos _____ days. In the State _____ yrs _____ mos _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Twin Falls**aug 12 1922*

20. UNDERTAKER

ADDRESS

*Ed Kurt**Twin Falls*

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Twin Falls* Registration District No. *37*
City of *"* Registration District No. *1085*
No. *923 Elm St* St.)File No. *39147*

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWER OR DIVORCED

Female *White* *Single*

6. DATE OF BIRTH

June 15 1916
(Month) (Day) (Year)

7. AGE

6 Yrs. *—* Mos. *24* ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed *Sept 1* 19*22*

Local Registrar

16. DATE OF DEATH

Aug 9th 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *Aug 6 1922* to *Aug 8 1922*
that I last saw him alive on *Aug 7 1922*
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Intestinal Toxemia(Duration) Yrs. mos. *3* ds.Contributors *Hypertrophic Thyroidism*
(Secondary) *probably with*(Duration) Yrs. mos. *1* ds.(Signed) *W. G. Ross* M. D.*Aug 9 1922* (Address) *Twin Falls, Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Twin Falls, Ida *8/11 1922*

20. UNDERTAKER

ADDRESS

R. J. Grossman *Twin Falls Ida*

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH *June Falls* Registration District No. *37*
 County of *June Falls* Primary Registration District No. *1085*
 City of *June Falls* (No. *Community Hospital* St.)

File No. *39448*

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Donald Wesley Hughes
 If death occurred in a hospital, institution or camp, give it NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Infant*

6. DATE OF BIRTH

July 11 1918
 (Month) (Day) (Year)

7. AGE

4 Yrs. *28* Mos. *ds.*

IF LESS than 1 day
 how many _____ hrs.
 or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

Infant

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Carl Hughes

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

May Talby

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Carl Hughes

(Address)

Hansen Idaho

15.

Filed

Sept. 10 1922

John F. Loughlin
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 9 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 4 1922, to *Aug 9 1922*
 that I last saw him alive on *Aug 9 1922*
 and that death occurred on the date stated above, at *8:00 P.M.*

The CAUSE OF DEATH* was as follows:

acute nephritis

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed)

Edmund

8-9 1922 (Address) *June Falls Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

June Falls

Aug 11 1922

20. UNDERTAKER

ADDRESS

J. E. Scott

June Falls

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *San* Registration District No. *37*
City of *1* Primary Registration District No. *2485*
St. *P. R.*File No. *39149*

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME *Infant Foster*

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Infant*

6. DATE OF BIRTH

Aug 13 19*22*
(Month) (Day) (Year)

7. AGE

0 Yrs. *0* Mos. *0* ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work *C*
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) *Idaho*

10. NAME OF FATHER

N M Foster

11. BIRTHPLACE OF FATHER

(State or Country) *Kansas*

12. MAIDEN NAME OF MOTHER

Saddie Edmonson

13. BIRTHPLACE OF MOTHER

(State or Country) *Kansas*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *J. F. Loughlin*(Address) *San Falls*

15.

Filed *Sept 1* 19*22*Local Registrar *J. F. Loughlin*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 13 19*22*
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *8-13* 19*22* to _____ 19____

that I last saw him alive on _____ 19____

and that death occurred on the date stated above, at *2* P.M.

The CAUSE OF DEATH* was as follows:

Sudden

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) *T. S. Watson* M. D.*8-13-1922* (Address) *San Falls*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

San Falls Ranch

DATE OF BURIAL

8-15 19*22*

20. UNDERTAKER

J. F. Loughlin Home *San Falls*

CERTIFICATE OF DEATH

1. PLACE OF DEATH

Registration District No. 37County of JeromeCity of EdenPrimary Registration District No. 2085

St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
SEP 1 1922
JEROME VITAL
REGISTERGladys Nora CraigState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 39150

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

FemaleWhite

(Write the word.)

6. DATE OF BIRTH

Jan
(Month)31
(Day)1920
(Year)

7. AGE

2 Yrs. 6 Mos. 7 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Infant

9. BIRTHPLACE

(State or Country)

Jerome County

10. NAME OF FATHER

John Craig

11. BIRTHPLACE OF FATHER

(State or Country)

Nebraska

12. MAIDEN NAME OF MOTHER

Bertha Hughes

13. BIRTHPLACE OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs Bertha Craig

(Address)

Eden

15.

Filed Sept. 1-22 1922John E. Thompson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

91

16. DATE OF DEATH

Aug.
(Month)7
(Day)1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

8/1 1922 to 8/7 1922
that I last saw her alive on 8/7 1922
and that death occurred on the date stated above, at 49 M.

The CAUSE OF DEATH* was as follows:

Pneumonia(Duration) _____ Yrs. _____ mos. 8 ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W. P. Scroggs M. D.8/7 1922 (Address) Eden, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Funeral19

20. UNDERTAKER

ADDRESS

EdenFuneral

CERTIFICATE OF DEATH

Morgan
State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH *Twin Falls* Registration District No. *37*
County of *Twin Falls* Primary Registration District No. *1005*
City of *"* St.)

File No. *39151*
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Walter B. Peterman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*

6. DATE OF BIRTH

Aug 9 1922
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

Yrs. *18* Mos. _____ ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Twin Falls Ida

10. NAME OF FATHER

J. G. Peterman

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Hazel S. Robst.

13. BIRTHPLACE OF MOTHER

(State or Country)

Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. G. Peterman
Twin Falls

15.

Filed *Sept. 1-22 19*

John S. Loughlin
Local Registrar

MEDICAL CERTIFICATE OF DEATH

152-b

16. DATE OF DEATH

Aug 27 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 25 1922 to *Aug 27 1922*
that I last saw him alive on *Aug 26 1922*
and that death occurred on the date stated above, at *29* M.

The CAUSE OF DEATH* was as follows:

Hemolytic Jaundice
Amputation

(Duration) _____ Yrs. _____ mos. *10* ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

J. R. Morgan M. D.

9-29 1922 (Address) *Twin Falls, Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Twin Falls

Aug 29 1922

20. UNDERTAKER

ADDRESS

J. R. Morgan

Twin Falls

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39152**

1. PLACE OF DEATH
County of Lewin Registration District No. 37
City of Lewin Primary Registration District No. 1085
(No.) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Martine Barry

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married

6. DATE OF BIRTH

1 Nov (Month) 18 (Day) 1843 (Year)

7. AGE

78 Yrs. 8 Mos. 29 ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Shoe maker
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Ireland

10. NAME OF FATHER

Martine Barry

11. BIRTHPLACE OF FATHER

(State or Country) Ireland

12. MAIDEN NAME OF MOTHER

Julia Moriarity

13. BIRTHPLACE OF MOTHER

(State or Country) Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Miss Agnes Barry

(Address)

Hutchinson Ida

15.

Filed Sept 1 1922

John F. Baughlin
Local Registrar

16. DATE OF DEATH

Aug (Month) 17 (Day) 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 1 1922 to Aug 17 1922
that I last saw him alive on Aug 17 1922
and that death occurred on the date stated above, at 8 P. M.
The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(Duration) 10 Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Hub Wilson M. D.

(Address) Lewin Falls, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lewin Falls

Aug. 21, 1922

20. UNDERTAKER

ADDRESS

J. J. Harrison Lewin Falls

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Washington
City of WenatcheeRegistration District No. 86Primary Registration District No. 1010

(No. _____ St.)

File No. 39153Registered No. 3

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John William Free

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

July 5 1922
(Month) (Day) (Year)

7. AGE

— Yrs. 6 Mos. — ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

None

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Ida

10. NAME OF FATHER

John Free

11. BIRTHPLACE OF FATHER

(State or Country)

Mo.

12. MAIDEN NAME OF MOTHER

Goldie Maccomb

13. BIRTHPLACE OF MOTHER

(State or Country)

Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. W. Free
Wenatchee, Ida

15.

Filed 8/5 1922W. J. Hamister
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 11 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 5 1922, to July 11 1922
that I last saw him alive on July 9 1922
and that death occurred on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH was as follows:

premature birth
about 7 mo.

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed) G. M. Stahman M. D.7/11/1922 (Address) Wenatchee, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Hillcrest Cemetery 7-11 1922

20. UNDERTAKER ADDRESS

Northam McCann Wenatchee, Ida

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Washington
City of WeiserRegistration District No. 86Primary Registration District No. 1010

(No. _____ St.)

File No. 39154

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Georgianna N Tifford

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

(Write the word.)

6. DATE OF BIRTH

July 5 1922
(Month) (Day) (Year)

7. AGE

Yrs. _____ Mos. _____ ds. _____

IF LESS than 1 day
how many 12 hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

None

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Ida

10. NAME OF FATHER

Elmer Tifford

11. BIRTHPLACE OF FATHER

(State or Country)

Ida

12. MAIDEN NAME OF MOTHER

Leah Sanford

13. BIRTHPLACE OF MOTHER

(State or Country)

Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Elmer Tifford
Weiser Ida

15.

Filed

8/81922J. P. Hamilton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 5 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from July 5 1922 to July 5 1922
that I last saw her alive on July 5 1922and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Premature birth
(about 7 mo.)(Duration) _____ Yrs. 12 mos. _____ ds. hoursContributory
(Secondary)

(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed)

G. M. Valukawa M. D.7/6 1922 (Address) Weiser Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hillcrest Cemetery7-7- 1922

20. UNDERTAKER

ADDRESS

Northam McCannWeiser Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 39155

1. PLACE OF DEATH **RECEIVED**
County of Washington Registration District No. 86
City of Wenatchee Primary Registration District No. 1010
(No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

Registered No. 2
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Clay Borham Poor

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH April 27
(Month) (Day) (Year)

7. AGE 11 Yrs. 2 Mos. 29 ds.
IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION School Boy
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE Mo.
(State or Country)

10. NAME OF FATHER A. L. Poor

11. BIRTHPLACE OF FATHER Idaho
(State or Country)

12. MAIDEN NAME OF MOTHER Peora Borham

13. BIRTHPLACE OF MOTHER Mo.
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mildred Morris
(Address) Weiser, Ida.

15. Filed 8/8 1922
W. R. Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 10 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 8 1922, to July 10 1922, that I last saw him alive on July 8 1922, and that death occurred on the date stated above, at 39 M.

The CAUSE OF DEATH* was as follows:
Infection of foot following nail puncture
(Duration) _____ Yrs. _____ mos. 7 ds.

Contributory (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) W. R. Hamilton M. D.
1922 (Address) Weiser, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Hillcrest Cemetery DATE OF BURIAL 7-11 1922

20. UNDERTAKER Northwest McLean ADDRESS Weiser, Ida.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Washington
City of Walla Walla

RECEIVED

Registration District No. 86Primary Registration District No. 1010St. (No. 1010)File No. 39156Registered No. 108

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

James Laney's Buchanan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

Wtr

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word)

6. DATE OF BIRTH

Feb
(Month)29th
(Day)1
(Year)

7. AGE

10 Yrs. 5 Mos. 1 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

School Boy

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

J H Buchanan

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Anna Manning

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J H Buchanan
Weiser Idaho

15.

Filed 8/8 1922W. H. Smith
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July
(Month)30th
(Day)1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 29 1922, to July 30th 1922that I last saw him alive on July 30th 1922and that death occurred on the date stated above, at 11 A. M.

The CAUSE OF DEATH* was as follows:

Acute Gangrenous
appendicitis(Duration) 1 Yrs. 1 mos. 11 ds.Contributory
(Secondary)(Duration) 1 yrs. 1 mos. 11 ds.(Signed) CCP M. D.7/21 1922 (Address) Weiser Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 1 yrs. 1 mos. 11 days. In the State 1 yrs. 1 mos. 11 days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Willow Cemetery

DATE OF BURIAL

7-30 1922

20. UNDERTAKER

Northrup McBurn

ADDRESS

Weiser

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Washington*
City of *Weiser*Registration District No. *86*Primary Registration District No. *1010*

(No. _____)

St. _____

File No. *39157*Registered No. *3*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Maxine Elizabeth De Spain

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

*Oct**31**1913*

(Month)

(Day)

(Year)

7. AGE

8 Yrs. *8* Mos. *28* ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

None

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Ida

10. NAME OF FATHER

Chas. M De Spain

11. BIRTHPLACE OF FATHER

(State or Country)

Virginia

12. MAIDEN NAME OF MOTHER

Ella Josephine Campbell

13. BIRTHPLACE OF MOTHER

(State or Country)

Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Minerva Campbell

(Address)

Weiser Ida

15.

Filed *8/8**1922**H. Hamilton*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

*July**30**1922*

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 23 19*22* to *July 30* 19*22*that I last saw her alive on *July 30* 19*22*and that death occurred on the date stated above, at *10 P.M.*

The CAUSE OF DEATH* was as follows:

*Endocarditis and
valvular incompetency.*

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)*Acute dilatation of
Heart.*

(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed)

Ernest O. Finney M. D.(Address) *Weiser Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Hillcrest Cemetery July 31 1922

20. UNDERTAKER

ADDRESS

Northrup McCann Weiser Ida

CERTIFICATE OF DEATH

1. PLACE OF DEATH **RECEIVED**
 County of Washington Registration District No. 102
 City of Green Primary Registration District No. 1010
 (No. 1045 St. West)

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 39158
 Registered No. 6

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Floretta A. Daseh

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE Wbr 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
 (Write the word.)

6. DATE OF BIRTH

July 24 1864
 (Month) (Day) (Year)

7. AGE

58 Yrs. 7 Mos. 7 ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Mo.

10. NAME OF FATHER

Oliver Chapman

11. BIRTHPLACE OF FATHER

(State or Country)

Indiana

12. MAIDEN NAME OF MOTHER

Lucy Ann Haldeck

13. BIRTHPLACE OF MOTHER

(State or Country)

No Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Frederick A. Daseh

(Address)

Weiser Ida

15.

Filed

Aug 1st 1922 M. R. Haulman

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 31 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 1st 1922, to July 31 1922
 that I last saw him alive on July 31 1922

and that death occurred on the date stated above, at 6 PM.

The CAUSE OF DEATH* was as follows:

Carcinoma of the uterus

(Duration) 2 Yrs. 0 mos. 0 ds.

Contributory
 (Secondary)

(Duration) 0 yrs. 0 mos. 0 ds.

(Signed)

C. C. Gandy M. D.
8/1/22 (Address) Weiser Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 0 yrs. 0 mos. 0 days. In the State 0 yrs. 0 mos. 0 days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Willcrest Cemetery

DATE OF BURIAL

8-2 1922

20. UNDERTAKER

Northman M. Gann

ADDRESS

Weiser Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH **RECEIVED**
 County of Canyon **SEP 18 1922**
 City of Nampa **BUREAU**
 Registration District No. 1606
 Primary Registration District No. 1606
 (No. 1606 St.)

File No. 24159
 Registered No. **39159**

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles C. Jordan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Married
 (Write the word.)

6. DATE OF BIRTH

— — 1885
 (Month) (Day) (Year)

7. AGE

37

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

Mechanic

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Unknown

10. NAME OF FATHER

John Jordan

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

" "

13. BIRTHPLACE OF MOTHER

(State or Country)

" "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs Leota Jordan

(Address)

Nampa Ida.

15.

Filed

Sept. 9 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 20 19 22
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

8/20/22 19 22, to 8/20/22 19 22
 that I last saw him alive on 8/20/22 19 22
 and that death occurred on the date stated above, at 8:30 PM.

The CAUSE OF DEATH* was as follows:

Paralysis of Heart

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)Cocaine abuser

(Duration)

Yrs.

mos.

ds.

(Signed)

Chilton Belknap

M. D.

8/21 1922 (Address) Nampa Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death... yrs... mos... days. In the State... yrs... mos... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL
Kohlerlawn Cem. NampaDATE OF BURIAL
8/23/219

20. UNDERTAKER

Frank Robinson

ADDRESS

Nampa

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Damascus*City of *Proctorville*

If death occurs away from usual residence, give facts called for under special information.

Registration District No. *28*Primary Registration District No. *216*(No. *216*)*John Bertolino*39162-0
State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *53*Registered No. *5888*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male Italian

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word)

6. DATE OF BIRTH

April 9th 1885
(Month) (Day) (Year)

7. AGE

37 Yrs. *3* Mos. *24* ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).*Truck Driver*

9. BIRTHPLACE

(State or Country)

Illinois

10. NAME OF FATHER

Louis Bertolino

11. BIRTHPLACE OF FATHER

(State or Country)

Italy

12. MAIDEN NAME OF MOTHER

Antonilla Dughera

13. BIRTHPLACE OF MOTHER

(State or Country)

Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. John Bertolino
(Address) *Remmure Wyo*

15.

Filed *85* 19 *22*Local Registrar *W. Schumacher*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 5 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 23 1922 to *Aug 5 1922*
that I last saw him alive on *Aug 5 1922*
and that death occurred on the date stated above, at *2:40 P.M.*

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach
Chronic Gastritis
(Duration) *3* Yrs. *3* mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. Schumacher M. D.
Aug 5 1922 (Address) *207 1st Nat Bank*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Remmure Wyo *Aug 8 1922*
20. UNDERTAKER *W. Schumacher* *Cur*

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of *Canyon*City of *Caldwell*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED
SEP 13 1922
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH
Registration District No. _____
Precinct or Registration District No. *1005*
(N. St.) _____

3 - 39160-8 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. *39160*
Registered No. *88*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

male white married

6. DATE OF BIRTH

Sept. 23 1845
(Month) (Day) (Year)

7. AGE

76 Yrs. *10* Mos. *23* ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

Retired

9. BIRTHPLACE

(State or Country)

Wisconsin

10. NAME OF FATHER

Wm. Robinson

11. BIRTHPLACE OF FATHER

(State or Country)

U.S.A.

12. MAIDEN NAME OF MOTHER

Rebecca Clark

13. BIRTHPLACE OF MOTHER

(State or Country)

U.S.A.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

William H. Robinson
211 N. 1st St.

15.

Filed

*Aug. 16 1922**John B. Meyer*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 15 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

*March 27 1922 to Aug 15 1922*that I last saw him alive on *Aug 14 1922*and that death occurred on the date stated above, at *8 P.M.*

The CAUSE OF DEATH* was as follows:

Anemia(Duration) Yrs. *5* mos. ds.Contributory
(Secondary)*Chronic Nephritis*(Duration) yrs. *not known* mos. ds.

(Signed)

*Thos. M. D.**913 1922* (Address) *Caldwell, Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Manis Hill**8-17 1922*

20. UNDERTAKER

ADDRESS

C. V. Chapman Caldwell

CERTIFICATE OF DEATH.

39161

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Ada
City of BoiseRegistration District No. 2Primary Registration District No. 1004
(No. 410 N. State St.)File No. 39161
Registered No. 244If death occurs away from
usual residence, give facts
called for under special
information.

2. FULL NAME

John R. MingleIf death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.M White Single
(Write the word.)

6. DATE OF BIRTH.

Oct-14 1885
(Month) (Day) (Year)

7. AGE

36 Yrs. 11 Mos. 6 ds.IF LESS than 1 day
how many.....hrs. or
.....min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work...
(b) General nature of in-
dustry, business, or estab-
lishment in which employ-
ed (or employer).....Farmer

9. BIRTHPLACE

(State or Country)

Pennsylvania10. NAME OF
FATHEREmanuel Emanuel Mingle11. BIRTHPLACE
OF FATHER

(State or Country)

Penn12. MAIDEN NAME
OF MOTHERSarah Runkle13. BIRTHPLACE
OF MOTHER

(State or Country)

Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Edith R. Mingle

(Address)

Boise, Ida.

15.

Filed

Sept 21 1912R.H. Pratt
Local Registrar

16. DATE OF DEATH

Sept 20 1912
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
Sept 19 1912, to Sept 20 1912,
that I last saw him alive on Sept 20 1912,
and that death occurred on the date stated above, at 4:30 M.

The CAUSE OF DEATH* was as follows:

Pertussis(Duration) Yrs. mos. ds. Sever
Contributory (Secondary) Keptured Offender
(Duration) yrs. mos. ds. Arrest
(Signed) W S Lister M. D.
Sept 21 1912 (Address) Boise*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted
if not at place of death?.....Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Harvard Sq. Sept 20 1912
20. UNDERTAKER Boise

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No.

Primary Registration District No.

(No.)

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Male

White

married
(Write the word.)

6. DATE OF BIRTH

November 24 about 1850
(Month) (Day) (Year)7. AGE Born Nov. 24 about 1850 - 70
Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

Farmer

9. BIRTHPLACE

(State or Country)

Indiana

10. NAME OF FATHER

George Stanfield

11. BIRTHPLACE OF FATHER

(State or Country)

Don't know.

12. MAIDEN NAME OF MOTHER

Mary Sweaney

13. BIRTHPLACE OF MOTHER

(State or Country)

Don't know.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Mrs. Alexander Stanfield
Gooding

15.

Filed

9-25-1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 28 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 1920, to July 28 1922, that I last saw him alive on July 28 1922, and that death occurred on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) 2 Yrs. mos. ds.

Contributory High Blood Pressure
(Secondary)

(Duration) 5 yrs. mos. ds.

(Signed) H. C. Lamb M. D.

Sp. 23 1922 (Address) Gooding, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Gooding

7-30 1922

20. UNDERTAKER

ADDRESS

A. E. Thompson

Gooding

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39164**Registered No. **91**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

Registration District No.
County of **Ada** Primary Registration District No.
City of **Boise** **Ada County Hospital** (St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
OCT 8 1922
BUREAU OF VITAL STATISTICS

2. F. STATE

Mrs. Nora Hart

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **M** 4. COLOR OR RACE **W** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Skidaw**
(Write the word.)6. DATE OF BIRTH **Don't know**
(Month) (Day) (Year)7. AGE **52** Yrs. — Mos. — ds. **IF LESS than 1 day**
how many — hrs. or — min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)**None.**

9. BIRTHPLACE

(State or Country)

Nevada

10. NAME OF FATHER

Don't know

11. BIRTHPLACE OF FATHER

(State or Country)

?

12. MAIDEN NAME OF MOTHER

?

13. BIRTHPLACE OF MOTHER

(State or Country)

?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Wm. McBratney
Boise, Idaho.

15.

Filed **9-28** 19**22****P. H. Pratt**
Local RegistrarMEDICAL CERTIFICATE OF DEATH **99**

16. DATE OF DEATH

Sept. 28, 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from **Mar.** 191**9**, to **Sept. 28** 19**22**
that I last saw her alive on **Sept. 25** 19**22**,
and that death occurred on the date stated above, at **7:30** AM.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis.(Duration) **3** Yrs. **6** mos. — ds.Contributory (Secondary) **Subacute Myocarditis**(Duration) yrs. **2** mos. — ds.(Signed) **J. N. Brastan** M. D.**9/28/22** (Address) **Boise, Idaho.**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. — mos. — days. In the State yrs. — mos. — days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

County Cemetery

DATE OF BURIAL

9/29 19**22**

20. UNDERTAKER

Wm. McBratney

ADDRESS

Boise
Ida

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. **39165**Registered No. **80**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of **Ada** Registration District No. **2**
City of **Boise** Primary Registration District No. **2008**
City of **Boise** (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lizzie M. Batty

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

(6)

3. SEX

F

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

March 18 18**77**
(Month) (Day) (Year)

7. AGE

45 Yrs. **5** Mos. **26** ds.
IF LESS than 1 day how many hrs. or min. 2)

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

at Home

9. BIRTHPLACE

(State or Country) **Nebraska**

10. NAME OF FATHER

Mike Rittthaler

11. BIRTHPLACE OF FATHER

(State or Country) **Unknown**

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country) **Unknown**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) **Fred Batty**

(Address) **1114 1/2 B. Ave. Boise, Idaho**

15.

Filed **Sept 18** 191**2** **R. N. Pratt**
Local Registrar

16. DATE OF DEATH

Sept. 14 19**22**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

after death 191**2**

that I last saw him alive on 191**2**

and that death occurred on the date stated above, at **79** M.

The CAUSE OF DEATH* was as follows:

Angina pectoris

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) **C. L. Duffin** M. D.

Sept 19 19**22** (Address) **Boise, Idaho**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Married Hill Cemetery

DATE OF BURIAL

Sept 18 19**22**

20. UNDERTAKER

Thurman & Sons **Boise, Idaho**

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39166**Registered No. **82**1. PLACE OF DEATH **RECEIVED**
County of **Ada** **0612** 1922
City of **Boise** **BUREAU** **Barber, Idaho** (No. **2008** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lillian Eileen Lant

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **F** 4. COLOR OR RACE **W.** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Single**
(Write the word.)6. DATE OF BIRTH **Sept - 18 - 1922**
(Month) (Day) (Year)7. AGE **2** **ds.**
Yrs. Mos. ds. **1** **1** **1**
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)**None**

9. BIRTHPLACE

(State or Country) **Barber Idaho.**

10. NAME OF FATHER

Walter Lant

11. BIRTHPLACE OF FATHER

(State or Country) **Bismark N.D.**

12. MAIDEN NAME OF MOTHER

Viola Whitney

13. BIRTHPLACE OF MOTHER

(State or Country) **Illinois**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Wm. McBratney**
(Address) **Boise Idaho.**15. Filed **9-21-1922** **R. H. Pratt**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **Sept, 20 - 1922**
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from **Sept 18, 1922** to **Sept 20, 1922**, that I last saw him alive on **Sept 20, 1922**, and that death occurred on the date stated above, at **11:00 A.M.** The CAUSE OF DEATH* was as follows:**Insanples from Oval**(Duration) Yrs. mos. **2** ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) **W. H. Parker** M. D.**9/21/1922** (Address) **Boise Idaho.**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Morris Hill Cemetery

DATE OF BURIAL

9/21/1922

20. UNDERTAKER

W. H. Parker

ADDRESS

Boise Idaho.

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH *Valley* Registration District No. *322*
 County of *Valley* Primary Registration District No. *322*
 City of *McCall* (No. *McCall* St.)

File No. *36*
 Registered No. *36*

If death occurs away from
 usual residence, give facts
 called for under special in-
 formation.

2. FULL NAME

Chas Stanton

If death occurred in a hos-
 pital, institution or camp,
 give its NAME, instead of
 street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *M* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED *Married*
 (Write the word.)

16. DATE OF DEATH

6. DATE OF BIRTH

Nov 10 - 1854
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
 19... to 19...

7. AGE

67

Yrs. Mos. ds.

IF LESS than 1 day
 how many hrs.
 or min.?

that I last saw him alive on *any date* 19...
 and that death occurred on the date stated above, at *8 P. M.*

The CAUSE OF DEATH* was as follows:

*Double the cause was
 Heart Failure (Aneurysm)*

8. OCCUPATION

(a) Trade, profession or
 particular kind of work
 (b) General nature of in-
 dustry, business or estab-
 lishment in which employ-
 ed (or employer)

Miner

9. BIRTHPLACE

(State or Country)

Battle Creek, Mich

10. NAME OF FATHER

John Stanton

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

W. J. Stanton
M. S. Vets Hospital

15.

Filed

9/6 - 19 22

R. V. Prady
 Local Registrar

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs mos. days. In the State yrs mos. days

Where was disease contracted
 if not at place of death?

Former or
 usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Dry Creek Cemetery**9/6 19 22*

20. UNDERTAKER

ADDRESS

Schreiber & Sidergaden *Boise, Ida*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH Idaho Registration District No. 2
County of Ada Primary Registration District No. 1004
City of Bonanza (No. 1816 W. State St.)

File No. **39169**
Registered No. 210

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Merle S. Welch

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH.

Nov. 5 1886
(Month) (Day) (Year)

7. AGE

35 Yrs. 10 Mos. 0 ds.

IF LESS than 1 day
how many.....hrs. or
.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).

Barber

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

John H. Welch

11. BIRTHPLACE OF FATHER

(State or Country)

Iowa

12. MAIDEN NAME OF MOTHER

Jane Smith

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

B. Welch

(Address)

1816 State St.

15.

Filed 9-7 1922

R. H. Pratt
Local Registrar

16. DATE OF DEATH

Sept 5 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 5 1922 to 191,
that I last saw him alive on 192
and that death occurred on the date stated above, at 8:00 M.

The CAUSE OF DEATH* was as follows:

Dementia Acute

(Duration) Yrs. mos. ds.

Contributory Myocardial Breakdown
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) E. Summers9/6 1922 (Address) Bonanza, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state the MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery Sept 7, 1922

20. UNDERTAKER

ADDRESS

Summers & Krebs Bonanza

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39170**Registered No. **223**

1. PLACE OF DEATH

Registration District No. **7**
County of **Ada** Primary Registration District No. **1004**
City of **Boise** (No. **410**, State St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Virginia Madge Thomas

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Single**
(Write the word.)6. DATE OF BIRTH **Feb. 7** 19**10**
(Month) (Day) (Year)7. AGE **12** Yrs. **7** Mos. **10** ds. IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).**Student**

9. BIRTHPLACE

(State or Country)

Mammoth Utah

10. NAME OF FATHER

J. C. Thomas

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Clo Bahr

13. BIRTHPLACE OF MOTHER

(State or Country)

Salem Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Mrs Clo Thomas**
(Address) **Boise**15. Filed **9-19** 19**22** **R. H. Pratt**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept. 17th 19**22**
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from **Aug. 27th** 19**22**, to **Sept. 17th** 19**22**
that I last saw her alive on **Sept. 17th** 19**22**
and that death occurred on the date stated above, at **6 P. M.**

The CAUSE OF DEATH* was as follows:

Embolus (fat) coronary artery - post operative -(Duration) Yrs. mos. **3** ds.
Contributory Comp. **Fract. left femur**
(Secondary)(Duration) yrs. mos. **2** ds.
(Signed) **B. W. Mather** M. D.**9/18** 19**22** (Address) **Boise, Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. **2** days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Salt Lake City Utah **9/20** 19**22**20. UNDERTAKER ADDRESS
Schreiber & Sidenfaden **Boise**

James

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. **39171**

Registered No. **230**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
OCT 2 1922

CERTIFICATE OF DEATH

1. PLACE OF DEATH **Idaho**
County of **Ada**
City of **Bose**
(No. **1621** St.)
Vitalization District No. **Ways**
Bureau of Vital Statistics
Registration District No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Ida A. Klanis**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **M** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WID-OWED OR DIVORCED **Single**
(Write the word.)

6. DATE OF BIRTH **Aug 10-1871**
(Month) (Day) (Year)

7. AGE **51** Yrs. **7** Mos. **17** ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION **School Teacher**
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE **Iowa**
(State or Country)

10. NAME OF FATHER **Henry C. Klanis**

11. BIRTHPLACE OF FATHER **New York**
(State or Country)

12. MAIDEN NAME OF MOTHER **Frances Miller**

13. BIRTHPLACE OF MOTHER **New York**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) **Deborah Davis**
(Address) **1621 Ways St.**

15. Filed **9-29 1922** **R.H. Pratt**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **Sept. 27 1922**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **May 13 1922** to **Sept 27 1922**
that I last saw him alive on **Sept 26 1922**
and that death occurred on the date stated above, at **7:11** M.

The CAUSE OF DEATH* was as follows:
Adenocarcinoma

Contributory
(Duration) Yrs. mos. ds.

Contributory
(Secondary)
(Duration) yrs. mos. ds.

(Signed) **Frederic K. Lewis** M. D.
Sept 29 1922 (Address) **Brose, Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **Morris Hill Cemetery** DATE OF BURIAL **Sept 29 1922**

20. UNDERTAKER **Thurman & Thibe** ADDRESS **Brose, Idaho**

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Ada* Registration District No. *1*
City of *Boise* Primary Registration District No. *1*
*Boise, Idaho*File No. *39172*
Registered No. *237*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Virginia Johnson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *F.* 4. COLOR OR RACE *W.* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*
(Write the word.)

6. DATE OF BIRTH

Sept. 26 - 1922
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many *6* hrs.
or *-* min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)*None.*

9. BIRTHPLACE

(State or Country)

Boise, Idaho.

10. NAME OF FATHER

E.L. Johnson.

11. BIRTHPLACE OF FATHER

(State or Country)

Boise Idaho.

12. MAIDEN NAME OF MOTHER

Josephine Vander. Kende

13. BIRTHPLACE OF MOTHER

(State or Country)

Patterson. N.J.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. M. Bratney
Boise Idaho.

(Address)

15.

Filed

*9/29 1922**R.H. Bratt*
Local Registrar

16. DATE OF DEATH

Sept. 26, 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *Sept 26 1922* to *Sept 26 1922*
that I last saw her alive on *Sept 26 1922*
and that death occurred on the date stated above, at *3 P.M.*

The CAUSE OF DEATH* was as follows:-

Chromatous berib -

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. Carl Hill M. D.
9/27/22 (Address) *Boise, Idaho.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Monie Hill Cemetery**9/27 1922*

20. UNDERTAKER

ADDRESS

*W. M. Bratney**Boise Idaho.*

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39173**Registered No. **229**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of **Ada**City of **Boise**

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. **St. Lukes Hospital** St.)

2. FULL NAME

Eugene L. Grice

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **M.** 4. COLOR OR RACE **W.** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Married**
(Write the word.)

6. DATE OF BIRTH

August 12, 1878
(Month) (Day) (Year)

7. AGE

44 Yrs **1** Mos **12** ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).**Assayer**

9. BIRTHPLACE

(State or Country)

Neb.

10. NAME OF FATHER

Joseph G. Grice

11. BIRTHPLACE OF FATHER

(State or Country)

Canada

12. MAIDEN NAME OF MOTHER

Jennette J. Kilman

13. BIRTHPLACE OF MOTHER

(State or Country)

Pa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wm M Bratney

(Address)

Boise Idaho.

15.

Filed

9-26-1922**R. A. Rath**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

107

16. DATE OF DEATH

Sept 24 - 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from **Sept 24 - 1922**, to **Sept 24 - 1922**, that I last saw him alive on **Sept 24 - 1922** and that death occurred on the date stated above, at **10:15 A.M.** The CAUSE OF DEATH* was as follows:**Burns.**

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

9/26/22

(Address)

Boise Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Morris Hill Cemetery

DATE OF BURIAL

9/27-1922

20. UNDERTAKER

W M Bratney

ADDRESS

Boise Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39174**Registered No. **228**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH **Adg.** Registration District No.
 County of **Ada** Primary Registration District No.
 City of **Boise** (No. **1206 E. Franklin** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Elmer Chambers**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **M** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED **Single**

(Write the word.)

6. DATE OF BIRTH

Sept 1, 1920
 (Month) (Day) (Year)

7. AGE

2 Yrs. **0** Mos. **24** ds.

IF LESS than 1 day
 how many..... hrs.
 or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

None

9. BIRTHPLACE

(State or Country)

Oregon

10. NAME OF FATHER

Charles Chambers

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Cecilia Carlson

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Charles C. Chambers

(Address)

1206 E. Franklin

15.

Filed

9-26 1922

R. H. Pratt
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept. 25 19**22**
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I **saw** attended deceased **from**

Sept 25 19**22** to **10**

that I last saw him **alive on** **10**

and that death occurred on the date stated above, at **3:30** M.

The CAUSE OF DEATH* was as follows:

blowding, Accidental

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Hyde E. Summers, Coroner
9/26 1922 Address **Boise Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery **Sept 27 1922**

20. UNDERTAKER

ADDRESS

Summers & Kropp **Boise Idaho**

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH
in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 2
County of Ada
City of Boise
Primary Registration District No. 1004
(No. 410, State Idaho St.)

File No. 39176
Registered No. 225

If death occurs away from
usual residence, give facts
called for under special in-
formation.

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

2. FULL NAME

Herman Meyers

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH

About 1852
(Month) (Day) (Year)

7. AGE

70 Yrs. Mos. ds. IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

Prospector
and Rancher

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

Not obtainable

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Not obtainable

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Gertrude Mulla Roller
(Address) Boise Id

15.

Filed 9-19 1922 R. H. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 18 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
9/10 1922 to 9/18 1922
that I last saw him alive on 9/18 1922
and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Senile Prostate
(Cause)
(Duration) Yrs. mos. ds.
Contributory (Secondary) Hemorrhage
(Duration) Yrs. mos. ds.
(Signed) Edw. A. Pittenger M. D.
9/9 1922 (Address) Boise Id

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days
Where was disease contracted if not at place of death?
Former or usual residence Garden Valley Id

19. PLACE OF BURIAL OR REMOVAL St. Johns Cemetery DATE OF BURIAL 9/19 1922
20. UNDERTAKER Amieba Widemeyer ADDRESS Boise

D. Pittenger

Parker.
CERTIFICATE OF DEATH.State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39177**Registered No. **224**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Ada Registration District No. 2
City of Boise Primary Registration District No. 1004
(No. 611 N 16 St St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Theodotie Alice Coal

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
Widower
(Write the word.)

6. DATE OF BIRTH.

Aug 13 1885
(Month) (Day) (Year)

7. AGE

65 Yrs. 1 Mos. 2 ds.IF LESS than 1 day
how many hrs. or
min. 2

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).At Home

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

William L. Parker

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Sarah Butt

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

E. E. Biggley
Plainville, Kans.

15.

Filed

9-191922R. H. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 15 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Aug 12 1922 to Sept 15 1922, that I last saw him alive on Sept 11 1922, and that death occurred on the date stated above, at 5:24 M. The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage

(Duration) Yrs. mos. ds.

Contributory (Secondary)

Hypertension

(Duration) yrs. mos. ds.

(Signed)

R. H. Pratt

M. D.

9-15-1922 (Address) Plainville

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill CemeterySept 19 1922

20. UNDERTAKER

ADDRESS

Summers & KrebsBoise, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFAADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Ada Registration District No. 2
City of Bosse Primary Registration District No. 1004
(No. 1511 Sherman St.)File No. 39178
Registered No. 222If death occurs away from
usual residence, give facts
called for under special
information.

2. FULL NAME

Helene B. Mc Birney
If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED. married

6. DATE OF BIRTH.

May 1, 1887
(Month) (Day) (Year)

7. AGE

35 Yrs. 4 Mos. 16 ds.IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work...
(b) General nature of in-
dustry, business, or estab-
lishment in which employ-
ed (or employer).....at Home

9. BIRTHPLACE

(State or Country) Kansas10. NAME OF
FATHERJames Matthew11. BIRTHPLACE
OF FATHER(State or Country) Ill.12. MAIDEN NAME
OF MOTHERViolet Gresham13. BIRTHPLACE
OF MOTHER(State or Country) Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. Schuppel(Address) 1608 W. Jefferson St. Boss

15.

Filed Sept 18 19122R. W. Pratt
Local Registrar

16. DATE OF DEATH

Sept 17 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
Sept 17 19122 to 191that I last saw h. alive on 191
and that death occurred on the date stated above, at 70 M.

The CAUSE OF DEATH* was as follows:

Gunshot wound (accidental)

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Clara E. Summers Corneil M. D.9/18, 1922 (Address) Bosse, Idaho*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted
if not at place of death?.....Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Coffeyville, Kansas Sept 22, 1922

20. UNDERTAKER

ADDRESS

Summers & Sons Bosse, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED
OCT 2 1922
1. PLACE OF DEATH
County of *Ada* Registration District No. *2*
City of *Boise* Vitality Registration District No. *1004*
State *Idaho*

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. *39179*
Registered No. *221*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

George Johnson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Widower*
(Write the word.)

6. DATE OF BIRTH *Nov 7 1859*
(Month) (Day) (Year)

7. AGE *62* Yrs *10* Mos *7* ds.
IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work *retired Farmer*
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE *Saline Co. Neb*
(State or Country)

10. NAME OF FATHER *Gas. Johnson*

11. BIRTHPLACE OF FATHER *American*
(State or Country)

12. MAIDEN NAME OF MOTHER *Sarah. Dont Know*

13. BIRTHPLACE OF MOTHER *Dont Know*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *Elva Linka*
(Address) *Boise, Idaho*

15. Filed *9-16* 1922 *R. H. Pratt*
Local Registrar

16. DATE OF DEATH *Sept 15 1922*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Sept 9 1922* to *Sept 10 1922*
that I last saw him alive on *Sept 15 1922*
and that death occurred on the date stated above, at *11 P.M.*

The CAUSE OF DEATH was as follows:

Appendicitis

(Duration) *15* Yrs. mos. ds.
Contributory (Secondary) *Peritonitis*

(Duration) yrs. mos. ds. *3*
(Signed) *M. H. Tallman* M. D.

9/16/22 (Address) *Boise*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence *Boise Ada County Idaho*

19. PLACE OF BURIAL OR REMOVAL *Morris Hill* DATE OF BURIAL *9/17 1922*

20. UNDERTAKER *Schreiber & Sidenfaden* ADDRESS *(Boise)*

Dr. Tallman

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39180**
Registered No. **220**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Ada Registration District No. 2
City of Boise Primary Registration District No. 1004
(No. 405 So 4 St.)

If death occurs away from usual residence, give facts called for under special information.

BUREAU OF VITAL STATISTICS

2. FULL NAME

Nellie J. Hill

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widow

6. DATE OF BIRTH.

March 20 1878
(Month) (Day) (Year)

7. AGE

44 Yrs. 5 Mos. 23 ds.IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....at home

9. BIRTHPLACE

(State or Country)

Kansas

10. NAME OF FATHER

John S. Thorn

11. BIRTHPLACE OF FATHER

(State or Country)

Illinois

12. MAIDEN NAME OF MOTHER

Viola R. Robins.

13. BIRTHPLACE OF MOTHER

(State or Country)

Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

John S. Thorn

(Address)

15.

Filed

Sept-15 1922R. N. Park

Local Registrar

MEDICAL CERTIFICATE OF DEATH

50

16. DATE OF DEATH

Sept 12 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 11 1922, to Sept 12 1922that I last saw her alive on Sept 12 1922and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Diabetes(Duration) Yrs. 3 mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) P. P. French M. D.9-15 1922 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cem.Sept 15 1922

20. UNDERTAKER

ADDRESS

Sumner & CorboBoise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

State

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 39181

Registered No. 219

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

9-15

1922

Local Registrar

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

19 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.

County of Ada

Primary Registration District No.

City of Boise

(No. St.)

File No.

Registered No.

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Stipan (Steve) RudelIf death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDMale White Married
(Write the word.)

6. DATE OF BIRTH

About 1882
(Month) (Day) (Year)7. AGE About
40 Yrs. Mos. ds. IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work Coal Miner
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country) Ljane, Jugo Slavia10. NAME OF
FATHERYure Rudel11. BIRTHPLACE
OF FATHER(State or Country) Jugo Slavia12. MAIDEN NAME
OF MOTHERYurka ? Rudel13. BIRTHPLACE
OF MOTHER(State or Country) Jugo Slavia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Marian Glavota
(Address) Boise Id.

15.

Filed 19.....

Local Registrar

16. DATE OF DEATH

..... 19.....
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

..... 19....., to 19.....

that I last saw him alive on 19.....

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

..... (Duration) Yrs. mos. ds.

Contributory
(Secondary)

..... (Duration) yrs. mos. ds.

(Signed) M. D.

..... 19..... (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

..... 19.....

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH
in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39183**
Registered No. **217**

1. PLACE OF DEATH

County of **Ada** Registration District No. **2**
City of **Boise** Primary Registration District No. **1004**
(No. **11th St.** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Laura B. Norton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **F** 4. COLOR OR RACE **W.** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Widow**
(Write the word.)

6. DATE OF BIRTH

Apr 13 - 1858
(Month) (Day) (Year)

7. AGE

64 Yrs. **4** Mos. **29** ds.If LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)**Postal Telegraph Manager**

9. BIRTHPLACE

(State or Country)

Illinois

10. NAME OF FATHER

Francis Cook Smith.

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Sarah Jane Weeks.

13. BIRTHPLACE OF MOTHER

(State or Country)

Don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Coral M. Norton
1711 N 11th St.

(Address)

15.

Filed

9-13 1922**R. H. Pratt**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept. 12 - 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

9/11 1922 to **9/12 1922**
that I last saw her alive on **9/12 1922**
and that death occurred on the date stated above, at **4:30 AM**.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
(Duration) Yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

9-13 1922 (Address) **Boise Idaho.**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Morris Hill Cemetery

DATE OF BURIAL

9-14 1922

20. UNDERTAKER

W. McBratney

ADDRESS

Boise Idaho.

CERTIFICATE OF DEATH.

Stone
State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada
City of Bose

Registration District No. 2Primary Registration District No. 1004(No. 110 E. Barnum St.)File No. **39184**Registered No. 216

If death occurs away from
usual residence, give facts
called for under special
information.

2. FULL NAME

Maurice Peck

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.MWhiteSingle
(Write the word.)

6. DATE OF BIRTH.

Mar 16 1 902
(Month) (Day) (Year)

7. AGE

20 Yrs. 5 Mos. 26 ds.

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work...
(b) General nature of in-
dustry, business, or estab-
lishment in which employ-
ed (or employer).....

Farmer

9. BIRTHPLACE

(State or Country)

Idaho10. NAME OF
FATHERGeorge W Peck11. BIRTHPLACE
OF FATHER

(State or Country)

Wisconsin12. MAIDEN NAME
OF MOTHERMary Frances Comant13. BIRTHPLACE
OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

William H. Peck
Parfield Ida

15.

Filed 9-12 1922

P. H. Pratt
Local Registrar

16. DATE OF DEATH

September 11 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 11 1922, to same 1922,
that I last saw him alive on Sept 11 1922,
and that death occurred on the date stated above, at 11:25 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage result of
fall from base

(Duration) Yrs. mos. 1 2 ds.Contributory
(Secondary)hypertension

(Duration) yrs. mos. ds.

(Signed) Harold Wilson M. D.9/13/1922 Address 413 Overland Bldg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted
if not at place of death?.....Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Parfield Idaho Sept 13 1922

20. UNDERTAKER

ADDRESS

Summers & Krebs Boswell

CERTIFICATE OF DEATH

1. PLACE OF DEATH

Registration District No. 2
 County of Ada Primary Registration District No. 1004
 City of Boise (No. 1004) (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

STATE

Jake Vettors

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 39185Registered No. 215

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
 (Write the word.)

6. DATE OF BIRTH

About 1849
 (Month) (Day) (Year)

7. AGE About 73 Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Miner & Prospector
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

Jacob Vettors

11. BIRTHPLACE OF FATHER

(State or Country)

Wuerttemberg Germany

12. MAIDEN NAME OF MOTHER

Fredericka ?

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Daniel Kirby

(Address)

Boise, Ida.

15.

Filed Sept 12 19 22 P. N. Prax
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 11 19 22
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 3 19 22, to Sept 10 19 22
 that I last saw him alive on Sept 10 19 22
 and that death occurred on the date stated above, at Idaho M.

The CAUSE OF DEATH* was as follows:

Gastric Ulcer Malignant

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed)

Chas. V. Henry M. D.

19

(Address)

Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

Atlanta, Idaho

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Monis Hill Cemetery 9/12 19 22

20. UNDERTAKER

ADDRESS

Schubert Widener Boise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.

County of

Primary Registration District No.

City of

(No. 3 miles W of Boise)

St)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

FULL NAME

William M. Tipton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

M White

Single
(Write the word.)

6. DATE OF BIRTH.

1843. 1
(Month) (Day) (Year)

7. AGE

79 Yrs. Mos. ds.

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
(b) General nature of in-
dustry, business, or estab-
lishment in which employ-
ed (or employer)

Veteran Civil War

9. BIRTHPLACE

(State or Country)

Unknown

10. NAME OF
FATHER

Unknown

11. BIRTHPLACE
OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME
OF MOTHER

Unknown

13. BIRTHPLACE
OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Elyde E. Summers

(Address)

Boise Idaho

15.

Filed

9-11 1922

R. H. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

40

16. DATE OF DEATH

Sept 9 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 1 1912, to Sep 9 1922

that I last saw him alive on Sep 7 1922

and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Fred A. Brough, M. D.

9/11 1922 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery

Sept 11 1922

20. UNDERTAKER

ADDRESS

Summers & Trefz Boise Idaho

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39187**
Registered No. **213**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH **Ada**
County of **Ada**
City of **Bair**
Registration District No. **2**
Primary Registration District No. **1004**
(No. **110 E Barnhart** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Sy Woo**

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX **M** 4. COLOR OR RACE **Yellow** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Single**
(Write the word.)6. DATE OF BIRTH **1874**
(Month) (Day) (Year)7. AGE **48**
Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?8. OCCUPATION **Gardner**
(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...9. BIRTHPLACE **Korea**
(State or Country)10. NAME OF FATHER **Unknown**11. BIRTHPLACE OF FATHER **Unknown**
(State or Country)12. MAIDEN NAME OF MOTHER **Unknown**13. BIRTHPLACE OF MOTHER **Unknown**
(State or Country)14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) **Elyde E. Summers**
(Address) **Bair, Idaho**15. Filed **9-11** 19**22** **R. H. Pratt**
Local Registrar16. DATE OF DEATH **Sy 8**
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from **Sy 7** 19**22** to **Sy 8** 19**22**
that I last saw him alive on **Sy 8** 19**22**
and that death occurred on the date stated above, at **2 P** M.The CAUSE OF DEATH* was as follows:
Rupture of bladder
(Duration) Yrs. mos. ds.Contributory (Secondary)
(Duration) Yrs. mos. ds.
(Signed) **John Bank** M. D.
April 11 19**22** (Address) **Bair, Idaho**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death....yrs....mos....days In the State....yrs....mos....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **Morris Hill Cemetery** DATE OF BURIAL **Sy 12 1922**
20. UNDERTAKER **Summers & Krebs Boise, Idaho** ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Registration District No.

Primary Registration District No.

(No.

St.)

File No.

Registered No.

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF
FATHER11. BIRTHPLACE
OF FATHER

(State or Country)

12. MAIDEN NAME
OF MOTHER13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1922

R. H. Pratt

Local Registrar

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from
9-5-22 to 19-22that I last saw him alive on 19-22
and that death occurred on the date stated above, at 7 PM.

The CAUSE OF DEATH* was as follows:

He had a burn on his
chest that in my opinion
was an electric burn

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. O. Springer M. D.
9-7-22 (Address) Boise Idaho*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39189**Registered No. **211**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of

City of

RECEIVED
OCT 9 1922Registration District No. **2**Primary Registration District No. **1004**CNo. **1509 Hazel.**

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Joachim Peterson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

M.**White****Married**

6. DATE OF BIRTH.

May 24**1853**

7. AGE

69 Yrs. **3** Mos. **13** ds.IF LESS than 1 day
how many hrs. or
min. 2)

8. OCCUPATION

(a) Trade, profession or
particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....**Retired Farmer**

9. BIRTHPLACE

(State or Country)

Sweden.

10. NAME OF FATHER

Peter Johansen

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden.

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

J. H. Peterson

(Address)

15.

Filed

9-7**1922****R. H. Pratt**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sep 6**1922**

17. I HEREBY CERTIFY, That I attended deceased from

Aug 29 1922 to **Sep 6** 1922that I last saw him alive on **Sep 6** 1922and that death occurred on the date stated above, at **2 P.** M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration)

Yrs. mos. ds.

Contributory
(Secondary)**Arteriosclerosis and Flu**

(Duration)

Yrs. mos. ds.

(Signed)

John Bank M. D.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death.....yrs.....mos.....days

In the

State.....yrs.....mos.....days

Where was disease contracted
if not at place of death?.....

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lafayette Minnesota**191**

20. UNDERTAKER

ADDRESS

Schummers & Sons. Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39190**
Registered No. **209**

1. PLACE OF DEATH **Admission**
County of **Bonneville** Registration District No. **2**
City of **Bonneville** Primary Registration District No. **1004**
(No. **410 W. State** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Maud E. M. Carness**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX **F** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Married**
(Write the word.)

6. DATE OF BIRTH. **April 18 1885**
(Month) (Day) (Year)

7. AGE **37** Yrs. **4** Mos. **16** ds.
IF LESS than 1 day how many... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... **At Home**
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE **Illinois**
(State or Country)

10. NAME OF FATHER **Thomas Henson**

11. BIRTHPLACE OF FATHER **Unknown**
(State or Country)

12. MAIDEN NAME OF MOTHER **Ryan**

13. BIRTHPLACE OF MOTHER **Unknown**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) **A. E. L...**
(Address) **214 W. Main**

15. Filed **9-6**
Local Registrar

16. DATE OF DEATH **Sept. 4th 1912**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Sept. 1st 1912** to **Sept. 4th 1912**, that I last saw her alive on **Sept. 4th 1912** and that death occurred on the date stated above, at **3:15 P.M.**

The CAUSE OF DEATH* was as follows:
Fracture of skull - (assault)
(Duration) Yrs. mos. **5** ds.
Contributory (Secondary) **Cerebral haemorrhage**

(Signed) **Reverend Father** M. D.
19 (Address) **317 Cleveland Bldg.**

*State the DISEASE or DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS of DEATH, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

RESIDENCE (For Hospitals, Institutions, and Transient Residents.)

PLACE OF BURIAL OR REMOVAL **Married Men's Cemetery** DATE OF BURIAL **Sept 10 1912**

28. UNDERTAKER **Shumner & Tribbs** ADDRESS **Boise Idaho**

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39191**Registered No. **201**

1. PLACE OF DEATH

County of **Ada**City of **Baie**Registration District No. **2**Primary Registration District No. **1004**(No. **412** State **Idaho** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Rufina Anchustegui

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **F** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Single**
(Write the word.)

6. DATE OF BIRTH

July 19th 1896
(Month) (Day) (Year)

7. AGE

26 Yrs **1** Mos **14** ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)**Domestic**

9. BIRTHPLACE

(State or Country)

Spain

10. NAME OF FATHER

Jose Anchustegui

11. BIRTHPLACE OF FATHER

(State or Country)

Spain

12. MAIDEN NAME OF MOTHER

Maria Y. Arregui

13. BIRTHPLACE OF MOTHER

(State or Country)

Spain

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Matt Arregui

(Address)

Boise Idaho

15.

Filed **Sept 5** 19**22**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

20

16. DATE OF DEATH

Sept 3rd 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from **Aug. 25** 19**22**, to **Sept. 3** 19**22**
that I last saw her alive on **Sept. 3** 19**22**
and that death occurred on the date stated above, at **4:00** P.M.
The CAUSE OF DEATH* was as follows:**Septicemia**

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Dr. Collier M. D.

19. (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

Boise, Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Jordan Valley, ID **9/3** 19**22**

20. UNDERTAKER

ADDRESS

Schreiber & Sidenfaden **Boise****Dr. Collier**

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

219

STANDARD CERTIFICATE OF DEATH

JUL 11 1923
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1 PLACE OF DEATH

County

Ada

IDAHO

State

IDAHO

Registered No.

39191
208

Township

Boise

or Village

City

No.

412 State

St.,

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME

Rufina Anchustegui

(a) Residence. No.

St., Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M.

4 COLOR OR RACE

W

5 SINGLE, MARRIED, WIDOWED,
OR DIVORCED (write the word)

Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

July 19 1896

7 AGE

Years

Months

Days

26

1

14

If LESS than
1 day, --- hrs.
or --- min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work

Domestic

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Spain

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Spain

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Spain

14

Informant
(Address)

15

Filed _____, 19 _____

11-3184

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sep. 3 19 22

17

I HEREBY CERTIFY, That I attended deceased from

_____, 19_____, to _____, 19_____,

that I last saw him _____ alive on _____, 19_____,

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Septicemia

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(SECONDARY)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis?

(Signed) _____, M. D.

_____, 19 (Address)

Boise Ida

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

19

20 UNDERTAKER

ADDRESS

41



STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BOISE, IDAHO

PUBLIC HEALTH SERVICE
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
BUREAU OF CHILD HYGIENE
VITAL STATISTICS
MEDICAL ADVISOR

C. C. MOORE, GOVERNOR

September 7, 1923.

Dr. Geo. Collister,
Boise, Idaho.

SECOND REQUEST.

Dear Doctor:

39191

On August 2nd we wrote you stating that the Government had requested further information in reference to the cause of death of Rufina Anchus

No reply has as yet been received to our letter and we trust you will kindly take a few minutes and give us the desired information, as we must complete these certificates before returning them to Washington. An immediate reply will be greatly appreciated.

Kindly give answer below and return in the enclosed self-addressed envelope for which no postage is required.

Yours very truly,

F. W. Almond, M. D.
Special Agent, Bureau of Census.

The Government desires to know:

ANSWER BELOW

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B. - Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A-25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

39192

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

SEP 5 1922

Registration District No. 11

County of

Ada

BUREAU OF VITAL STATISTICS

Primary Registration District No.

City of

Meridian

(No.

St.)

File No. 20

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Hazel Lorraine Carpenter

If death occurred in a hospital, institution or camp, give its NAME instead of city and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

Sept 28 1922
(Month) (Day) (Year)

7. AGE

4 Yrs. 11 Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Albion Idaho

10. NAME OF FATHER

Harry J. Carpenter

11. BIRTHPLACE OF FATHER

(State or Country) Michigan

12. MAIDEN NAME OF MOTHER

Rose E. Mills

13. BIRTHPLACE OF MOTHER

(State or Country) Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

H. J. Carpenter

(Address)

Meridian Idaho

15.

9-1

19 22

H. J. Carpenter

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 28 19 22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 20 19 22 to Aug 28 19 22

that I last saw h. alive on Aug 28 19 22

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Diphtheria

(Duration) Yrs. mos. 8 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

H. J. Carpenter M. D.

8/28 19 22 (Address) Meridian Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Meridian

DATE OF BURIAL

Aug 28 19 22

20. UNDERTAKER

W. J. Mather undertaker

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 18
Registered No. 39193

1. PLACE OF DEATH *Ada* Registration District No. _____
County of *Ada* Primary Registration District No. _____
City of *Meridian* (No. _____ St.) _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Olive M. Swanson*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*

6. DATE OF BIRTH *July 9 1865*

7. AGE *57* Yrs. *20* Mos. *ds.* IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION *Housekeeper*

(a) Trade, profession or particular kind of work *Housekeeper*
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE *Iowa*
(State or Country)

10. NAME OF FATHER *Aretis Schoonover*

11. BIRTHPLACE OF FATHER *Indiana*
(State or Country)

12. MAIDEN NAME OF MOTHER *Ester Cunningham*

13. BIRTHPLACE OF MOTHER *Ohio*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mrs. Helen Stark*
(Address) *Barse Idaho*

15. *488 S. M. 1st St.*
Filed *7-30-1922*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *July 29 1922*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Mar 3 1922* to *July 29 1922*
that I last saw her alive on *July 29 1922*
and that death occurred on the date stated above, at _____ M.
The CAUSE OF DEATH* was as follows: *Carcinoma of Uterus*

(Duration) *9* Yrs. _____ mos. _____ ds.
Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) *H. F. Neal* M. D.

7-30-1922 (Address) _____

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL *Norris Hills* DATE OF BURIAL *July 30 1922*

20. UNDERTAKER *W. B. Mather Meridian Idaho* ADDRESS _____

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Ada Registration District No. _____
City of Meridian Registration District No. _____
St. _____

File No. 19
Registered No. 39194

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lovinia Roath

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female White Married (Write the word)

6. DATE OF BIRTH

Aug. 1 1840
(Month) (Day) (Year)

7. AGE

80 Yrs. 9 Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Housekeeper
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) North Co. Indiana

10. NAME OF FATHER

Joseph Oxtell

11. BIRTHPLACE OF FATHER

(State or Country) Unknown

12. MAIDEN NAME OF MOTHER

Anna Cramer

13. BIRTHPLACE OF MOTHER

(State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Helen Z. Roath
(Address) Meridian Idaho

15.

Filed 9-1 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 9 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 8 1922 to Aug 9 1922
that I last saw him alive on Aug 9 1922
and that death occurred on the date stated above, at 4 P.M.
The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) Yrs. mos. 1 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. R. Numbers Jr. M. D.
8/10 1922 (Address) Meridian Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Meridian Cemetery 1922

20. UNDERTAKER

ADDRESS

W. D. Matur Meridian Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

39195

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.

County of

Primary Registration District No.

City of

(No.

St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Arlene White

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of industry
business, or establishment in
which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF
FATHER

11. BIRTHPLACE
OF FATHER

(State or Country)

12. MAIDEN NAME
OF MOTHER

13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

191

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

THE CAUSE OF DEATH* was as follows:

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

(Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

1. PLACE OF DEATH

County of *Bannock*
City of *Arimo*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Evelyn Olson

CERTIFICATE OF DEATH

Registration District No. *83*Registration District No. *2160*

(No. _____, _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *39200*

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Oct., 13, 1921
(Month) (Day) (Year)

7. AGE

10 Yrs. *23* Mos. *23* ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Infant

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Armo, Ida

10. NAME OF FATHER

Wilford Olson,

11. BIRTHPLACE OF FATHER

(State or Country)

Armo, Ida

12. MAIDEN NAME OF MOTHER

Luella Martin,

13. BIRTHPLACE OF MOTHER

(State or Country)

Armo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wilford Olson

(Address) _____

15.

Filed *9-7-1922**A. H. Hestergren*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept., 6, 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *Sept., 6, 1922*, to *Sept., 6, 1922*, that I last saw him alive on *Sept., 6, 1922* and that death occurred on the date stated above, at *5:00 P.M.*

The CAUSE OF DEATH* was as follows:

Enteritis(Duration) _____ Yrs. _____ mos. *3* ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

H. Hestergren M. D.*9-7-1922* (Address) *Armo, Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Armo, Ida

DATE OF BURIAL

9-7-1922

20. UNDERTAKER

none

ADDRESS

PLACE OF

Bonn
Dorney

BUREAU OF STATISTICS

St.)

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

John Henry Dyson

PERSONAL AND STATISTICAL PARTICULARS

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

male

white

(Write the word.)

6. DATE OF BIRTH

November

18

1859

(Month)

(Day)

(Year)

7. AGE

63

Yrs.

5

Mos.

21

ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Farmer

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

Henry Dyson

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Betty Buckley

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

C. E. Layton

(Address)

Dorney, Idaho

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May

9

1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 3

1922

to May 9

1922

that I last saw him alive on May 8 1922

and that death occurred on the date stated above, at 11:45 P.M.

The CAUSE OF DEATH was as follows:

Chronic Cardiac Asthma

(Duration) 5 Yrs. 6 mos. 6 ds.

Contributory (Secondary) Mitral Insufficiency

(Duration) 10 yrs. mos. ds.

(Signed) E. W. Shurcliff M. D.

May 11 1922 (Address) Dorney, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF

Dorney

May 11 1922

20. UNDERTAKER

ADDRESS

C. E. Layton

Dorney

Local Registrar

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should be stated EXACTLY, and so that it may be properly classified. Exact statement of OCCUPATION is very important. See

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock
City of Poester

Registration District No. _____

Primary Registration District No. _____

(No. _____)

File No. 53Registered No. 3889

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William M. Smith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male White Single
(Write the word.)

6. DATE OF BIRTH

Dec 19 1913
(Month) (Day) (Year)

7. AGE

8 Yrs. 7 Mos. 15 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

Student

9. BIRTHPLACE

(State or Country)

Poester, Ida.

10. NAME OF FATHER

W. W. Smith

11. BIRTHPLACE OF FATHER

(State or Country)

N. Y.

12. MAIDEN NAME OF MOTHER

Rosa C. Tolman

13. BIRTHPLACE OF MOTHER

(State or Country)

W. Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. W. Smith(Address) 1732 Tipton Ave

15.

Filed

87 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 7 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 27 1922 to Aug-7 1922
that I last saw him alive on Aug-7 1922
and that death occurred on the date stated above, at 1022 AM.

The CAUSE OF DEATH* was as follows:

Respiratory failure following operation for Cerebellar tumor causing hydrocephalus(Duration) 2 Yrs. mos. ds.

Contributory (Secondary)

Cerebellar tumor(Duration) Yrs. mos. ds.

(Signed)

A. C. Laurin

M. D.

8/7 1922

(Address)

Poester

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mountain ViewAug 10 1922

20. UNDERTAKER

ADDRESS

Schmuckler & SonsPoester

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

39203

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock Registration District No. 28City of Coastella Primary Registration District No. 2161 File No. 53If death occurs away from usual residence, give facts called for under special information. STA (No. 101) Coastella Idaho

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Amey E. DaltonRegistered No. 3892
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widowed
(Write the word.)

6. DATE OF BIRTH

Dec 19 1869
(Month) (Day) (Year)

7. AGE

52 Yrs. 7 Mos. 23 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

9/14 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 12th 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 10th 1922 to Aug 12th 1922
that I last saw her alive on Aug 12th 1922
and that death occurred on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:

General weakness following operation (shock)(Duration) Yrs. mos. 4 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

Amey E. Dalton M. D.(Address) Coastella Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mountain View Aug 14 1922

20. UNDERTAKER

ADDRESS

Schumacher & Son City

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

39204

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock Registration District No. 28
City of Pocatello Primary Registration District No. 2161
(No. On Viaduct St.)If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

James HearneFile No. 53
Registered No. 3896If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH

Not Known
(Month) (Day) (Year)7. AGE approximately LESS than 1 day
how many hrs.
Yrs. Mos. ds. or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)Stock Man.

9. BIRTHPLACE

(State or Country)

Kansas10. NAME OF
FATHERPeter Hearne11. BIRTHPLACE
OF FATHER

(State or Country)

Ireland.12. MAIDEN NAME
OF MOTHERNot Known.13. BIRTHPLACE
OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Joe Evans
(Address) Moreland, Ida

15.

Filed

8/22 1922R. F. McMan
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

August 21 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
.....19....., to19.....that I last saw him alive on19.....
and that death occurred on the date stated above, atM.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

S. S. Ferguson, Coroner822-22 (Address) Pocatello, Ida*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Blackfoot, Ida Aug. 24 1922

20. UNDERTAKER

ADDRESS

R. F. McMan Pocatello
Idaho.

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

39205

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock
City of GaeremRegistration District No. 28Primary Registration District No. 2101(No. 647)N. 6th

St.)

File No. 53Registered No. 3890

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant Marketti

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Female

4. COLOR OR RACE

Italian

5. SINGLE, MARRIED, WID-

Single
(Write the word.)

6. DATE OF BIRTH

Aug 10th 1922
(Month) (Day) (Year)

7. AGE

1 Yrs. 1 Mos. 1 ds.
IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Ciriaco Marketti

11. BIRTHPLACE OF FATHER

(State or Country) Italy

12. MAIDEN NAME OF MOTHER

Kate Malin

13. BIRTHPLACE OF MOTHER

(State or Country) Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ciriaco Marketti
(Address) Gaerem, Id.

15.

Filed

9/1 1922J. Young
Local Registrar

16. DATE OF DEATH

8/10 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

8/10 1922 to 8/10 1922
that I last saw her dead 8/10 1922
and that death occurred on the date stated above, at 89 M.

The CAUSE OF DEATH* was as follows:

Still Birth (dead in Utero)

(Duration) Yrs. mos. ds.

Contributory (Secondary) None known

(Duration) yrs. mos. ds.

(Signed) J. Young M. D.9/1 1922 (Address) Bozette, Id.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Mountain View

20. UNDERTAKER

Schumacher & Sons

DATE OF BURIAL

Aug 11, 1922

ADDRESS

Cari

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

39206

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 53
Registered No. 3891

1. PLACE OF DEATH

Registration District No. 28
County of Pocatello Primary Registration District No. 241
City of Pocatello (No.) Donatello Ben Hosp St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Chas W Lee

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH

June 4 1870
(Month) (Day) (Year)

7. AGE

52 Yrs. 2 Mos. 8 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Laborer

9. BIRTHPLACE

(State or Country)

Indiana

10. NAME OF FATHER

J. W. Lee

11. BIRTHPLACE OF FATHER

(State or Country)

Michigan

12. MAIDEN NAME OF MOTHER

Stogell

13. BIRTHPLACE OF MOTHER

(State or Country)

Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. R. Lee

(Address)

1750 Roosevelt Ave

15.

Filed

8/14 1922W. F. McFar
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 12 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

August 11, 1922, to Aug 12 1922,
that I last saw him alive on Aug 12 1922,
and that death occurred on the date stated above, at 11:45 A.M.

The CAUSE OF DEATH* was as follows:

Double barrel. Skull fracture
due to injury in
motor cycle accident.(Duration) Yrs. mos. 1 1/2 hrs.Contributory, none
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

C. W. Clark

M. D.

8/14 1922 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

M. A. New Cemetery Aug 14 1922

20. UNDERTAKER

ADDRESS

W. F. McFar Pocatello
Ida.

1. PLACE OF DEATH

County of *Pennock*City of *Pocatello*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED CERTIFICATE OF DEATH

Registration District No. *28*Primary Registration District No. *2161*

General Hosp. St.)

F. L. Cate

39207

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *5-8*Registered No. *3893*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male Negro

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Married
(Write the word.)

6. DATE OF BIRTH

Not Known 1881
(Month) (Day) (Year)

7. AGE

41 Yrs. *not known* Mos. *not known* or min. ?
IF LESS than 1 day how many hrs.

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

Newspaper Editor
Reverend

9. BIRTHPLACE

(State or Country)

Tennessee

10. NAME OF FATHER

Not Known

11. BIRTHPLACE OF FATHER

(State or Country)

Not Known

12. MAIDEN NAME OF MOTHER

Not Known

13. BIRTHPLACE OF MOTHER

(State or Country)

Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Reverend Thornton

(Address)

140 So 1 Ave.

15.

Filed

8/18 19*22**J. F. Mylan*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

August 16 19*22*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 6 19*22*, to *Aug 16* 19*22*
that I last saw him alive on *July 16* 19*22*
and that death occurred on the date stated above, at *11 A*. M.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis,
(with thrombosis in left
ventricle) recumbent(Duration) *2* Yrs. mos. ds.Contributory
(Secondary)*Pathology, chronic*(Duration) *4* yrs. mos. ds.

(Signed)

Carl W. Clark M. D.*7/1* 19*22* (Address) *Pocatello Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Pueblo, Colo.**Aug 20* 19*22*

20. UNDERTAKER

ADDRESS

*V. F. Mylan**Pocatello*
Ida.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

39208

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH **RECEIVED**
 County of **Blaine** Registration District No. **28**
 City of **Pocatello** Primary Registration District No. **2161**
 If death occurs away from usual residence, give facts called for under special information.

File No. **53**
 Registered No. **3894**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

E. Jones

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Married**

6. DATE OF BIRTH **Nov 19 1877**
 (Month) (Day) (Year)

7. AGE **about 50 years** IF LESS than 1 day
50 Yrs. **8** Mos. **28** ds. how many..... hrs.
 or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Virginia

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15. **8/19 1922**
 Filed **8/19 1922**
J. H. Jones
Essex St. Wash.
J. H. Jones
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

19 **22**
(Year)

17. I HEREBY CERTIFY, That I attended deceased from **Aug 16 1922** to **Aug 16 1922**
 that I last saw him alive on **Aug 16 1922**
 and that death occurred on the date stated above, at **12:30 P.** M.

The CAUSE OF DEATH* was as follows:

Thrombosis of Left ventricle of heart, (dependent upon into vessels of neck)

(Duration) **20** mos. ds.

Contributory (Secondary)

(Duration) **20** yrs. mos. ds.

(Signed)

C. W. Clark M. D.8/17 1922 (Address) **Pocatello Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **Newbury** DATE OF BURIAL **8/20 1922**

20. UNDERTAKER **H. H. Wacker** ADDRESS **Pocatello**

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

39209

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 28
County of Bannock Primary Registration District No. 2161
City of Pocatello General Hosp. St.)File No. 53
Registered No. 3895

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Albert Renshaw.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-OWED OR DIVORCED Single
(Write the word.)6. DATE OF BIRTH not known. 1887
(Month) (Day) (Year)7. AGE 35 Yrs. not known Mos. us. If LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. musician
(b) General nature of industry, business or establishment in which employed (or employer)9. BIRTHPLACE Not known.
(State or Country)10. NAME OF FATHER Renshaw.11. BIRTHPLACE OF FATHER Not known.
(State or Country)12. MAIDEN NAME OF MOTHER Not known.13. BIRTHPLACE OF MOTHER Not known.
(State or Country)14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Miss Pond.
(Address) Pocatello Ida.15. Filed 8/21 1922 W. F. M. Han.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

20

16. DATE OF DEATH

August 17 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Aug 10 1922 to Aug 17 1922
that I last saw him alive on Aug 17 1922
and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Streptococcus septicemia(Duration) Yrs. ____ mos. 10 ds.
Contributory (Secondary) severe nasal sepsis

(Duration) Yrs. ____ mos. ____ ds.

(Signed) W. F. M. Han. M. D.
Pl. 1922 (Address) Pocatello, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days

Where was disease contracted if not at place of death?

Former or usual residence Chicago Ill.19. PLACE OF BURIAL OR REMOVAL Pocatello Ida DATE OF BURIAL Aug 21 192220. UNDERTAKER W. F. M. Han. ADDRESS Pocatello Ida.

CERTIFICATE OF DEATH

39210

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. *28*
County of *Bannock* Primary Registration District No. *2161*
City of *Pocatello* (No. *705* - St. *to Arthur*)File No. *53*
Registered No. *3887*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant Johnson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *Male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WID-OWED OR DIVORCED *Infant*
(Write the word.)

6. DATE OF BIRTH

August 1 19*22*
(Month) (Day) (Year)

7. AGE

Stillborn IF LESS than 1 day
Yrs. Mos. ds. *15h* how many hrs. or *15* min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).*Infant*

9. BIRTHPLACE

(State or Country)

Pocatello Idaho

10. NAME OF FATHER

Joseph Henry Johnson

11. BIRTHPLACE OF FATHER

(State or Country)

Salt Lake City Ut.

12. MAIDEN NAME OF MOTHER

Laura Bell Magdon

13. BIRTHPLACE OF MOTHER

(State or Country)

Michigan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. Henry Johnson

(Address)

Pocatello

15.

Filed

8/2 19*22*

Local Registrar

16. DATE OF DEATH

August 1 19*22*
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *8/1* 19*22* to *Aug 1* 19*22* that I last saw him alive on *Aug 1* 19*22* and that death occurred on the date stated above, at *M.* M.

The CAUSE OF DEATH* was as follows:

Shock following delivery

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

19*22* (Address)*D. C. Ray* M. D.
Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Mountain View Cem *Aug 2* 19*22*

20. UNDERTAKER

ADDRESS

Schumacher & Hall *Pocatello*

County Ducatello **RECEIVED** District No. 28 State of Idaho
 City Ducatello **SEP 13 1922** **DEPT. OF PUBLIC WELFARE**
 Bureau of Vital Statistics
 File No. 83
 Registered No. 3904
 If death occurs away from usual residence, give facts called for under special information.
 2. FULL NAME Mrs. A. Austin
 (No. 2141 St.)
 If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX. 4. COLOR OR RACE. 5. Single, married, Widowed or Divorced.

Male White Married (Write the word.)

6. DATE OF BIRTH.

May 20 1865
(Month) (Day) (Year)

7. AGE.

37 Yrs. 3 Mos. 11 ds. IF LESS than 1 day, how many hrs. or min.?

8. OCCUPATION.

(a) Trade, profession, particular kind of work. Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).

9. BIRTHPLACE.

Illinois
(State or Country.)

10. NAME OF FATHER.

Jessie Austin

11. BIRTHPLACE OF FATHER.

(State or Country.)

12. MAIDEN NAME OF MOTHER.

Sarah Sellers

13. BIRTHPLACE OF MOTHER.

(State or County.)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Mrs. N. A. Austin
Irwin Falls, Ida

15.

Filed

8/31 1922

Thompson
Local Registrar.

Place Where Remains are to be Sent (Date of Shipment)

Irwin Falls, Ida Sept 1 1922

SHIPPING UNDERTAKER

ADDRESS

Firm Name

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH.

Aug 31 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 28 1922 to Aug 31 1922;

that I last saw him alive on Aug 31 1922 and that death occurred on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH was as follows:

Encephalitis, Cerebral Hemorrhage, Cholera, Cholera

Possibly for years
(Duration) Years mos. ds.

Contributory (Secondary)

Acute exacerbation of chronic cholera

(Duration) Years mos. ds.

Signed

M. D.

8/31 1922 (Address) Irwin Falls, Ida

* State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (for Hospitals, Institutions, Transient or Recent Residents.)

At place in the

of death yrs. mos. days State yrs. mos. ds

Where was disease contracted

if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Date of Burial

20. UNDERTAKER

Address

Irwin Falls, Ida 9/1 1922
M. Wacker Ducatello

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH
in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

CERTIFICATE OF DEATH

39212

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Cannock
City of Pocatello

Registration District No. 28
Registration District No. 2161
St. St. Anthony Hosp

File No. 53

Registered No. 3905

If death occurs away from
usual residence, give facts
called for under special in-
formation.

If death occurred in a hos-
pital, institution or camp,
give NAME instead of
street and number.

2. FULL NAME

Frankie Mildred Williamson

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

married
(Write the word.)

6. DATE OF BIRTH

Dec 10 1892
(Month) (Day) (Year)

7. AGE

29 Yrs. 8 Mos. 19 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

Housewife

9. BIRTHPLACE

(State or Country) Colorado

10. NAME OF
FATHER

Sherrin Smulling

11. BIRTHPLACE
OF FATHER

(State or Country) Missouri

12. MAIDEN NAME
OF MOTHER

Theodosia Hayworth

13. BIRTHPLACE
OF MOTHER

(State or Country) Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James Scott Williams
(Address) 1133 So 5 Ave.

15.

Filled

8/31 1922

J. Young
Local Registrar

16. DATE OF DEATH

August 29 19 22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 19 19 22 to Aug 29 19 22
that I last saw her alive on Aug 29 19 22
and that death occurred on the date stated above, at 5:15 AM.

The CAUSE OF DEATH* was as follows:

Streptococci peritonitis

(Duration) Yrs. mos. 5 ds.

Contributory Childbirth
(Secondary)

(Duration) yrs. mos. 9 ds.

(Signed) R. M. Newton M. D.

Aug 30 19 22 (Address) Ram Bldg Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
if not at place of death?

at
usual residence

19. PLACE OF BURIAL OR REMOVAL

Mt View Cemetery
B. H. McMan

DATE OF BURIAL

Aug 30 19 22

20. UNDERTAKER

ADDRESS

Pocatello
Ida.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

39213

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

Registration District No.

Primary Registration District No.

(No.)

St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Signed)

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

39214

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock Registration District No. 28
City of Bozartville Suburban Registration District No. 2141
City of Bozartville (No. General Hospital St.)File No. 53
Registered No. 3898

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ernie B. Murrell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Infant
(Write the word.)

6. DATE OF BIRTH

April 7 1922
(Month) (Day) (Year)

7. AGE

4 Yrs. 19 Mos. 19 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Infant

9. BIRTHPLACE

(State or Country) South of Bozartville Idaho

10. NAME OF FATHER

Archie Murrell

11. BIRTHPLACE OF FATHER

(State or Country) Utah

12. MAIDEN NAME OF MOTHER

Nettie Broadhead

13. BIRTHPLACE OF MOTHER

(State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Archie Murrell(Address) Bozartville Idaho

15.

Filed 8/26 1922Local Registrar J. J. Young

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

August 26 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

8/25 1922, to 8/26 1922
that I last saw him alive on 8/26 1922
and that death occurred on the date stated above, at 12:30 M.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction(Duration) Yrs. 5 mos. 5 ds.Contributory (Secondary) Intussusception(Duration) Yrs. 5 mos. 5 ds.(Signed) J. J. Young M. D.8/26 1922 (Address) Bozartville

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Bozartville Idaho

DATE OF BURIAL

8/28 1922

20. UNDERTAKER

Schumacher & Hall

ADDRESS

Bozartville

SEP 1922

CERTIFICATE OF DEATH

39215

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Bannock*
City of *Pocatello*

Registration District No.

Primary Registration District No.

(No. *General Hospital* St.)

File No.

Registered No. *3900*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Shizuka Frank Matsumoto

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

*male Japanese**Single*
(Write the word.)

6. DATE OF BIRTH

March 4 1916
(Month) (Day) (Year)

7. AGE

6 Yrs. *5* Mos. *24* ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).*Student*

9. BIRTHPLACE

(State or Country)

California

10. NAME OF FATHER

R. Matsumoto

11. BIRTHPLACE OF FATHER

(State or Country)

Japan

12. MAIDEN NAME OF MOTHER

S. Ueta

13. BIRTHPLACE OF MOTHER

(State or Country)

Japan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

R. Matsumoto
511 Hal, Ida.

15.

Filed

8/30 1922
J. P. [Signature]
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

August 29 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *Aug 9 1922* to *Aug 29 1922* that I last saw him alive on *Aug 29 1922* and that death occurred on the date stated above, at *12:30 P.M.*

The CAUSE OF DEATH* was as follows:

Acute obstruction of bowels following ruptured appendix
(Duration) Yrs. mos. *20* ds.Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

M. D.

Aug 30 1922 (Address)*Pocatello, Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mt View Cemetery
*J. F. McHan**Aug 30 1922*
Pocatello

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

39216

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Bannock*City of *Pocatello*Registration District No. *116*(No. *St. Anthony's Hospital*)File No. *52*Registered No. *3901*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Susan Negrete

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female Mexican

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word)

single

6. DATE OF BIRTH

June 1 - 1922
(Month) (Day) (Year)

7. AGE

2 Yrs. *29* Mos. *29* ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Julio C. Negrete

11. BIRTHPLACE OF FATHER

(State or Country)

Mexico

12. MAIDEN NAME OF MOTHER

Esaura Calderon

13. BIRTHPLACE OF MOTHER

(State or Country)

Mexico

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Julio C. Negrete
(Address) *H 14 E. 3rd St. Pocatello, Idaho*

15.

Filed *8/30* *1922*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 30 19*22*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 27 19*22* to *Aug 30* 19*22*
that I last saw him alive on *Aug 30* 19*22*
and that death occurred on the date stated above, at *11 A. M.*

The CAUSE OF DEATH* was as follows:

Infectious Diarrhea(Duration) Yrs. mos. *14* ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

8:30 1922 (Address) *Pocatello, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

Mountain View
*Chenoweth Hall**Sept 1 1922*
Pocatello
Idaho

1. PLACE OF DEATH

County of BannockCity of Kelly

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No. 2161Primary Registration District No. 84(No. 1000 St.)John Mc CannState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 39219

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDsingle

(Write the word.)

6. DATE OF BIRTH

June 5 1907
(Month) (Day) (Year)

7. AGE

#15 Yrs. 2 Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

school boy

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Kelly Ida10. NAME OF
FATHERT.N. Mc Cann11. BIRTHPLACE
OF FATHER

(State or Country)

Utah12. MAIDEN NAME
OF MOTHERUnice Teeples13. BIRTHPLACE
OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(Address) _____

15.

Filed 9-1-22 19 Walter S. Raeh
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 5 1922 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 1 1922, to Aug 5 19 that I last saw him alive on Aug 5 22 19 and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Pumonyary embolus(Duration) Yrs. mos. ds.Contributory para tonsillar

(Secondary)

(Duration) yrs. mos. ds.(Signed) Walter S. Raeh M. D.9-1-22 (Address) Bancroft Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. daysWhere was disease contracted if not at place of death? Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Bear Lake Ida

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of **Bannock**

City of **Kelly**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Jennie Steely Whitworth**

Registration District No. **2161**

Primary Registration District No. **84**

File No. **39220**

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

F **White**

widow
(Write the word.)

6. DATE OF BIRTH

March 14 **1884**
(Month) (Day) (Year)

7. AGE

38 Yrs. **4** Mos. _____ ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work **Housewife**

(b) General nature of industry, business or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country) **Penn**

10. NAME OF FATHER

M.J. Steely

11. BIRTHPLACE OF FATHER

(State or Country) **Penn**

12. MAIDEN NAME OF MOTHER

Jennie ?

13. BIRTHPLACE OF MOTHER

(State or Country) **Penn**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **John T. Whitworth**

(Address) **Kelly**

15.

Filed **9-1** **1922** **Walter R. Bach**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 19 **1922**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to **19**

that I last saw him **or** alive on **Aug 19 - 22** **19**

and that death occurred on the date stated above, at **6** P.M.

The CAUSE OF DEATH* was as follows:

Acute septin endocarditis

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory (Secondary) **para tonsilar abscess**

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) **Walter R. Bach** M. D.

9-1-22 (Address) **Bancroft, Ida**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Kelly Ida

9-14-22

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH.

39221

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 63

County of Bear Lake

Primary Registration District No.

City of Paris

BUREAU

St.)

File No. 32

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Vivian Stucki

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

female

White

Single

(Write the word.)

6. DATE OF BIRTH.

Sept

15

1922

(Month)

(Day)

(Year)

7. AGE

About 4 hours

IF LESS than 1 day
how many hrs. or
min.?

Yrs. Mos. da.

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Will B. Stucki

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Millie Mary Ludlum

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

O. D. Moore

(Address)

Paris Idaho

15.

Filed

Sept 17

1922

Mrs J. Stucki

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept

16

1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 15 1922 to Sept 16 1922

that I last saw her alive on Sept 16 1922

and that death occurred on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Nemophilus, from navel

Bleeder's Discharge

(Duration)

about 2 hours

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

O. D. Moore

M. D.

9/16 1922 Address) Paris Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Paris Idaho

Sept 17 1922

20. UNDERTAKER

ADDRESS

M. B. Low

Paris Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

39222

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 5-3
County of Bear Lake Primary Registration District No. OCT 5
City of Paris (St.)

File No. 31Registered No. 31

If death occurs away from
usual residence, give facts
called for under special
information.

2. FULL NAME John Humphreys

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

Male White Single
(Write the word.)

6. DATE OF BIRTH.

Sept 3 1922
(Month) (Day) (Year)

7. AGE

..... Yrs. Mos. ds.

IF LESS than 1 day
how many 3 hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work...
(b) General nature of in-
dustry, business, or estab-
lishment in which employ-
ed (or employer).....

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

John Henry Humphreys

11. BIRTHPLACE OF FATHER

(State or Country) Idaho

12. MAIDEN NAME OF MOTHER

Maudie Sophia Lindsay

13. BIRTHPLACE OF MOTHER

(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. Moore

(Address) Paris Idaho

15.

Filed Sept 6 1922

Mary S. Skinner
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 3 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Sept 3 1922 to Sept 3 1922
that I last saw him alive on Sept 3 1922
and that death occurred on the date stated above, at 9:30 AM

The CAUSE OF DEATH* was as follows:

Premature Birth-7 months
Baby

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) C. Moore M. D.

9/7 1922 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place In the
of death.....yrs.....mos.....days. State.....yrs.....mos.....days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Paris Idaho

Sept 4 1922

20. UNDERTAKER

ADDRESS

M. H. Low

Paris Ida

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39223**

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Bear Lake
City of Idaho Falls

Registration District No. _____

Primary Registration District No. 38

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Elva Law Pugnire

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married

(Write the word.)

6. DATE OF BIRTH.

July 25 1896July
(Month)25
(Day)1896
(Year)

7. AGE

26 Yrs. _____ Mos. _____ ds.IF LESS than 1 day
how many _____ hrs. or
_____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....Housewife

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Isaac B. Law

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Susan J. Price

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) X Susan J. Law(Address) Paris, Ida.

15.

Filed Oct 3 19221922John Mattison
Local Registrar

MEDICAL CERTIFICATE OF DEATH

79

16. DATE OF DEATH

Aug
(Month)1
(Day)1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 7 1922 to Aug 1 1922that I last saw her alive on Aug 1 1922and that death occurred on the date stated above, at 5:45 P.M.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation(Duration) 5 Yrs. _____ mos. _____ ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) C. O. Moore M. D.8-2-1922 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St Charles Id.Aug 3 1922

20. UNDERTAKER

ADDRESS _____

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
SEP 13 1922BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bennett
City of St. MaryRegistration District No. 32
Primary Registration District No. 2049
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Isaac H. AtkinsonState of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 39225
Registered No. 42

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDsingle
(Write the word.)

6. DATE OF BIRTH

851
(Month) (Day) (Year)

7. AGE

71 Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry, business or establishment in which employed (or employer)

Common laborer

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

not known

11. BIRTHPLACE OF FATHER

(State or Country)

not known

12. MAIDEN NAME OF MOTHER

not known

13. BIRTHPLACE OF MOTHER

(State or Country)

not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Geo. E. Mitchell

(Address)

St. Mary, Ida

15.

Filed

Aug 22 1922Examiner

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 21 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Feb 1 1922 to Aug 21 1922that I last saw him alive on Aug 20 1922and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

General Anasarca(Duration) Yrs. 6 mos. ds.Contributory (Secondary) Cardiac Failure(Duration) 5 yrs. mos. ds.(Signed) Ed. Platt M. D.Aug 11 1922 (Address) St. Mary, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Woodlawn

DATE OF BURIAL

8-22-1922

20. UNDERTAKER

Mitchell & Meraga

ADDRESS

St. Mary, Ida

1. PLACE OF DEATH

County of Bennett
City of St. Maries

If death occurs away from usual residence, give facts called for under special information.

RECEIVED

CERTIFICATE OF DEATH

SEP 15 1922

BUREAU OF VITAL STATISTICS

Registration District No. 32Primary Registration District No. 2049State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 39226Registered No. 39

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Herman Thompson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white5. SINGLE, MARRIED, WIDOWED OR DIVORCED
single
(Write the word.)

6. DATE OF BIRTH

May 31 1914
(Month) (Day) (Year)

7. AGE

8 Yrs. 2 Mos. 7 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

student

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

British Columbia

10. NAME OF FATHER

Ole A. Thompson

11. BIRTHPLACE OF FATHER

(State or Country)

Minnesota

12. MAIDEN NAME OF MOTHER

Edith Knutson

13. BIRTHPLACE OF MOTHER

(State or Country)

Wilbur Wash

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Albert Thompson

(Address)

St. Maries, Ida.

15.

Filed

Aug 8 1922 Esmeralda

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

August 7th 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 7 1922 to Aug 7 1922
that I last saw him alive on Aug 7 about 11:30 A.M.
and that death occurred on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH* was as follows:

accidental drowning while playing on a boom of logs in St. Joe River at St. Maries Mill.

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

H. H. Lyons, Coroner
Aug 7 1922 (Address) St. Maries, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wilbur Wash 8-10 1922

20. UNDERTAKER

ADDRESS

Julian Ayce Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *General*
City of *St. Marys*

SEP 13 1922
BUREAU OF VITAL STATISTICS

Registration District No. *32*
Registration District No. *2049*
St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Ernest A. Huntington*

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. *39227*
Registered No. *43*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *married*
(Write the word.)

6. DATE OF BIRTH *Apr. 7 1882*
(Month) (Day) (Year)

7. AGE *40* Yrs. *4* Mos. *2* ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. *mechanic*
(b) General nature of industry, business or establishment in which employed (or employer). *autos & factories*

9. BIRTHPLACE *Missouri*
(State or Country)

10. NAME OF FATHER *George M Huntington*

11. BIRTHPLACE OF FATHER *Missouri*
(State or Country)

12. MAIDEN NAME OF MOTHER *Lara Craig*

13. BIRTHPLACE OF MOTHER *Missouri*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *Mrs. Lela Huntington*
(Address) *St Marys Ida*

15. Filed *Aug 10 1922* *Osborne*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *Aug 9 1922*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Aug 7 1922* to *Aug 9 1922* that I last saw him alive on *Aug 9 1922* and that death occurred on the date stated above, at *7 P. M.*
The CAUSE OF DEATH* was as follows:

Skull fracture - meningitis

(Duration) Yrs. mos. *2* ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) *Belton Wall* M. D.
810 1922 (Address) *St Marys Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Likoa, Wash* DATE OF BURIAL *8-11 1922*

20. UNDERTAKER *Carl Schaefer* ADDRESS *Likoa Wn*

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

SEP 13 1922

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

BUREAU OF VITAL STATISTICS

Registration District No.

(No.)

St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED
(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from
Aug 18 1922 to Aug 18 1922
that I last saw h. alive on Aug 17 1922
and that death occurred on the date stated above, at 3 a. M.

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Signed)

8/19/1922 (Address) St. Marie Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. In the days. State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

39229

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 31

County of Bennett

Primary Registration District No. 1322

File No. 2

City of Bennett

No. 1322

St.)

Registered No. 4

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Elvie Luan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

F.Indian

(Write the word.)

6. DATE OF BIRTH

Sept271922

(Month)

(Day)

(Year)

7. AGE

1

Yrs.

1

Mos.

2

ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Patrick Luan

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Josephine Falcon

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Patrick Luan

(Address)

Bennett,Idaho

15.

Filed

Sept 301922J. L. Bilman
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept291922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 101922

to

Sept 291922

that I last saw her..... alive on.....

Sept 29 1922and that death occurred on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(Duration)

Yrs.

mos.

19 ds.Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

Fred Barber

M. D.

9/30/1922 (Address) Bennett, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bennett,Idaho10/1/1922

20. UNDERTAKER

ADDRESS

J. FalconBennett

CERTIFICATE OF DEATH

39230

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of BenevolenceCity of Bennett

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 31Primary Registration District No. 102File No. 2Registered No. 18

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Hazel Louisa Michell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F.

4. COLOR OR RACE

Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Jan 29 1922
(Month) (Day) (Year)

7. AGE

8 Yrs. 8 Mos. ds.

IF LESS than 1 day

how many hrs.or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work none(b) General nature of industry, business or establishment in which employed (or employer) none

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Stanley Michell

11. BIRTHPLACE OF FATHER

(State or Country) Idaho

12. MAIDEN NAME OF MOTHER

Louisa La Rose

13. BIRTHPLACE OF MOTHER

(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Louisa La Rose(Address) Bennett

15.

Filed Sept 30 1922J. E. Bihan
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 28 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

.....19....., to19.....

that I last saw h..... alive on.....19.....

and that death occurred on the date stated above, at.....M.

The CAUSE OF DEATH* was as follows:

not known.....(Duration).....Yrs.....mos.....7 ds.Contributory
(Secondary)

.....(Duration).....Yrs.....mos.....ds.

(Signed) Frank Barker

M. D.

9/30/1922 (Address) Bennett, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....Yrs.....mos.....days. In the State.....Yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Bennett

DATE OF BURIAL

10/1/1922

20. UNDERTAKER

J. Falcon

ADDRESS

Bennett Idaho

CERTIFICATE OF DEATH

39231

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Benedict Registration District No. 31
City of Desmet Registration District No. 17 St.File No. 2Registered No. 17

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Suzan Franks

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-OWED OR DIVORCED

F.IndianMarried
(Write the word.)

6. DATE OF BIRTH

Aug 26 1892
(Month) (Day) (Year)

7. AGE

30 Yrs. 13 Mos. 3 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Bedell

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

not known

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Peter Franks

(Address)

Desmet

15.

Filed Sept 11 1922G. L. Bihan
Local Registrar

MEDICAL CERTIFICATE OF DEATH

28

16. DATE OF DEATH

Sept 8 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

.....19....., to19.....

that I last saw her..... alive on..... Sept 8 1922and that death occurred on the date stated above, at..... 9 P. M.

The CAUSE OF DEATH* was, as follows:

Pulmonary tuberculosis

(Duration) Yrs. mos. ds.

Contributory.....
(Secondary)(Duration) 12 yrs. mos. ds.

(Signed)

Frank Barbeau

M. D.

9/11/1922 (Address) Desmet Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DesmetIdaho

DATE OF BURIAL

9/11/1922

20. UNDERTAKER

E. Falcon

ADDRESS

Desmet

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39232**
Registered No. **7333**

1. PLACE OF DEATH

County of BinghamCity of MorelandRegistration District No. 121Primary Registration District No. 2194St. (None)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Kralik

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

(Write the word.)

6. DATE OF BIRTH

January

(Month)

29th

(Day)

1914

(Year)

7. AGE

8

Yrs.

6

Mos.

18

ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

At home

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Steph Kralik

11. BIRTHPLACE OF FATHER

(State or Country)

Bohemia

12. MAIDEN NAME OF MOTHER

Mary Ozanchin

13. BIRTHPLACE OF MOTHER

(State or Country)

Bohemia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Moreland, Idaho.

15.

Filed

19

Mr. Walter E. Polue

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

August 17th

(Month)

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I investigated attended deceased from19 to 19that I last saw him alive on 19and that death occurred on the date stated above, at 7:30 M.

The CAUSE OF DEATH* was as follows:

Smothered to death
under large rock
accidental

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

8/18 1922 E. L. Egli, Coroner
(Address) Blackfoot, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Moreland Cemetery,

DATE OF BURIAL

8/17 1922

20. UNDERTAKER

E. L. Egli

ADDRESS

Blackfoot,

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 121County of BinghamPrimary Registration District No. 2194City of Blackfoot SER (No. 121)

St.)

File No. 39233Registered No. 730

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

BUREAU

STATISTICAL

L. D. Amer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

MaleCaucasianmarried
(Write the word.)

6. DATE OF BIRTH

June 15
(Month)15
(Day)1878
(Year)

7. AGE

44 Yrs.1 Mos.28 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Farmer

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

Not known

11. BIRTHPLACE OF FATHER

(State or Country)

Not known

12. MAIDEN NAME OF MOTHER

Not known

13. BIRTHPLACE OF MOTHER

(State or Country)

Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

19

Mrs. Helen C. Vainie

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

August - Saturday
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec. 6 1921, to August 12 1922that I last saw him alive on night of 11 Aug. 1922and that death occurred on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:

Coma of Paralysis

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed)

Dr. J. H. Brown M. D.8-12-22 (Address) Blackfoot, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. 8 mos. 6 days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

Emmett, Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

E. L. EglerBlackfoot

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 121County of BinghamPrimary Registration District No. 2194City of Shelley(No. 100 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Verge Van Buren MalcomFile No. 39234Registered No. 137

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

(Write the word.)

6. DATE OF BIRTH

April 18

(Month)

(Day)

1

(Year)

7. AGE

27

Yrs.

1

Mos.

4

ds.

IF LESS than 1 day
how many yrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Mechanic

(b) General nature of industry, business or establishment in which employed (or employer).

Automobile

9. BIRTHPLACE

(State or Country)

Illinois

10. NAME OF FATHER

Henry L Malcom

11. BIRTHPLACE OF FATHER

(State or Country)

Virginia

12. MAIDEN NAME OF MOTHER

Nellie F Woodbell

13. BIRTHPLACE OF MOTHER

(State or Country)

Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Henry L Malcom

(Address)

Shelley

15.

Filed

19

Mr. H. E. Patrick

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May

(Month)

22

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

investigated

19

19

that I last saw him alive on 19

and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Drowned in Snake River
west of Shelley, Ida.May 22, 1922

(Duration)

Yrs.

mos.

ds. accidentalContributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

E. L. Egli, Coroner9/3 1922

(Address)

Blackfoot, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Shelley, Ida.

DATE OF BURIAL

9/4 1922

20. UNDERTAKER

E. L. Egli

ADDRESS

Blackfoot, Ida.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Bingham*City of *Shelley*

If death occurs away from usual residence, give facts called for under special information.

Registration District No. *131*Primary Registration District No. *2194*

Vital

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *39236*Registered No. *731*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

David Charles Landon

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

8 - 17 - 1922
(Month) (Day) (Year)

7. AGE

Yrs. *2* Mos. *2* ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) *Shelley Idaho.*

10. NAME OF FATHER

David Landon

11. BIRTHPLACE OF FATHER

(State or Country) *Utah.*

12. MAIDEN NAME OF MOTHER

Elva Sibbets

13. BIRTHPLACE OF MOTHER

(State or Country) *Idaho.*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Maria E. Landon*(Address) *Postage Utah**Aug. 17 1922*
Filed*Mrs. Marie E. Pature*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

8 - 15 - 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *8 - 15 - 1922* to *8 - 17 - 1922*that I last saw him alive on *8 - 17 - 1922*and that death occurred on the date stated above, at *—* M.

The CAUSE OF DEATH* was as follows:

Unknown(Duration) Yrs. *—* mos. *2* ds.Contributory
(Secondary)*Unknown*(Duration) yrs. *—* mos. *—* ds.(Signed) *Maria E. Landon*19 (Address) *Postage Utah*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. *—* mos. *—* days. In the State yrs. *—* mos. *—* days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Basalt Cemetery

DATE OF BURIAL

8 - 17 - 1922

20. UNDERTAKER

None Employed

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

2 #6

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of BinghamCity of Blackfoot

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 181Primary Registration District No. 1007(No. 1007 St.)State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 39237Registered No. 732

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William W. Priestley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widowed (e word.)

6. DATE OF BIRTH

December 19

(Month)

(Day)

1843

(Year)

7. AGE

78

Yrs.

7

Mos.

28

ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Farmer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

South Africa

10. NAME OF FATHER

William H. Priestley

11. BIRTHPLACE OF FATHER

(State or Country)

France

12. MAIDEN NAME OF MOTHER

Wilhelmina Lincoln

13. BIRTHPLACE OF MOTHER

(State or Country)

Holland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wilhelmina Price
(Address) Salt Lake City, Utah

15.

Filed

Aug. 18 1922 Mrs. Kate E. Pate
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

August 17th

(Month)

(Day)

1922
(Year)17. I HEREBY CERTIFY, That I attended deceased from June 1st 1922 to July 5 1922that I last saw him alive on July 5 1922and that death occurred on the date stated above, at 1:45 P.M.

The CAUSE OF DEATH* was as follows:

Bright's disease(Duration) 2 Yrs. mos. ds.Contributory
(Secondary)(Duration) 6 yrs. mos. ds.

(Signed)

1922 (Address) Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Grove City Cemetery

DATE OF BURIAL

8/21 1922

20. UNDERTAKER

E. L. Egli

ADDRESS

Blackfoot Idaho

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bingham
City of Belfort

Registration District No. 121Primary Registration District No. 2194File No. 39238Registered No. 134

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Martha F. Hall

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married

6. DATE OF BIRTH

Nov 8 1888
(Month) (Day) (Year)

7. AGE

33 Yrs. 9 Mos. 10 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Housewife

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Kentucky

10. NAME OF FATHER

John W. Kinney

11. BIRTHPLACE OF FATHER

(State or Country)

Kentucky

12. MAIDEN NAME OF MOTHER

Mrs Nancy Frazier

13. BIRTHPLACE OF MOTHER

(State or Country)

Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John W. Hall

(Address)

Belfort Idaho

15.

Filed

19

Mrs. Hester E. Frazier

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 18 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 1921, to Aug 1922
that I last saw her alive on 17th Aug 1922
and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(Duration) 8 Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Joseph B. Davis M. D.8/19/22 (Address) Belfort

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Marieland Idaho Aug 19 1922

20. UNDERTAKER

ADDRESS

E. J. Fisk Blackfoot

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bingham Registration District No. 121
 City of Blackfoot Primary Registration District No. 2194
 (No. 3) (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Pearl Carpenter

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 39239

Registered No. 136

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE Caucasian 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
 (Write the word.)

6. DATE OF BIRTH Aug. 30, 1895
 (Month) (Day) (Year)

7. AGE 27 Yrs. 0 Mos. 0 ds. IF LESS than 1 day
 how many 0 hrs. or 0 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Housewife
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Pennsylvania

10. NAME OF FATHER

L. H. Carpenter

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Martha E. High - Blackfoot
 (Address) Idaho State Asylum, Bluff

15. Filed Aug. 30, 1922 Mrs. Helen E. Tate
 Local Registrar

16. DATE OF DEATH

Aug. 30, 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug. 18, 1922, to Aug. 29, 1922
 that I last saw her alive on Aug. 29, 1922
 and that death occurred on the date stated above, at 1:00 A.M.

The CAUSE OF DEATH* was as follows:

Status Epilepticus

(Duration) Yrs. 11 mos. 11 ds.

Contributory (Secondary) Epilepsy 1 year

standing up near road can learn
 (Duration) Yrs. 0 mos. 0 ds.

(Signed) Dr. J. H. Hoyer M. D.

Aug. 30, 1922 (Address) Blackfoot, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 11 yrs. 11 mos. 11 days In the few days State Idaho yrs. 0 mos. 0 days

Where was disease contracted if not at place of death? Unknown

Former or usual residence Boardman, Oregon

19. PLACE OF BURIAL OR REMOVAL

Cedar Point Mausoleum 19 22

UNDERTAKER

E. J. Park ADDRESS

CERTIFICATE OF DEATH

1. PLACE OF DEATH

Registration District No. 131
 County of Bingham Primary Registration District No. 107
 City of Blackfoot (No. 215 East Jackson St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Largus W. Carmen

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 39240
 Registered No. 131

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
 (Write the word.)

6. DATE OF BIRTH

Oct 15 1871
 (Month) (Day) (Year)

7. AGE

50 Yrs. 9 Mos. 23 ds.

IF LESS than 1 day
 how many..... hrs.
 or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

Janitor of School

9. BIRTHPLACE

(State or Country)

New York

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Largus W. Carmen
Blackfoot, Idaho

15.

Filed

10 1922 Mr. Walter E. Davis
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 8th 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 2nd 1922 to Aug 8 1922
 that I last saw him alive on Aug 8 1922
 and that death occurred on the date stated above, at 1:45 p.m.

The CAUSE OF DEATH* was as follows:

pelvic abscess with
peritonitis

(Duration) Yrs. mos. 7 ds.

Contributory
 (Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. O. Hamplain M. D.

8/9 1922 (Address) Blackfoot Id

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Calarks Veb 19

20. UNDERTAKER

ADDRESS

E. J. Rusk Blackfoot

CERTIFICATE OF DEATH

39241 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Brigham
City of Sheridan

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Kathleen Dancliff

Registration District No. 116

Primary Registration District No. 2193

File No. 4

Registered No. 25

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single

6. DATE OF BIRTH

Aug 19 1922
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many 3 hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Ralph Glen Dancliff

11. BIRTHPLACE OF FATHER

(State or Country) Iowa

12. MAIDEN NAME OF MOTHER

Bessie Dora Green

13. BIRTHPLACE OF MOTHER

(State or Country) Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

R. G. Dancliff
Sheridan, Ida

15.

Filled

Aug 19 1922 McMurtre
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 19 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 19 1922 to Aug 19 1922 that I last saw him alive on Aug 19 1922 and that death occurred on the date stated above, at 10:15 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage

(Duration) since birth Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

McMurtre M. D.

(Address)

Sheridan, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Do. of Cemetery
Sheridan, Ida

Aug 20 1922

20. UNDERTAKER

ADDRESS

R. N. Southwaite

Sheridan, Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

39242

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bingham Registration District No. 116
City of Abertus Registration District No. 2195 St.)File No. 4Registered No. 74

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Vera Phillips

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female white Single
(Write the word.)

6. DATE OF BIRTH

Aug 8 1922
(Month) (Day) (Year)

7. AGE

— Yrs. — Mos. — ds.IF LESS than 1 day
how many 3 hrs.
or — min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Roscoe Phillips

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Karna Peterson

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

G. W. Phillips
Abertus Idaho

15.

Filed

Aug 8 22 1922
McMurtre
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 8 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 8 1922, to Aug 8 1922
that I last saw him alive on Aug 8 1922
and that death occurred on the date stated above, at 4:20 A.M.

The CAUSE OF DEATH* was as follows:

Premature birth
34 1/2 weeks gestation

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) McMurtre M. D.Aug 8 22 (Address) Abertus Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

D. O. Cemetery Abertus Idaho Aug 8 1922

20. UNDERTAKER

ADDRESS

Friends

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of *Bingham*
City of *Blackfoot*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED CERTIFICATE OF DEATH

Registration District No. *131*BUREAU OF VITAL STATISTICS
Registration District No. *2194*State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *39243*Registered No. *137*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female Caucasian

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

married
(Write the word.)

6. DATE OF BIRTH

8/22
(Month) (Day) (Year)

7. AGE

40 Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)*Housewife*

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Francis Joplin

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Martha Miller

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

According to my knowledge
(Informant) *Martha E. High-Borkkapu*
(Address) *Idaho Evans Gayles, Blft.*

15.

Filed *Sept 1* 19 *Mo Thaler E. Pat*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 1 19 *22*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 18 19 *21*, to *Sept 1* 19 *22*
that I last saw her alive on *Sept 1* 19 *22*
and that death occurred on the date stated above, at *4:30* P.M.

The CAUSE OF DEATH* was as follows:

Internal hemorrhage
due to rupture of blood vessel
sudden (Duration) Yrs. mos. ds.
Contributory *Psychosis, Chronic*
(Secondary) *Recurrent Type*
(Duration) Yrs. mos. ds.(Signed) *W. H. Joplin* M. D.*9-4* 19 *22* (Address) *Blackfoot, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death *1* yrs. *1* mos. *14* days. In the State *40* yrs. mos. daysWhere was disease contracted if not at place of death? *Unknown*Former or usual residence *Boise*

19. PLACE OF BURIAL OR REMOVAL

Boise Idaho

DATE OF BURIAL

On arrival

20. UNDERTAKER

E. L. Egli

ADDRESS

Blackfoot

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39244**Registered No. **138**

1. PLACE OF DEATH

County of *Bingham*City of *Blackfoot*Registration District No. *131*Registration District No. *1007*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ernest Valon Barnard

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

*Female White**Single*

6. DATE OF BIRTH

Aug 8 1915
(Month) (Day) (Year)

7. AGE

7 Yrs. *0* Mos. *19* ds.LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

At school

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

John N. Barnard

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Elizabeth E. Barnard

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John M. Barnard

(Address)

Blackfoot

15.

Filed

13 19 *22**Mrs. Valon E. Pate*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 2 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 1 1922 to *Sept 7 1922*
that I last saw her alive on *Sept 7 1922*
and that death occurred on the date stated above, at *6 P* M.

The CAUSE OF DEATH* was as follows:

Cardiac insufficiency(Duration) Yrs. *5* mos. *7* ds.Contributory (Secondary) *Rheumatism + Mitral Stenosis + insufficiency*(Duration) Yrs. *1* mos. *7* ds.(Signed) *W. W. Beck* M. D.*9/3 1922* (Address) *Blackfoot, Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. *3* mos. *7* days. In the State Yrs. *3* mos. *7* days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Grove City Cem.**9/3 1922*

20. UNDERTAKER

ADDRESS

*E. L. Egli**Blackfoot*

1. PLACE OF DEATH

County of Bingham Registration District No. 121
 City of Blackfoot Principal Registration District No. 2194 St.)
 BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Edward Merrill

CERTIFICATE OF DEATH

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 39246

Registered No. 140

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED

Male | Caucasian | Single
 (Write the word.)

6. DATE OF BIRTH

..... 1 860
 (Month) (Day) (Year)

7. AGE

62 Yrs. Mos. ds. IF LESS than 1 day
 how many hrs.
 or min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

New York

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

New York

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

According to ussary. Recd. by
 (Informant) Martha E. High - Bookkeeper
 (Address) Idaho Lumber Co. Bldg. Blft

15.

Filed Sept. 5 19 22 Mrs. Thelma E. P. P. P.
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept. 4 19 22
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 13 19 22, to Sept 4 19 22
 that I last saw him alive on Sept 4 19 22
 and that death occurred on the date stated above, at 4:02 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis
Parenchymatous

(Duration) 1 Yrs. mos. ds.

Contributory Arteriosclerosis of Cor. Artery
 (Secondary)

(Duration) 1 Yrs. mos. ds.

(Signed) Dr. J. H. P. P. M. D.

8-5 19 22 (Address) Blackfoot, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. 2 mos. 22 days. In the State 3 yrs. mos. days

Where was disease contracted if not at place of death? Unknown

Former or usual residence Pocatello, Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bingham Cemetery Sept. 5 19 22

20. UNDERTAKER

ADDRESS

Frank Wilkerson Blackfoot, Ida.

FORM V. S. No. 5-25 M. 1-19:

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39247**Registered No. **141**

1. PLACE OF DEATH

Registration District No. **121**
County of **Blaine** Primary Registration District No. **2194**
City of **Blackfoot** (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

James Almstead

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OR DIVORCED**Male Caucasian Single**
(Write the word.)

6. DATE OF BIRTH

1861
(Month) (Day) (Year)

7. AGE

61 Yrs. Mos. ds.
IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

Laborer

9. BIRTHPLACE

(State or Country)

Pennsylvania

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

According to my records
(Informant) **Mrs. M. E. High - Bookkeeper**
(Address) **Idaho Empire City, Sept.**

15.

Filed **Sept. 9 1922** **Mrs. M. E. High**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept. 8 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 7 1922, to Sept. 8 1922that I last saw him alive on **Sept. 8 1922**and that death occurred on the date stated above, at **6:15 P.M.**

The CAUSE OF DEATH* was as follows:

Exhaustion of Senile Dementia

(Duration) Yrs. mos. ds.

Contributory **Senile Dementia**
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) **C. H. Hopson M. D.****8/19/22** (Address) **Blackfoot, Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. **5** mos. days. In the State yrs. mos. daysWhere was disease contracted if not at place of death? **unknown**Former or usual residence **Parma, Idaho**

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Gaylum Cemetery Sept. 9 1922

20. UNDERTAKER

ADDRESS

F. Wilkerson Blackfoot

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bingham Registration District No. 121
 City of Blackfoot Primary Registration District No. 1007
14 East Court St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ben Muir

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 39248Registered No. 142

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
 (Write the word.)

6. DATE OF BIRTH

Jun 27 1867
 (Month) (Day) (Year)

7. AGE

55 Yrs. 2 Mos. 20 ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

Timber Suburban

9. BIRTHPLACE

(State or Country)

Bountiful Utah

10. NAME OF FATHER

Wm Muir

11. BIRTHPLACE OF FATHER

(State or Country)

Scotland

12. MAIDEN NAME OF MOTHER

Lucy Marks

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Ben Muir
 (Address) Blackfoot, Idaho

15.

Filed Sept 20 1922 Mrs Kate E. Palmer
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 15 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 15 1922 to 19
 that I last saw h..... alive on.....19.....
 and that death occurred on the date stated above, at.....M.

The CAUSE OF DEATH* was as follows:

acute dilatation of heart

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) J. O. Hays M. D.

9/20.19.22 (Address) Blackfoot Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....Yrs.....mos.....days. In the State.....Yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Green City Cemetery Sept 21, 1922

20. UNDERTAKER

ADDRESS

E. J. Park Blackfoot

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39250**Registered No. **744**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

Registration District No. **121**
County of **Bingham** Primary Registration District No. **2194**
City of **Blackfoot** (No. _____) St. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Walter E. Golden

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

Caucasian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

August 8, 1884
(Month) (Day) (Year)

7. AGE

38 Yrs. 1 Mos. 19 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)**Carpenter**

9. BIRTHPLACE

(State or Country)

Kansas

10. NAME OF FATHER

George Golden

11. BIRTHPLACE OF FATHER

(State or Country)

Illinois

12. MAIDEN NAME OF MOTHER

Anna Allen

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Wm. H. E. High - Blackfoot**
(Address) **Blackfoot, Idaho**

15. Filled

Sept. 30, 1922 Mrs. Hales E. P. Baker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept. 27, 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 7, 1922, to Sept. 27, 1922
that I last saw him alive on **Sept. 27, 1922**
and that death occurred on the date stated above, at **8 P.M.**
The CAUSE OF DEATH* was as follows:**Parasites**(Duration) **2 Yrs. mos. ds.**

Contributory (Secondary)

(Duration) **4 Yrs. mos. ds.**

(Signed)

W. H. E. High M. D.(Address) **Blackfoot, Ida**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death, **1 yrs. 2 mos. 20 days** In the State **10 yrs. mos. days**Where was disease contracted if not at place of death? **Unknown**Former or usual residence **Twin Falls, Idaho**

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Byron K. Kiska 19

20. UNDERTAKER

ADDRESS

E. J. Baker **Blackfoot**

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Bingham Registration District No. 121
City of Thomas Primary Registration District No. 2194
(No. _____) St. _____

File No. 39251

Registered No. 146

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robert Walters

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH Feb. 12 1885
(Month) (Day) (Year)

7. AGE 67 Yrs. 7 Mos. 17 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE England
(State or Country)

10. NAME OF FATHER Henry Walters

11. BIRTHPLACE OF FATHER England
(State or Country)

12. MAIDEN NAME OF MOTHER Sarah Booth

13. BIRTHPLACE OF MOTHER England
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Emily Walters
(Address) Blackfoot R.R. 2

15. Filed Oct 3 1922 Mrs J. E. Walters
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 29 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I investigated attended deceased from _____ to _____
that I last saw him _____ alive on _____
and that death occurred on the date stated above, at 11:20 P. M.
The CAUSE OF DEATH* was as follows:

Endocarditis

(Duration) _____ Yrs. 6 mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) E. L. Egli Coroner, M. D.
9/30 1922 (Address) Blackfoot Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Thomas Riverside DATE OF BURIAL 10/3 1922

20. UNDERTAKER E. L. Egli ADDRESS Blackfoot

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39252**Registered No. **143**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

Registration District No. **131**
County of **Bingham** Primary Registration District No. **2194**
City of **Groveland** (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ernest F. Hale

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male**White****Married**

6. DATE OF BIRTH

Sept 4 1863
(Month) (Day) (Year)

7. AGE

59 Yrs. 0 Mos. 25 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Farmer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Grantville Ill

10. NAME OF FATHER

Alma H. Hale

11. BIRTHPLACE OF FATHER

(State or Country)

Mass.

12. MAIDEN NAME OF MOTHER

Sarah Ann Clark

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Ernest F. Hale
Blackfoot R.R. 1

15.

Filed

Oct 2 1922
Mr. Hale
Blackfoot

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 29 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 20 1922 to **Sept 29 1922**that I last saw him alive on **Sept 20 1922**and that death occurred on the date stated above, at **9 P.M.**

The CAUSE OF DEATH* was as follows:

Sub. Aortal Goitre(Duration) **Probably 3 Yrs.** — mos. — ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) **W. U. Beck** M. D.**10/2 1922** (Address) **Blackfoot, Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Groveland Cemetery

DATE OF BURIAL

10/2 1922

20. UNDERTAKER

E. L. Egle

ADDRESS

Blackfoot

FORM V. S. No. 5-25 M. 1-19.

RECORDED

1922

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39253**
Registered No. **147**

1. PLACE OF DEATH

County of *Bingham*Registration District No. *121*City of *near Taylor*(No. *near Taylor*)

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Francis Paterson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

(Write the word.)

6. DATE OF BIRTH

Dec 21
(Month)*1922*
(Day)*1922*
(Year)

7. AGE

1 Yrs. *9* Mos. ds.

IF LESS than 1 day

how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

no.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Tamworth Idaho

10. NAME OF FATHER

James R Paterson

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Irvin Bousson

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

James R Paterson

(Address)

Tamworth Idaho

15. Filed

*Sept. 11 1922**Wm. H. E. Paterson*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

64

16. DATE OF DEATH

(Month)

(Day)

Sept 9 1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 9 1922 to *Sept 9 1922*that I last saw *her* alive on *Sept 9 1922*and that death occurred on the date stated above, at *945 P.M.*

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration)

Yrs.

mos.

ds.

Contributory (Secondary)

Acute Gastro Enteritis

(Duration)

Yrs.

mos.

ds.

(Signed)

W. R. Egbert

M. D.

Sept. 11 1922

(Address)

Shelley Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

yrs.

mos.

days

In the

State

yrs.

mos.

days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Taylor, Ida.**Sept 11 1922*

20. UNDERTAKER

ADDRESS

*Egbert**Idaho Falls**W. R. Egbert**Idaho*

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39254**
Registered No. **148**

1. PLACE OF DEATH

County of Bingham Registration District No. 121
City of Moore Primary Registration District No. 2194 (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Leroy R. Adams

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH

Sept. 1 1921
(Month) (Day) (Year)

7. AGE

1 Yrs. 25 Mos. 25 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

St. house

9. BIRTHPLACE

(State or Country)

Idaho.

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

Leroy R. Adams

Idaho.

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Mabel Hammer

Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Joseph Adams
Shelley Idaho

Filed

Sept. 25, 1922 Mo. Hallett

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

9-26- 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9-16 1922 to 9-26 1922 that I last saw him alive on 9-26-1922 and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Catarrhal Enterocolitis

(Duration) Yrs. mos. 3 ds.
Contributory (Secondary) Acute Dysentery

(Duration) yrs. mos. 10 ds.

(Signed) Edwin Cutler M. D.

9/27, 1922 (Address) Shelley, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Shelley, Idaho 9-28, 1922

20. UNDERTAKER

ADDRESS

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
SEP 13 1922
BUREAU OF STATISTICS
CERTIFICATE OF DEATHState of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 39255

Registered No. 30

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Blaine

City of Stanley

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

(No.)

St.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married

(Write the word.)

6. DATE OF BIRTH

Sept 20 1872

(Month)

(Day)

(Year)

7. AGE

49 Yrs. 9 Mos. 24 ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Merchant

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Wyoming

10. NAME OF FATHER

Christian Mitschke

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Mrs. F. H. Mitschke

15.

Filed

9-10

1922

F. H. Wright

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 14 1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 1919, to July 1922

that I last saw him alive on July 13 1922

and that death occurred on the date stated above, at 7 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) 3 Yrs. — mos. — ds.

Contributory (Secondary)

(Duration) — yrs. — mos. — ds.

(Signed) J. H. Turner M. D.

19 (Address) Stanley, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Stanley, Ida.

DATE OF BURIAL

7/28 1922

20. UNDERTAKER

J. H. Harris

ADDRESS

Stanley, Ida.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39256**Registered No. **29**1. PLACE OF DEATH **Blaine, Idaho**
County of **Blaine** Registration District No. **57**
City of **Blaine** Primary Registration District No. **2022**
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME **Nesley Fletcher Breshears**

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

283. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Married**
(Write the word.)6. DATE OF BIRTH **Oct. 25 1866**
(Month) (Day) (Year)7. AGE **56** Yrs. **9** Mos. **17** ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)**Merchant.**

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

Frederick Breshears

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Mary

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **John Davies**
(Address) **Bellevue Ida**15. **9-10 1922** **R. H. Wright**
Filed Local Registrar16. DATE OF DEATH **Tue. July 7 1922**
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from **6-10 1922** to **7-7 1922**
that I last saw him alive on **7-7 1922**
and that death occurred on the date stated above, at **2 A.M.**

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lunge(Duration) **4** Yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) **E. H. Reed** M. D.**7-7 1922** (Address) **Hailey Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **Bellevue Ida** DATE OF BURIAL **7/9 1922**20. UNDERTAKER **O. D. Davis** ADDRESS **Bellevue, Ida**
Hailey,

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39257**
Registered No. **48**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH **RECEIVED**County of **Blaine** Registration District No. **57**
City of **Bellevue** Primary Registration District No. **2022**
(Write the word.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Theresa Mary Puscoe**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Widowed**
(Write the word.)

6. DATE OF BIRTH

Sept. 17 19**22**
(Month) (Day) (Year)

7. AGE

55 Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work **Housewife**
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) **Germany**

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country) **✓**

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country) **✓**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **R. H. Wright**
(Address) **Bellevue, Idaho**15. **9-10** 19**22** **R. H. Wright**
Filed Local RegistrarMEDICAL CERTIFICATE OF DEATH **48**

16. DATE OF DEATH

Teed
June 15 19**22**
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from **6-15** 19**22** to **6-15** 19**22**that I last saw her alive on **6-15** 19**22** and that death occurred on the date stated above, at **3 P.M.**

The CAUSE OF DEATH* was as follows:

Rheumatism(Duration) Yrs. **7** mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) **Dr. E. H. Teed** M. D.**7-7** 19**22** (Address) **Hailey Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bellevue **7-7** 19**22**

20. UNDERTAKER

ADDRESS

Harris **Hailey, Idaho**

Dr. Page

CERTIFICATE OF DEATH

1. PLACE OF DEATH

Registration District No. 78
 County of Bonner
 City of Sandpoint Primary Registration District No. 2155
 (No. _____) (St. _____)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Kitchen

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 39258
 Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
 (Write the word.)

6. DATE OF BIRTH

Aug. 3 1922
 (Month) (Day) (Year)

7. AGE

IF LESS than 1 day
 how many _____ hrs.
 or _____ min. ?
 _____ Yrs. _____ Mos. _____ ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

None

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Fred Kitchen

11. BIRTHPLACE OF FATHER

(State or Country)

Canada

12. MAIDEN NAME OF MOTHER

Alice Boylen

13. BIRTHPLACE OF MOTHER

(State or Country)

Wisc. Minn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Fred Kitchen

(Address)

Sandpoint Idaho

15.

Filed Sept 4 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

August 3 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 3 - 1922 to Aug 3 1922
 that I last saw him alive on Aug 3 1922
 and that death occurred on the date stated above, at 2:30 A.M.

The CAUSE OF DEATH* was as follows:

Exhaustion
Probable cause Operation
(abdominal) on mother during pregnancy
 (Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed)

O. J. Page

M. D.

Sept 4 1922(Address) Sandpoint

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Lakeview Cemetery

DATE OF BURIAL

8/3 1922

20. UNDERTAKER

MOON & DALE

ADDRESS

Sandpoint Idaho

Dr. ~~William~~ *William*

CERTIFICATE OF DEATH

1. PLACE OF DEATH **SEP 1**
 County of *Bonner* Registration District No. *78*
 City of *Sandpoint* Primary Registration District No. *2155*
 (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Mass

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. **39259**
 Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Widowed*
 (Write the word.)

6. DATE OF BIRTH

Dec. 25 19*22*
 (Month) (Day) (Year)

7. AGE

92 Yrs. *7* Mos. *6* ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer)

Contractor; Retired.
Builder.

9. BIRTHPLACE

(State or Country)

England.

10. NAME OF FATHER

William Mass.

11. BIRTHPLACE OF FATHER

(State or Country)

England.

12. MAIDEN NAME OF MOTHER

Unknown.

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs E. L. Burgess

(Address)

Sandpoint, Idaho.

15.

Filed *Aug 4* 19*22*

Viola Allen
 Deputy Local Registrar

MEDICAL CERTIFICATE OF DEATH

154

16. DATE OF DEATH

July 19*22*
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *July* 19*22*, to *July 31* 19*22*
 that I last saw him alive on *July 31* 19*22*
 and that death occurred on the date stated above, at *7:30* M.

The CAUSE OF DEATH* was as follows:

Senile Ulcerative Stomach
Arterio Sclerosis
Old age

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

E. J. Anderson M. D.

Aug 2 19*22* (Address) *Sandpoint*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

La Cross Wre

19

20. UNDERTAKER

ADDRESS

MOON & DALE *Sandpoint, Idaho*
L. B. Moon,

FORM V. S. No. 5-25 M. 7-16-17

Dr. Wendell

CERTIFICATE OF DEATH.

1. PLACE OF DEATH
 Registration District No. 78.
 County of Conner
 Primary Registration District No. 2155
 City of Selle
 (No. St.)

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 39260

Registered No.

If death occurs away from
 usual residence, give facts
 called for under special
 information.

2. FULL NAME

John H. Peterson

If death occurred in a hos-
 pital, institution or camp,
 give its NAME instead of
 street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED.

MaleWhiteMarried

(Write the word.)

6. DATE OF BIRTH.

Jan.30.1884.

(Month)

(Day)

(Year)

7. AGE

38

Yrs.

6

Mos.

12

ds.

IF LESS than 1 day
 how many hrs. or
 min. 2)

8. OCCUPATION

(a) Trade, profession or
 particular kind of work....
 (b) General nature of in-
 dustry, business, or estab-
 lishment in which employ-
 ed (or employer).....

Farmer.

9. BIRTHPLACE

(State or Country)

Finland.

10. NAME OF FATHER

Pete Bobacka.

11. BIRTHPLACE OF FATHER

(State or Country)

Finland.

12. MAIDEN NAME OF MOTHER

Unknown.

13. BIRTHPLACE OF MOTHER

(State or Country)

Finland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Lena Peterson

(Address)

Selle, Idaho.

15.

Filed Sept 7 1922

Vivita Allen
 Deputy Local Registrar

MEDICAL CERTIFICATE OF DEATH

40

16. DATE OF DEATH

Aug.

(Month)

11.

(Day)

1922.

(Year)

17. I HEREBY CERTIFY, That I attended deceased from
 191..... to 191.....

that I last saw him alive on Aug-10 1922

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Floyd C. Wells M. D.Sept 4 1922 (Address) Sandpoint, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
 MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
 Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted
 if not at place of death?.....

Former or
 usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sandpoint Idaho.8/13 1922

20. UNDERTAKER

ADDRESS

MOON & DALESandpoint Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13 Bonner Moore CERTIFICATE OF DEATH.

1. PLACE OF DEATH. 622 Registration District No. 78
County of Bonner Primary Registration District No. 2155
City of Midvale (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME E. W. Pember

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 39261

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widowed
(Write the word.)

6. DATE OF BIRTH.

Nov 23 1
(Month) (Day) (Year)

7. AGE

66 Yrs. _____ Mos. _____ ds.
IF LESS than 1 day how many _____ hrs. or _____ min. >]

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

Day labor.

9. BIRTHPLACE

(State or Country)

Ill.

10. NAME OF FATHER

Unknown.

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dr. C. C. Cator(Address) Sanford, Idaho

15.

Filed Sept 4 1922

V. J. Moore
Deputy Local Registrar

MEDICAL CERTIFICATE OF DEATH 167

16. DATE OF DEATH

Aug 19 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____ 191____, to _____ 191____,
that I last saw him _____ alive on _____ 191____

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Suicide

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) E. M. Moore M.D.8/19/22 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lakeview Cemetery. 8/22/22

20. UNDERTAKER

ADDRESS

Moore and Dale
by E. M. Moore Sanford, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

Dr. Stackhouse

CERTIFICATE OF DEATH

1. PLACE OF DEATH **RECEIVED** Registration District No. **78**
County of **Bonner** Primary Registration District No. **2155**
City of **Sandpoint** (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Elizabeth Marie Bergstrom**

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. **39262**

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Single**
(Write the word.)

6. DATE OF BIRTH. **May 13, 1919.**
(Month) (Day) (Year)

7. AGE **3** Yrs. **4** Mos. **11** ds.
IF LESS than 1 day how many hrs. or min. 2)

8. OCCUPATION
(a) Trade, profession or particular kind of work... **None**
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE **Idaho**
(State or Country)

10. NAME OF FATHER **Carl Bergstrom**

11. BIRTHPLACE OF FATHER **Sweden**
(State or Country)

12. MAIDEN NAME OF MOTHER **Selina Anderson**

13. BIRTHPLACE OF MOTHER **Wisconsin**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) **Carl Bergstrom**
(Address) **Sandpoint, Idaho**

15. _____

Filed **Sept 4** 19**22** **Vida** Deputy Local Registrar

MEDICAL CERTIFICATE OF DEATH **92**

16. DATE OF DEATH **August 24, 1922.**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Aug 22 1922** to **Aug 24 1922**, that I last saw her alive on **Aug 24 1922** and that death occurred on the date stated above, at **9 P.M.**

The CAUSE OF DEATH* was as follows:
Tubercular Pneumonia -

(Duration) Yrs. _____ mos. **3** ds.
Contributory (Secondary) **Enteric Colitis.**

(Duration) Yrs. _____ mos. **3** ds.
(Signed) **C. P. Stackhouse** M. D.
16.19.22 (Address) **Sandpoint**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **Lakeview Cemetery** DATE OF BURIAL **8/27 1922**

20. UNDERTAKER **MOON & DALE** ADDRESS **Sandpoint, Idaho.**

Dr Page
CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of BonnerCity of Sandpoint

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No. 78Primary Registration District No. 2155

(No. _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 39263

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the words)

6. DATE OF BIRTH

(Month)

(Day)

(Year)

7. AGE

76 Yrs.

Mos.

ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

Woodman.

9. BIRTHPLACE

(State or Country)

Virginia

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

"

12. MAIDEN NAME OF MOTHER

"

13. BIRTHPLACE OF MOTHER

(State or Country)

"

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

City HospitalSandpoint, Idaho

15.

Filed

Sept 21922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

August 29, 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Aug 15 1922 to Aug 29 1922 that I last saw him alive on Aug 29 1922 and that death occurred on the date stated above, at 5 A M.

The CAUSE OF DEATH was as follows:

Cerebral hemorrhage.

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

M. D.

1922 (Address) Sandpoint

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Greenview Cemetery 9/8 1922

20. UNDERTAKER

ADDRESS

Moore & Sons Sandpoint, Ida.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

39264

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of **Bonner**City of **Priest River**

If death occurs away from usual residence, give facts called for under special information.

RECEIVED

SEP 15 1922

BUREAU OF VITAL STATISTICS

Registration District No.

Primary Registration District No. **2486**

St.)

File No. **2**Registered No. **66**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME **John Peter Hagman**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widowed

(Write the word.)

6. DATE OF BIRTH

March 17 1840
(Month) (Day) (Year)

7. AGE

82 Yrs. 4 Mos. 29 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Sweden

10. NAME OF FATHER

Johnson

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME OF MOTHER

Not known

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Albert Hagman
Priest River, Ida,

15.

Filed

Sept. 1**1922**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 15 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 6 1922 to Aug 15 1922
that I last saw him alive on **Aug 11 1922**
and that death occurred on the date stated above, at **10A** M.

The CAUSE OF DEATH* was as follows:

Intestinal Hemorrhage.(Duration) Yrs. mos. **6.** ds.Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

C. F. Getz M. D.**Aug 16 1922** (Address **Priest River,**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Priest River,**Wm Davis**

DATE OF BURIAL

Aug 17 1922

ADDRESS

Newport

FORM V. S. No. 5-25 M.

RECEIVED
OCT 3 1922
BUREAU OF VITAL
STATISTICSDr. Wendle
CERTIFICATE OF DEATH.

39265

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics1. PLACE OF DEATH
County of Bonneville
City of Hope
Registration District No. 2157
Primary Registration District No. 2157
St.)File No. 1
Registered No. 32

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Joseph Spencer Harming

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.Male White Married
(write the word.)

6. DATE OF BIRTH.

June 17 1897
(Month) (Day) (Year)

7. AGE

15 Yrs. 2 Mos. 3 ds.

IF LESS than 1 day
how many.....hrs. or
.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

Carpenter.

9. BIRTHPLACE

(State or Country)

New York.

10. NAME OF FATHER

John M. Harming.

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown.

12. MAIDEN NAME OF MOTHER

"

13. BIRTHPLACE OF MOTHER

(State or Country)

"

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Antoinette Harming

(Address) Hope Idaho.

15.

Filed

Sept. 18 1922 John Larson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

79

16. DATE OF DEATH

Sept. 15 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 1920 to Sept. 1922.

that I last saw him alive on Sept. 11 1922.

and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

(Duration) 3 Yrs. mos. ds.

Contributory
(Secondary)

Sensitivity

(Duration) yrs. mos. ds.

(Signed) Floyd G. Wendle M. D.

9-18-22 (Address) Sandpoint, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Hope, Idaho.

DATE OF BURIAL

7/17, 1922.

20. UNDERTAKER

Moon & Sons
139 S. 8th St.

ADDRESS

Sandpoint Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF BIRTH		REGISTRATION DISTRICT No.		39266		BOARD OF HEALTH Bureau of Vital Statistics	
Trestle Creek		Idaho		80		Idaho	
City of		Trestle Creek		St.)		Registered No.	
If death occurs away from usual residence, give facts called for under special information.		2. FULL NAME		Leta C. White.		If death occurred in a hospital, institution or camp, give its NAME instead of street and number.	
PERSONAL AND STATISTICAL PARTICULARS							
3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED					
Female	White	Married					
6. DATE OF BIRTH							
October 8, 1887.							
7. AGE							
35 Yrs. 11 Mos. 9 ds.							
8. OCCUPATION							
Housewife							
9. BIRTHPLACE							
Pennsylvania							
10. NAME OF FATHER							
Gaylore Hume							
11. BIRTHPLACE OF FATHER							
Pennsylvania							
12. MAIDEN NAME OF MOTHER							
Unknown							
13. BIRTHPLACE OF MOTHER							
Pennsylvania							
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE							
(Informant) W. H. White							
(Address) Trestle Creek, Idaho.							
15. Filed Sept 18 1922 John Larson							
Local Registrar							
MEDICAL CERTIFICATE OF DEATH							
16. DATE OF DEATH							
September 17, 1922.							
17. I HEREBY CERTIFY, That I attended deceased from 9/16/22 19 to 9/16/22 19 that I last saw her alive on 9/16/22 19 and that death occurred on the date stated above, at M. The CAUSE OF DEATH* was as follows: strychnine poisoning, self administered with suicidal intent							
(Duration) Yrs. mos. ds.							
Contributory (Secondary) Insanity							
(Duration) 2 yrs. mos. ds.							
(Signed) M. P. Waller M. D.							
7/18 19 22 (Address) Sandpoint Idaho							
*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.							
18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)							
At place of death yrs. mos. days. In the State yrs. mos. days.							
Where was disease contracted if not at place of death?							
Former or usual residence							
19. PLACE OF BURIAL OR REMOVAL							
Hope, Idaho.							
DATE OF BURIAL							
9/19/22							
20. UNDERTAKER							
MOON & DALE							
ADDRESS							
Sandpoint, Idaho.							
By L. Moon							

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of BonnerCity of Sandpoint

If death occurs away from usual residence, give facts called for under special information.

Dr. W. Valentine
RECEIVED
OCT 6 1922
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 78Primary Registration District No. 2155

State of Idaho,
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 39267

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

John Alexander Stewart

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write one word.)

6. DATE OF BIRTH

march - 15th 1948
(Month) (Day) (Year)

7. AGE

14 Yrs. 5 Mos. 19 ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Book-keeper

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Canada

10. NAME OF FATHER

Alexander Stewart

11. BIRTHPLACE OF FATHER

(State or Country)

Scotland

12. MAIDEN NAME OF MOTHER

Mary Stewart

13. BIRTHPLACE OF MOTHER

(State or Country)

Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Geo. Auland

(Address)

Genfield Wash

15.

Filed

Sept 14 1922

Viola Allen
Deputy Local Registrar

MEDICAL CERTIFICATE OF DEATH

39.

16. DATE OF DEATH

Sept 4 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug. 20 1922 to Sept 11 1922that I last saw him alive on Sept 4 1922and that death occurred on the date stated above, at 7:39 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of throat(Duration) _____ Yrs. 6 mos. _____ ds.Contributory Hemorrhage throat
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W. R. Valentine M. D.9-5 1922 (Address) Sandpoint

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Genfield Wash.9/6 1922

20. UNDERTAKER

ADDRESS

Moore and Dale
By L. M. J.

Sandpoint, Ida.

1. PLACE OF DEATH OCT 6 1922
 Registration District No. 78.
 County of Conner BUREAU OF VITAL STATISTICS
 Primary Registration District No. 2155
 City of Sandpoint (No. _____ St.)

File No. 39268
 Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

J. G. Wager.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male White Single
 (Write the word.)

6. DATE OF BIRTH

1868
 (Month) (Day) (Year)

7. AGE

54 Yrs. — Mos. — ds.

IF LESS than 1 day
 how many _____ hrs.
 or _____ min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

Woodman.

9. BIRTHPLACE

(State or Country)

Unknown

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

City Hospital
Sandpoint

15. Sept 4
 Filed Sept 4 1922

Viola Allen
Deputy Local Registrar

MEDICAL CERTIFICATE OF DEATH

31

16. DATE OF DEATH

Sept. 6 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 3 1922, to Sept 6 1922
 that I last saw him alive on Sept 6 1922,
 and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Syphilis

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed)

Sept 19 22

(Address)

W. J. P. M. D.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Funerary Building

7/9 1922

20. UNDERTAKER

Moore & Sons
By J. Moore

ADDRESS

Sandpoint, Ida.

Dr. Wallentine

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of BonnerCity of Sandpoint

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 78Primary Registration District No. 2155

(No. _____ St.)

2. FULL NAME

David Henry LegerState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 39269

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Dec. 1 1921
(Month) (Day) (Year)

7. AGE

9 Yrs. 14 Mos. 14 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Edgar Leger

11. BIRTHPLACE OF FATHER

(State or Country)

Neb.

12. MAIDEN NAME OF MOTHER

Norma Hale

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Edgar H. Leger

(Address)

Sandpoint Idaho

15.

Filed

Oct. 2 1922Viola Allen
Deputy Local Registrar

MEDICAL CERTIFICATE OF DEATH

61-5

16. DATE OF DEATH

Sept. 15 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from 9/12/1922 to 9/15/1922 that I last saw him alive on 9/14/1922 and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

acute fibrin meningitis(Duration) _____ Yrs. _____ mos. 7 ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Dr. Wallentine M. D.7/18/22 (Address) Sandpoint Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lakewood Cemetery9/16 1922

20. UNDERTAKER

MOON & DALE

ADDRESS

Sandpoint Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39270**

1. PLACE OF DEATH **RECEIVED**
County of **Bonner** Registration District No. **76**
City of **Kootenai** Primary Registration District No. **2153**
(No.) (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

(Infant) Basden

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

male | white | single (Write the word.)

6. DATE OF BIRTH

Sept 26 1922
(Month) (Day) (Year)

7. AGE

Yrs. Mos. 1 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Clon Dike Basden

11. BIRTHPLACE OF FATHER

(State or Country) Okla.

12. MAIDEN NAME OF MOTHER

Mildred Schedler

13. BIRTHPLACE OF MOTHER

(State or Country) Wis

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C.D. Basden

(Address) Kootenai

15.

Filed Oct 2 1922

Viola Allen
Deputy Local Registrar

16. DATE OF DEATH

Sept 27 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

9/26/22 19 to 9/27/22 19
that I last saw him alive on 9/27/22 19
and that death occurred on the date stated above, at 11:30 AM.

The CAUSE OF DEATH* was as follows:

prematurity (7 months gestation)

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. R. W. M. D.

1922 (Address) Sandpoint Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDER TAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 78

County of Blaine

Primary Registration District No. 2155

City of Sandpoint

(No.)

St.)

File No. 39271

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Walfrid Bystrom

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male White

Unknown
(Write the word.)

6. DATE OF BIRTH.

Not Known

(Month)

(Day)

(Year)

7. AGE

38

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs. or
min. >

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Not Known

9. BIRTHPLACE

(State or Country)

Sweden

10. NAME OF FATHER

Not Known

11. BIRTHPLACE OF FATHER

(State or Country)

Not Known

12. MAIDEN NAME OF MOTHER

Not Known

13. BIRTHPLACE OF MOTHER

(State or Country)

Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

E. M. Moore
Sandpoint Ida

15.

Filed Oct 3 1922

Viola Allen
Deputy Local Registrar

16. DATE OF DEATH

Sept.

26

1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191

to

191

that I last saw him alive on

191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Diseases of the arteries of the left arm, hanging by the neck.
- Suicidal -

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed) E. M. Moore

9/30/1922 (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

yrs. mos. days

In the

State

yrs. mos. days

Where was disease contracted if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lakeview Cemetery

9/30 1922

20. UNDERTAKER

MOON & DALE

ADDRESS

R. Moon

Sandpoint Ida

REGISTRATION DISTRICT No. 73
CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bannock Registration District No. 73
City of Idaho Falls Secondary Registration District No. 215-0 St.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Christina BrostromState of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 39272
Registered No. 103

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

July 19 1870
(Month) (Day) (Year)

7. AGE

57 Yrs. 1 Mos. 0 ds.IF LESS than 1 day
how many hr.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)at Home

9. BIRTHPLACE

(State or Country)

Sweden

10. NAME OF FATHER

Christian Swanson

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME OF MOTHER

!

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John Brostrom

(Address)

R. D. 1, Idaho Falls

15.

Filed

Aug 14 1922
W. H. Woodley
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 19 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 1st 1922 to June 19 1922
that I last saw her alive on June 19 1922and that death occurred on the date stated above, at 119 M.

The CAUSE OF DEATH* was as follows:

Congestive Embolism.(Duration) Yrs. mos. 1 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) A. P. Soderquist M. D.6/21/22 (Address) Idaho Falls, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Farmer or usual residence

19. PLACE OF BURIAL OR REMOVAL

Idaho Falls

DATE OF BURIAL

6/21/22

20. UNDERTAKER

W. H. Woodley

ADDRESS

Idaho FallsA. P. Soderquist

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of *Bonerville* District No. *73*
City of *Idaho Falls* District No. *21* St. *Idaho Falls*

File No. *39273*
Registered No. *6*

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

John Ross Tyler

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *single*
(Write the word.)

16. DATE OF DEATH *July 21 1922*
(Month) (Day) (Year)

6. DATE OF BIRTH *Apr 10 1908*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *July 16 1922* to *July 21 1922*
that I last saw him alive on *July 21 1922*
and that death occurred on the date stated above, at *5 P. M.*
The CAUSE OF DEATH* was as follows:

7. AGE *14* Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

Tetanus

8. OCCUPATION
(a) Trade, profession or particular kind of work *School boy*
(b) General nature of industry, business or establishment in which employed (or employer)

(Duration) Yrs. mos. ds. *4*

9. BIRTHPLACE *Idaho*
(State or Country)

Contributory (Secondary) *Injury to knee*

10. NAME OF FATHER *Geo P. Tyler*

(Duration) Yrs. mos. ds. *19*

11. BIRTHPLACE OF FATHER *Utah*
(State or Country)

(Signed) *Jabez West* M. D.
7/24 1922 (Address) *Idaho Falls*

12. MAIDEN NAME OF MOTHER *Myrtle D. Gye*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

13. BIRTHPLACE OF MOTHER *Utah*
(State or Country)

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *Geo P Tyler*
(Address) *Idaho Falls*

At place of death yrs. mos. *3* days. In the State yrs. mos. days

Where was disease contracted if not at place of death? *Utah*

Former or usual residence

15. Filed *Aug 14 1922* Local Registrar *Idaho Falls*

19. PLACE OF BURIAL OR REMOVAL *Idaho Falls* DATE OF BURIAL *July 22 1922*

20. UNDERTAKER *Idaho Falls* ADDRESS *Idaho Falls*

1. PLACE OF DEATH

County of Blaineville Registration District No. 73
 City of Idaho Falls Primary Registration District No. 2100
Idaho Falls Idaho Falls St.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Thos. Walter Williams

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 39274

Registered No. 113

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widowed
 (Write the word.)

6. DATE OF BIRTH Oct 13 1853
 (Month) (Day) (Year)

7. AGE 68 Yrs. 9 Mos. 8 ds. IF LESS than 1 day how many..... hrs. or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer)

Farming

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

Joseph S. Williams

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Wester

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Guy Wilson
Rd 5 City

(Address)

15. Filed Oct 26 1922 C. J. Williams
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 21 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 10 1922, to July 21 1922
 that I last saw him alive on July 21 1922
 and that death occurred on the date stated above, at 59 M.

The CAUSE OF DEATH* was as follows:

Delayed Shock.

(Duration) Yrs. mos. 2 hrs.
 Contributory (Secondary) Prostatectomy operation
 (Duration) yrs. mos. 4 ds.
 (Signed) J. D. West M. D.
 19. (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cottman, Ida July 23 1922

20. UNDERTAKER

ADDRESS

66 Elmwood Idaho Falls

Dr. West

RECORDED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39275**
Registered No. **102**

1. PLACE OF DEATH

County of Bonneville Registration District No. 73
City of Idaho Falls Primary Registration District No. 2150
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Harriet M McKay

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH

Oct 27 1893
(Month) (Day) (Year)

7. AGE

28 Yrs. 9 Mos. 15 ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

at home

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

James Ward

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Francis Hardman

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

H. M. McKay
Idaho Falls

15.

Filed Aug 11 1922 W. J. McQuinn
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 11 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 3 1922 to Aug 11 1922 that I last saw h. alive on 11 of Aug. 1922 and that death occurred on the date stated above, at 2:49 M.

The CAUSE OF DEATH* was as follows:

Myocarditis (acute)
(Duration) Yrs. mos. 3 ds.
Contributory (Secondary) Ascending Hepatic Infection
(Duration) yrs. mos. 7 ds.
(Signed) H. J. McQuinn M. D.
1922 (Address) Idaho Falls, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Salt Lake, Utah

DATE OF BURIAL

8-12 1922

20. UNDERTAKER

B. B. Woodward

ADDRESS

Idaho Falls

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39276**
Registered No. **104**

1. PLACE OF DEATH **Homeville** Registration District No. **73**
County of **Bannock** Primary Registration District No. **214-0**
City of **Coltman** (Name) _____ (St.) _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Virginia Hansen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Married**
(Write the word.)

6. DATE OF BIRTH **January 17 1922**
(Month) (Day) (Year)

7. AGE **1 Yrs. 6 Mos. 10 ds.** IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. _____
(b) General nature of industry, business or establishment in which employed (or employer) _____

9. BIRTHPLACE **Idaho**
(State or Country)

10. NAME OF FATHER **Elias Hansen**

11. BIRTHPLACE OF FATHER **Utah**
(State or Country)

12. MAIDEN NAME OF MOTHER **Ivy Campbell**

13. BIRTHPLACE OF MOTHER **Utah**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **E. Hansen**
(Address) **Idaho Falls**

15. Filed **Aug 14 1922** **W. J. Hansen**
Local Registrar

16. DATE OF DEATH **July 27 1922**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **6 July 1922** to **27 July 1922**
that I last saw him alive on **27 July 1922**
and that death occurred on the date stated above, at **4:30 P.M.**
The CAUSE OF DEATH* was as follows:

Pneumonia
(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory (Secondary) _____

(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed) **B. M. Blaine** M. D.

7-28-22 (Address) **Idaho Falls**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL **Idaho Falls** DATE OF BURIAL **7-28-22**

20. UNDERTAKER **none** ADDRESS _____

RECEIVED
1922 CERTIFICATE OF DEATHState of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 39278

Registered No. 106

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Bannock Registration District No. 73
City of Idaho Falls Primary Registration District No. 2150
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Frank J. Lutz

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)6. DATE OF BIRTH Dec 11 1880
(Month) (Day) (Year)7. AGE 41 Yrs. 8 Mos. 1 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)Farming

9. BIRTHPLACE

(State or Country)

Miner Oregon

10. NAME OF FATHER

John Lutz

11. BIRTHPLACE OF FATHER

(State or Country)

Miner

12. MAIDEN NAME OF MOTHER

Eliy Repaugh

13. BIRTHPLACE OF MOTHER

(State or Country)

Miner

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. Bradley
near Idaho15. Filed Aug 14 1922 Amman
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 12 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Jan 10 1922 to Aug 12 1922
that I last saw him alive on July 12 1922
and that death occurred on the date stated above, at 8 a. M.
The CAUSE OF DEATH* was as follows:Pulmonary Tuberculosis

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) J. C. Hallister M. D.8-12-22 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Portland, Ore 8-13-22

20. UNDERTAKER

ADDRESS

B. E. Mumwood Idaho Falls

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bonneville Registration District No. 73
City of Idaho Falls Primary Registration District No. 214-0 St.

File No. 39279
Registered No. 107

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ether May Nickels

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH

Dec 6 1882
(Month) (Day) (Year)

7. AGE

39 Yrs. 7 Mos. 25 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

at home

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

H. F. Haskins

11. BIRTHPLACE OF FATHER

(State or Country)

New York

12. MAIDEN NAME OF MOTHER

Jennie May Bean

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

M. L. Nickels

(Address)

Idaho Falls

15. Filed

Aug 7 1922

Local Registrar

16. DATE OF DEATH

July 31 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19____, to 19____
that I last saw him alive on 19____
and that death occurred on the date stated above, at ____ M.

The CAUSE OF DEATH* was as follows:

Poison - self administered.

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

B. B. Llewellyn

8/3/22 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Idaho Falls

DATE OF BURIAL

8/5 1922

20. UNDERTAKER

B. B. Llewellyn

ADDRESS

Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Bonneville*
City of *Idaho Falls*

Registration District No. *73*

Primary Registration District No. *21V*

(No. *20* Street *St.*)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Leila Maund Ellis

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. **39280**

Registered No. *102*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*
(Write the word.)

6. DATE OF BIRTH *Aug 4 1918*
(Month) (Day) (Year)

7. AGE *3* Yrs. *8* Mos. *9* ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. *no.*
(b) General nature of industry, business or establishment in which employed (or unemployed).

9. BIRTHPLACE

(State or Country) *Idaho.*

10. NAME OF FATHER

Philip D Ellis

11. BIRTHPLACE OF FATHER

(State or Country) *Idaho.*

12. MAIDEN NAME OF MOTHER

Hazel G. Waring

13. BIRTHPLACE OF MOTHER

(State or Country) *Utah.*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Philip D Ellis
Susan Ida

(Address)

15.

Filed

Aug 14 1922
Wm. D. Quinn
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

August 13 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *July 29 1922* to *Aug 13 1922*, that I last saw her alive on *Aug 13 1922*, and that death occurred on the date stated above, at *1 P.M.*

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease Mitral Insufficiency

(Duration) Yrs. *5* mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

Andrew M. Canley M.D.

Aug 18 1922 (Address) *Idaho Falls Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rose Heights Falls

Aug 15 1922

20. UNDERTAKER

ADDRESS

Ed. Hays

Idaho Falls

FORM V. S. No. 5-5 M. 1-19.

VERIFIED CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bonneville
City of Idaho FallsRegistration District No. 73Primary Registrar District No. 214-0(No. 7108)

St.)

File No. 39281Registered No. 110

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Ida May Heymouth

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Child
(Write the word.)

6. DATE OF BIRTH

mch 7 1922
(Month) (Day) (Year)

7. AGE

10 Yrs. 5 Mos. 14 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

H.A. Heymouth

11. BIRTHPLACE OF FATHER

(State or Country)

Maine

12. MAIDEN NAME OF MOTHER

Julia Mahoney

13. BIRTHPLACE OF MOTHER

(State or Country)

Pa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

H.A. Heymouth
Salt Lake City, Utah

15.

Filed

Aug 26 1922
Idaho Falls

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 21 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Aug 20 1922 to Aug 21 1922 that I last saw her alive on Aug 21 1922 and that death occurred on the date stated above, at 20 M.

The CAUSE OF DEATH* was as follows:

Diphtheria

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

C.M. Clive

M. D.

8-22-22 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. 2 In the days. State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Salt Lake City, Utah 8-22-22

20. UNDERTAKER

ADDRESS

B.B. Drummond Idaho Falls

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39282**Registered No. **111**

1. PLACE OF DEATH

County of Bonneville
City of AmmonRegistration District No. 73
Primary Registration District No. 215-0
(Vol. 108) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Dale L Lindsey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDInfant
(Write the word.)

6. DATE OF BIRTH

Aug 7 1922
(Month) (Day) (Year)

7. AGE

0 Yrs. 0 Mos. 4 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

L. W. Lindsey

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Myrtle Ball

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Leonard Ball

(Address)

Rt 3

15.

Filed

Aug 16 1922

Local Registrar

D. M. Meller

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 11 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Aug. 6 1922 to Aug 11 1922that I last saw him alive on Aug. 8 1922

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Illegitimate child premature.
about 6 1/2 mos.

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

8-12-22 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Ammon Id 8-12-1922

20. UNDERTAKER

ADDRESS

B. B. DeWooden Idaho Falls

FORM V. S. No. 5-2; M. 1-19.

RECEIVED
SEP 10 1922
VITAL
STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock Registration District No. 73
City of McCon Primary Registration District No. 214-0
State of Idaho (St.)File No. 39283Registered No. 172

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Donald J. Manning

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Child
(Write the word.)

6. DATE OF BIRTH

Aug 18 1919
(Month) (Day) (Year)

7. AGE

3 Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

McCon, Ida

10. NAME OF FATHER

Geo. J. Manning

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Lillian Petersen

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Geo. J. Manning
McCon, Ida

15.

Filed

Aug 26 1922 Certification

Local Registrar

J. West

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 8 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
Aug 7 1922, to Aug 8 1922
that I last saw him alive on Aug 7 1922
and that death occurred on the date stated above, at 12:00 M.

The CAUSE OF DEATH* was as follows:

Ileo Colitis

(Duration) Yrs. mos. ds.

Contributory
(Secondary)None

(Duration) yrs. mos. ds.

(Signed)

M. D.

19

(Address)

Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

McCon, Ida8-9 1922

20. UNDERTAKER

ADDRESS

Barney WoodleyIdaho Falls

RECEIVED CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock
City of Idaho FallsRegistration District No. 13
Primary Registration District No. 21
(No. 100 St.)File No. 39284
Registered No. 114If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Baby EdwardIf death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDInfant
(Write the word.)

6. DATE OF BIRTH

July 4 1922
(Month) (Day) (Year)

7. AGE

Three yrs.
Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho10. NAME OF
FATHERGeo Q Edwards11. BIRTHPLACE
OF FATHER

(State or Country)

Utah12. MAIDEN NAME
OF MOTHERLenna Williams13. BIRTHPLACE
OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Phone - B. E. Duwood
Idaho Falls

(Address)

15.

Filed

July 7 1922
W. J. Williams
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, MOSE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 4 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19... to 19...

that I last saw h... alive on 19...

and that death occurred on the date stated above, at... M.

The CAUSE OF DEATH* was as follows:

Still born

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

P. A. Hallister M. D.7-5-22 (Address) Idaho Falls*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death... yrs. mos. days. In the State... yrs. mos. days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Idaho Falls

DATE OF BURIAL

7-5-22

20. UNDERTAKER

B. E. Duwood
Idaho Falls

ADDRESS

P. A. Hallister

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH
in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of BannaryCity of Bonnery Ferry

If death occurs away from usual residence, give facts called for under special information.

SEP 15 1922

Registration District No. 79Primary Registration District No. 2156

(No. St.)

2. FULL NAME

Rose Ann DonohooState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 39285

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

FWMarried
(Write the word.)

6. DATE OF BIRTH

March
(Month)23
(Day)1871
(Year)

7. AGE

51 Yrs4 Mos9 dsIF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Housewife

9. BIRTHPLACE

(State or Country)

Ireland

10. NAME OF FATHER

James M^c Namara

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

R. A. Donohoo

(Address)

Bonnery Ferry, Ida

15.

Filed

Aug. 30 1922E. E. Fry
Local Registrar

MEDICAL CERTIFICATE OF DEATH

51

16. DATE OF DEATH

Aug
(Month)2
(Day)1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 5 1922, to Aug. 2 1922
that I last saw h. alive on Aug. 2 1922
and that death occurred on the date stated above, at 4 P. M.
The CAUSE OF DEATH* was as follows:Erapphelane Goutre(Duration) 2 Yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

8/3 1922(Address) Bonnery Ferry, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Bonnery Ferry, Ida

DATE OF BURIAL

Aug. 14 1922

20. UNDERTAKER

E. E. Fry

ADDRESS

Bonnery Ferry

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B. - Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Boundary Registration District No. 79
City of Bonner Ferry Primary Registration District No. 3156
St. AND OVERSEAS

File No. 39286

Registered No. _____
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Blarence Edwin Wedeven

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH 64

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH July 30th 1922
(Month) (Day) (Year)

7. AGE 4 IF LESS than 1 day how many _____ hrs. or _____ min.?
Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work. _____
(b) General nature of industry, business or establishment in which employed (or employer). _____

9. BIRTHPLACE Idaho
(State or Country)

10. NAME OF FATHER Henry Wedeven

11. BIRTHPLACE OF FATHER Wis.
(State or Country)

12. MAIDEN NAME OF MOTHER Irish P. Bath

13. BIRTHPLACE OF MOTHER Eng.
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. E. Fry
(Address) Bonner Ferry, Ida.

15. Filed Aug. 3rd 1922 E. E. Fry
Local Registrar

16. DATE OF DEATH Aug. 3rd 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 30 1922 to Aug 3 1922
that I last saw him alive on Aug. 1 1922
and that death occurred on the date stated above, at 8 A.M.
The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage
(Duration) _____ Yrs. _____ mos. 4 ds.
Contributory (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) E. E. Fry M. D.
8/3. 19. 22 (Address) Bonner Ferry, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Bonner Ferry, Ida. DATE OF BURIAL 8/3/1922

20. UNDERTAKER Henry Wedeven ADDRESS Bonner Ferry, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39287**

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Boundary Registration District No. 29
City of Indian Village Primary Registration District No. 356 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Else Mitchell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

Red.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married

6. DATE OF BIRTH.

1/8/55
(Month) (Day) (Year)

7. AGE

67 Yrs. Mos. ds.

IF LESS than 1 day
how many hrs. or
min. 2

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

Cover Keeper
as stated above

9. BIRTHPLACE

(State or Country)

United States (Idaho)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

No record
Idaho (?)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

No record
Idaho (?)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

M. Fisher
Boundary, Idaho

15.

Filed Aug 24 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 21 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to 191
that I last saw him alive on 191
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Tuberculosis of lungs(Duration) 2 Yrs. mos. ds.Contributory
(Secondary)

(Duration) _____ Yrs. mos. ds.

(Signed) M. Fisher

19. (Address) _____

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Indian Village, Boundary Aug 22 1922

20. UNDERTAKER

ADDRESS

Fisher
Idaho

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39288**
Registered No.

If death occurs away from usual residence, give facts called for under special information.

Primary Registration District No

2. **FULL NAME**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
 how many..... hrs.
 r.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

.....19....., to19.....
that I last saw h..... alive on.....19.....
and that death occurred on the date stated above, at.....M.....

The CAUSE OF DEATH* was as follows:

**Contributory
(Secondary)**

.....(Duration)yrs.....mos.....ds.

(Signed)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted
if not at place of death?.....

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

1. PLACE OF DEATH.

County of Bernard
City of Indian Village

Registration District No. 79
Primary Registration District No. 3156
(No. 5015 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Paul

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. **39289**

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

Paul

5. SINGLE, MARRIED, WID-OWED OR DIVORCED.

Widowed

6. DATE OF BIRTH.

— — — 1885
(Month) (Day) (Year)

7. AGE

69 Yrs. — Mos. — ds.

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...

Indian Farmer & Laborer

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Not Known

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho (?)

12. MAIDEN NAME OF MOTHER

Not Known

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho (?)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Wm. Fisher

(Address)

Bernard Ferry Idaho

15.

Filed

Sept. 15 19225Wm. Fisher

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 12 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to 191
that I last saw him alive on 191

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

Duration 4 years Yrs. mos. ds.

Contributory
(Secondary)

(Duration) 7 yrs Yrs. mos. ds.

(Signed) Wm. Fisher M. D.

19 (Address) Bernard Ferry Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death....yrs....mos....days In the State....yrs....mos....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Indian Village

DATE OF BURIAL

Sept 13 1922

20. UNDERTAKER

Indians

ADDRESS

Bernard Ferry Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A-25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

State of Idaho

BOARD OF HEALTH

Bureau of Vital Statistics

File No. 39290

1. PLACE OF DEATH
County of Bonanza
City of Bonanza Ferry
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Genevieve Josephine Henthorn

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH Mar 17 1901
(Month) (Day) (Year)

7. AGE 21 Yrs 5 Mos 18 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE Wash
(State or Country)

10. NAME OF FATHER J. J. Johnson

11. BIRTHPLACE OF FATHER Wash
(State or Country)

12. MAIDEN NAME OF MOTHER Sadie Mary Causon

13. BIRTHPLACE OF MOTHER England
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) L. M. Henthorn

(Address)

15. Sept 16 1922
Filed Sept 16 1922 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 15 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 19 22 to Sept 15 22
that I last saw her alive on Sept 15 1922,
and that death occurred on the date stated above, at 4 P. M.
The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis
(Duration) Yrs. 7 mos. ds.

Contributory (Secondary)

(Signed) E. E. Tracy M. D.
7/16 1922 (Address) Bonanza Ferry, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Bonanza Ferry Ida DATE OF BURIAL Sept 17 1922

20. UNDERTAKER E. E. Tracy ADDRESS Bonanza Ferry

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39292**

1. PLACE OF DEATH **Idaho**
Registration District No. **58^d**
County of **Bannock**
Primary Registration District No. **2138**
City of **Fairfield** (State) **Idaho**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Otis Deveny Miller

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX **Male** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Single**

6. DATE OF BIRTH

Feb 18 1900
(Month) (Day) (Year)

7. AGE

22 Yrs. **7** Mos. **10** ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Oregon

10. NAME OF FATHER

Fred Lincoln Miller

11. BIRTHPLACE OF FATHER

(State or Country)

Oregon

12. MAIDEN NAME OF MOTHER

Laura McMorris

13. BIRTHPLACE OF MOTHER

(State or Country)

Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Fred L. Miller

(Address)

Fairfield Idaho

15.

Filed

Sept 29 1932

19

L. Wilencheck

Local Registrar

16. DATE OF DEATH

Sept 29th 1932
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Died before arrival of physicians.

that I last saw him alive on 19

and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage & Fracture of Spine

(Duration) Yrs. mos. ds. **Instant**

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

L. Wilencheck

M. D.

10-2-1922

(Address)

Fairfield Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 4 yrs. mos. days. In the State 4 yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

Oregon

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Eugene Oregon

Sept 30 1932

20. UNDERTAKER

ADDRESS

H. L. McHon

Pocatello

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39293**
Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Camas Registration District No. 58th
City of Fairfield Primary Registration District No. 2138
(Not _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Dorothy V. Ashmead

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

single
(Write the word.)

6. DATE OF BIRTH

June 12th 1919
(Month) (Day) (Year)

7. AGE

3 Yrs. 3 Mos. 14 ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

None

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Camas County, Idaho

10. NAME OF FATHER

Charles Nathan Ashmead

11. BIRTHPLACE OF FATHER

(State or Country)

Iowa

12. MAIDEN NAME OF MOTHER

Bertha Mack

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Chas. Ashmead

(Address)

Corral Ida

15.

Filed

Oct 3 1922

L. W. Llencheck
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 26th 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 23rd 1922 to Sept 26th 1922
that I last saw him alive on Sept 26th 1922
and that death occurred on the date stated above, at 4:30 A.M.
The CAUSE OF DEATH* was as follows:

Acute Ileo. Colitis

(Duration) _____ Yrs. _____ mos. 7 ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

L. W. Llencheck M. D.

Oct 3 1922 (Address) Fairfield, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Camas, Idaho

DATE OF BURIAL

Sept. 27th 1922

20. UNDERTAKER

ADDRESS

DISINTERMENT PERMIT

IDAHO STATE BOARD OF HEALTH

BOISE, IDAHO

APPLICATION HAVING BEEN MADE for the disinterment of the body of Dorothy V. Ashmead
now lying buried in Corral Cemetery, in the City or Town of Corral
County of Camas State of Idaho, who died on the 26 day of Sept, 1922, Aged 3 years 3 months
14 days, the cause of death being Acute Ileo Colitis and
not directly or indirectly by diphtheria; (membranous croup); scarlet fever; smallpox; leprosy; asiatic cholera; typhus fever
or yellow fever as shown by the certificate of death of said deceased, given by
L. Wilencheck attending physician

THIS IS TO CERTIFY that permission is hereby given for such disinterment and removal by private
to Elmwood Cemetery in the City or Town of Gooding County of Gooding
State of Idaho to take effect upon the approval by the local board of health of the City, Town, or County of

Camas it being understood and provided that nothing herein shall be deemed as contravening or in
anywise modifying or releasing the Regulations of the State Board of Health governing the Transportation of corpses
or the requirements for a Transportation permit, and all Transportation Companies and Common Carriers will be
governed accordingly; and provided further, that where the disinterment is for the purpose of reinterment in another
part of the same cemetery, or in a contiguous cemetery, the removal shall not be made by any public conveyance. The
disinterment and removal must be done under the personal supervision of a licensed Embalmer in good standing. If
the remains are to be removed from the cemetery they (including the disinterred casket), must be enclosed in a new
metallic lined outer case before removal.

Given under my hand and Seal of the State Board of Health at Boise, Idaho,

Permit issued to: this 29th day of May, A.D. 1959.

Robert S. Meyer
Thompson Chapel
Gooding, Idaho

W. W. Benson

by Director, Division of Vital Statistics

The foregoing application for disinterment and removal is hereby approved by the local Board of Health of the City,
Town or County of _____ State of Idaho, this _____ day of _____, 19____.

Health Officer

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Canyon Registration District No. 2866
 City of Nauppa Primary Registration District No. 2866
 (No. Mercy Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

L. V. Larsen

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 39294
 Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-OWED OR DIVORCED

Male White Married

6. DATE OF BIRTH

Feb 17 1894
 (Month) (Day) (Year)

7. AGE

28 Yrs. Mos. ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

Farmer

9. BIRTHPLACE

(State or Country)

Kansas

10. NAME OF FATHER

L. J. Larson

11. BIRTHPLACE OF FATHER

(State or Country)

Denmark

12. MAIDEN NAME OF MOTHER

Emma Isberg

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Geo. King

(Address)

Nauppa, Ida

15.

Filed Sept 9 1922

Pearle Lodge
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 17 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 11 1922 to Aug 17 1922
 that I last saw him alive on Aug 11 1922
 and that death occurred on the date stated above, at 4 A. M.
 The CAUSE OF DEATH* was as follows:

Cerebral Embolism

(Duration) Yrs. mos. 1/2 ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed)

M. J. Frank M. D.

(Address)

Nauppa, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Kohlhaas Cem 8-15 1922

20. UNDERTAKER

ADDRESS

Frank Robinson Nauppa

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada

City of _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED
SEP 18 1922
BUREAU OF VITAL
STATISTICS

Registration District No. _____

Registration District No. 2056

City of _____ (St.)

File No. 39295

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male white

(Write the word.)

6. DATE OF BIRTH

Aug 6 1922
(Month) (Day) (Year)

7. AGE

Yrs. — Mos. — ds. —

IF LESS than 1 day
how many 4 hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed Sept 9 1922Clara Good

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

August 7th 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

August 6th 1922 to Aug 7th 1922
that I last saw him alive on Aug 6th 1922
and that death occurred on the date stated above, at 1.4 M.

The CAUSE OF DEATH* was as follows:

Birth, Premature - gestation 32 1/2 weeks

(Duration) Yrs. — mos. — ds.

Contributory Mother's condition poor
(Secondary) in bed about 3 months before
birth of baby Yrs. — mos. — ds.(Signed) J. M. Taylor M. D.8-7 1922 (Address) Butte, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. — mos. — days. In the State Yrs. — mos. — days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lawrence Cem8-7 1922

20. UNDERTAKER

ADDRESS

None

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

(No.)

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 39296

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

19..... to 19.....

that I last saw h..... alive on 19.....

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Struck by Switch
Engine O. B. R. yards at
Nampa - Accidental

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Paul L. Base M.D.

G. C. Bonner (Address) Caldwell, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

1. PLACE OF DEATH

County of Canyon
 City of Nampa

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

No.

St.)

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. **39297**

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male | white | Single
 (Write the word.)

6. DATE OF BIRTH

June | 19 | 1869
 (Month) (Day) (Year)

7. AGE

52 Yrs. 11 Mos. 25 ds.

IF LESS than 1 day
 how many..... hrs.
 or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Ill

10. NAME OF FATHER

W. E. Parker

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Loana Stobler

13. BIRTHPLACE OF MOTHER

(State or Country)

Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H. G. Parker(Address) Nampa

15.

Filed Aug 12 1922

Pearl L. Ladd
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

5 | 23 | 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 1921 1921, to Feb 7 1922,

that I last saw her alive on Feb 1922,

and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) H. C. Robinson M. D.19. (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Kohlertown Cem

DATE OF BURIAL

May 25 1922

20. UNDERTAKER

Fred K. Robinson

ADDRESS

Nampa Ida

FORM V. S. No. 5-A-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. _____
County of Carson Primary Registration District No. 1006
City of Naupaka St. _____File No. 39298

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James E. Greeno

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)6. DATE OF BIRTH July 30 1932
(Month) (Day) (Year)7. AGE 90 Yrs. _____ Mos. _____ ds. _____
IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Farmer, Retired

9. BIRTHPLACE

(State or Country)

Nova Scotia

10. NAME OF FATHER

Edward Greeno

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Edward A. Greeno

(Address)

Wt Home Ida

15.

Filed Sept 9 1932Pearl Dodds
Local Registrar

16. DATE OF DEATH

Sept - 4 1932
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 2, 1922 to Sept 4, 1932
that I last saw him alive on Sept 3, 1932
and that death occurred on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:

Myocardial infarction

(Duration) Yrs. _____ mos. _____ ds. _____

Contributory
(Secondary)

(Duration) yrs. _____ mos. _____ ds. _____

(Signed) W. E. McGuire M. D.9-9-32 (Address) Naupaka Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Naupaka Ida9-6 1932

20. UNDERTAKER

ADDRESS

JK RobinsonNaupaka

FORM V. S. No. 5-A—25 M. 1-19-17

CERTIFICATE OF DEATH

1. PLACE OF DEATH SEP 13 1922
 County of Idaho BUREAU OF VITAL STATISTICS
 City of Naupaka (No. 100) (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Christina Baker

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 39299
 Registered No. 157

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
 (Write the word.)

6. DATE OF BIRTH

Dec 10 1
 (Month) (Day) (Year)

7. AGE

78 Yrs. 8 Mos. 5 ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

Housekeeper

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

Martin

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

W. M. Love
Naupaka

15.

Filed Sept 9 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 15 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 15 1922
 to Aug 15 1922

that I last saw him alive on Aug 15 1922
 and that death occurred on the date stated above, at 7:30 A.M.

The CAUSE OF DEATH* was as follows:

Natural causes
probably heart failure

(Duration) Yrs. mos. ds.

Contributory (Secondary)

Scrubty

(Duration) Yrs. mos. ds.

(Signed)

Paul D. Goss, Coroner
Geo. P. Proctor, M.D.

(Address) Naupaka

*State the Disease Causing Death; or in death from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Naupaka Ida

DATE OF BURIAL

Aug 17 1922

20. UNDERTAKER

H. K. Robinson

ADDRESS

Naupaka Ida

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Canyon Registration District No. 7
 City of ... Primary Registration District No. 1006 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Loretta Muel Roberts

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 39300Registered No. ...

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
 (Write the word.)

6. DATE OF BIRTH

June 2 1920
 (Month) (Day) (Year)

7. AGE

2 Yrs. 2 Mos. 28 ds.

IF LESS than 1 day
 how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed Sept 9 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 1 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 28th 1922, to Aug. 31st 1922, that I last saw him alive on Aug. 31st 1922 and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Acute de. colitis(Duration) — Yrs. — mos. ? ds.

Contributory (Secondary)

(Duration) — yrs. — mos. — ds.(Signed) Geo. R. A. Kelley M. D.19 Nampa, Idaho (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death — yrs. — mos. — days. In the State — yrs. — mos. — days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Nampa Ida

DATE OF BURIAL

9-6 1922

20. UNDERTAKER

Geo. R. A. Kelley

ADDRESS

Nampa Ida

CERTIFICATE

1. PLACE OF DEATH

County of CanyonCity of Nampa

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No.)

St.)

State of Idaho
DEPARTMENT OF HEALTH
Office of Vital Statistics
39301

Record No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Nels E Christensen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male white Married

6. DATE OF BIRTH

Jan 4 1891
(Month) (Day) (Year)

7. AGE

30 Yrs 7 Mos 20 ds.
IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Blacksmith

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

N.C. Christensen

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Miriam Thompson

13. BIRTHPLACE OF MOTHER

(State or Country)

Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

N.E. Christensen

(Address)

225 - Kelsey Ave

15.

Filed Sept 9 1922Pearl D. Noble
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 24 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 15 1922 to Aug 24 1922that I last saw him alive on Aug 23 1922and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

Peritonitis and
Septicemia - Indura
to appendix
(Duration) Yrs. mos. ds.Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) Geo R. Proctor D.St 9 1922 (Address) Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Kohlertown IdaAug 17 1922

20. UNDERTAKER

ADDRESS

F.K. RobinsonNampa

DISINTERMENT PERMIT

IDAHO STATE BOARD OF HEALTH

BOISE, IDAHO

APPLICATION HAVING BEEN MADE for the disinterment of the body of Niels Edward Christensen
now lying buried in Kohlerlawn Cemetery, in the City or Town of Nampa
County of Canyon State of Idaho, who died on the 24 day of August, 1922, Aged _____ years _____ months
_____ days, the cause of death being appendicitis and
not directly or indirectly by diphtheria; (membranous croup); scarlet fever; smallpox; leprosy; asiatic cholera; typhus fever
or yellow fever as shown by the certificate of death of said deceased, given by
Dr. Proctor attending physician

THIS IS TO CERTIFY that permission is hereby given for such disinterment and removal by private
to Valley View Memorial Park Cemetery in the City or Town of Salt Lake City County of Salt Lake
State of Utah to take effect upon the approval by the local board of health of the City, Town, or County of
Canyon it being understood and provided that nothing herein shall be deemed as contravening or in
anywise modifying or releasing the Regulations of the State Board of Health governing the Transportation of corpses
or the requirements for a Transportation permit, and all Transportation Companies and Common Carriers will be
governed accordingly; and provided further, that where the disinterment is for the purpose of reinterment in another
part of the same cemetery, or in a contiguous cemetery, the removal shall not be made by any public conveyance. The
disinterment and removal must be done under the personal supervision of a licensed Embalmer in good standing. If
the remains are to be removed from the cemetery they (including the disinterred casket), must be enclosed in a new
metallic lined outer case before removal.

Given under my hand and Seal of the State Board of Health at Boise, Idaho,

Permit issued to:
McDougal Funeral Homes
4330 South Redwood Road
Salt Lake City, Utah

this 29th day of March, A.D. 1966.

W. W. Benson

by Director, Division of Vital Statistics

The foregoing application for disinterment and removal is hereby approved by the local Board of Health of the City,
Town or County of _____ State of Idaho, this _____ day of _____, 19____.

Health Officer

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED

SEP 13 1922

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

BUREAU OF VITAL STATISTICS

Registration District No.

Registration District No.

(No.)

(St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw h. e. alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed)

8-15-1922

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

FORM V. S. No. 5-A-25 M. 1-19.

RECEIVED

SEP 13 1922

CERTIFICATE OF DEATH

3

1. PLACE OF DEATH

County of CanyonCity of Calderwell

If death occurs away from usual residence, give facts called for under special information.

BUREAU OF VITAL STATISTICS

2. FULL NAME

Registration District No.

Registration District No.

1005

(No.

St.)

File No.

39303

Registered No.

91

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female

white

Widow

(Write the word.)

6. DATE OF BIRTH

Sept 5

1830

(Month)

(Day)

(Year)

7. AGE

85

Yrs.

11

Mos.

22

ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Housewife

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

N.Y.

10. NAME OF FATHER

Perry Nichols

11. BIRTHPLACE OF FATHER

(State or Country)

N.Y.

12. MAIDEN NAME OF MOTHER

Phoebe Caldwell

13. BIRTHPLACE OF MOTHER

(State or Country)

N.Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

The N. S. Curtis

(Address)

517 N. S. Caldwell

15.

Filed

Aug 29 1922

John H. Meyer

Local Registrar

MEDICAL CERTIFICATE OF DEATH

96

16. DATE OF DEATH

Aug 27

(Month)

(Day)

1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 25 - 1922 to Aug 27 - 1922

that I last saw her alive on Aug 25 - 1922

and that death occurred on the date stated above, at Aug 26 P.M.

The CAUSE OF DEATH* was as follows:

Asthma

(Duration)

?

Yrs.

mos.

ds.

Contributory (Secondary)

Age

(Duration)

yrs.

mos.

ds.

(Signed)

S. S. Dudley

M. D.

19

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

yrs.

mos.

In the

days.

State

yrs.

mos.

days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Canyon Hill

8-29 1922

20. UNDERTAKER

ADDRESS

Paul L. Case

Caldwell

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of CanyonCity of Caldwell

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
SEP 13 1922BUREAU OF VITAL
STATISTICSRegistration District No. 3Primary Registration District No. 2005

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 39304Registered No. 93

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Albert Julius Dennerline

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married

(Write the word.)

6. DATE OF BIRTH

9-25-1876

(Month)

(Day)

1

(Year)

7. AGE

45

Yrs.

11

Mos.

11

ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Blacksmith

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ills

10. NAME OF FATHER

John Dennerline

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Margaret Decker

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John Hollrich
Caldwell Idaho

15.

Filed Sept 8 - 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 6 1922

(Month)

(Day)

19

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 18 1922 to Sept 6 1922that I last saw him alive on Sept 6 1922and that death occurred on the date stated above, at 5 M.

The CAUSE OF DEATH* was as follows:

Syphilitic fever

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

John L. Meyer M. D.
Caldwell, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....Yrs.....mos.....days, State.....Yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Canyon Hill

DATE OF BURIAL

9-8-22

20. UNDERTAKER

Paul L. Case

ADDRESS

Caldwell Idaho

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

SEP 13 1922 CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Canyon Indian Reservation District No. 3
City of Greenleaf (No. 2005 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Josephine D. WilliamsState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 39305Registered No. 92

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED married6. DATE OF BIRTH Feb 20 1985
(Month) (Day) (Year)7. AGE 69 Yrs. 6 Mos. 13 ds. IF LESS than 1 day
how many hrs. or min.?8. OCCUPATION House wife
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).9. BIRTHPLACE Indiana
(State or Country)10. NAME OF FATHER Jacob Mendenhall11. BIRTHPLACE OF FATHER North Carolina
(State or Country)12. MAIDEN NAME OF MOTHER Hannah Morgan13. BIRTHPLACE OF MOTHER Tenn
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Floyd W. Williams
(Address) Greenleaf Idaho15. Filed Sept 6 1922 John V. Meyer
Local Registrar16. DATE OF DEATH Sept 3 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Apr 20 1922 to Sept 3 1922
that I last saw her alive on Sept 3 1922
and that death occurred on the date stated above, at 3 P. M.
The CAUSE OF DEATH* was as follows:
apoplexy(Duration) Yrs. mos. ds.
Contributory (Secondary) Mr. Nephritis

(Duration) yrs. mos. ds.

(Signed) M. D.(Address) Advised

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Greenleaf Cem. DATE OF BURIAL Sept 7 192220. UNDERTAKER C. V. Pichman Caldwell ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
SEP 18 1922

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. **39306**
Registered No. **90**

1. PLACE OF DEATH

County of Banyon Registration District No. 2005
City of Huston St.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Marvin Carol Eells

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word)

6. DATE OF BIRTH

Sept 23 1921
(Month) (Day) (Year)

7. AGE

Yrs. 10 Mos. 24 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Otter Eells

11. BIRTHPLACE OF FATHER

(State or Country) Kan.

12. MAIDEN NAME OF MOTHER

Edna Gannett

13. BIRTHPLACE OF MOTHER

(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

James R. Biggs
(Address) Huston, Ida

15.

Filed Aug. 17 - 1922 John H. Mayes
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug. 16 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19
that I last saw h. alive on 19
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Accidental Drowning
in irrigation ditch
near house.

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Paul L. Base M. D.
Coroner, Caldwell
(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Riverside Cemetery 8-18 1922

20. UNDERTAKER

Paul L. Base Caldwell

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39307**Registered No. **89**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of CanyonCity of Baldwell

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No. 3Registration District No. 2.005

(No. _____)

(St. _____)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

Unknown remains found east of ramp and brook

7. AGE

in by County Atty

IF LESS than 1 day

how many hrs.

or min.

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Clarence Hill(Address) Baldwell

15.

Filed Aug. 19 - 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Not Known
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19....., to 19.....

that I last saw h..... alive on 19.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Not Known

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Paul H. Case

M. D.

19.....

(Address) Baldwell

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Canyon Hill

DATE OF BURIAL

8-19 19 22

20. UNDERTAKER

Paul H. Case

ADDRESS

Baldwell

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39309**Registered No. **85**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of CanyonCity of Caldwell

SEP 13 1922

Registration District No. 3Primary Registration District No. 2005(No. 1 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Bledsoe

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

Aug 11 1922
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many 2 hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Caldwell, Ida

10. NAME OF FATHER

Floyd Bledsoe

11. BIRTHPLACE OF FATHER

(State or Country)

Missouri

12. MAIDEN NAME OF MOTHER

Agnes Selley

13. BIRTHPLACE OF MOTHER

(State or Country)

Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Floyd Bledsoe

(Address)

Ontario Ave

15.

Filed Aug 11 - 1922John H. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 11 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 Aug 11 to Aug 11 19 22
that I last saw him alive on Aug 11 19 22
and that death occurred on the date stated above, at 9:45 A.

The CAUSE OF DEATH* was as follows:

Premature birth

(Duration) Yrs. mos. ds.

Contributory couldn't wait
(Secondary)

(Duration) yrs. mos. ds.

(Signed) W. Montgomery M. D.(Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Canyon Well

DATE OF BURIAL

8-11-1922

20. UNDERTAKER

C. H. Beckham Caldwell

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 82County of Garibou Primary Registration District No. 2154City of Soda Springs (No. 1) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Laura Maud TaylorFile No. 39310Registered No. 11

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

December 23 1890
(Month) (Day) (Year)

7. AGE

31 Yrs. 8 Mos. 7 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).House wife

9. BIRTHPLACE

(State or Country)

Shannon Co Oregon

10. NAME OF FATHER

Nathan Eaton

11. BIRTHPLACE OF FATHER

(State or Country)

Wm Knowen

12. MAIDEN NAME OF MOTHER

Maggie Maud

13. BIRTHPLACE OF MOTHER

(State or Country)

Wm Knowen

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Laura Maud Taylor
Soda Springs Idaho

15.

Filed

Aug 31 1922E. C. Kaeley
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 30 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 29 1922 to Aug 30 1922
that I last saw her alive on Aug 30 1922
and that death occurred on the date stated above, at 4:10 P.M.

The CAUSE OF DEATH* was as follows:

Purpural Eclampsia

(Duration) Yrs. mos. ds.

Contributory
(Secondary)Pregnancy

(Duration) yrs. mos. ds.

(Signed)

Russell T. T. T. M. D.(Address) Soda Springs Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

The Dalles OregonAug 3 1922

20. UNDERTAKER

ADDRESS

Schumacher & Hall Co. Seattle

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-19

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH OCT 2, 1922 Registration District No. 82
County of Bannock **BUREAU OF VITAL STATISTICS** Primary Registration District No. 2159
City of Grace (No. _____, _____ St.)

File No. 39311

Registered No. 11/2

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alma A Jansen Nelsen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
Married
(Write the word.)

6. DATE OF BIRTH
Not known
(Month) (Day) (Year)

7. AGE
50 yrs. 0 mos. 0 ds.
IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Utah

10. NAME OF FATHER
F.A.Nelsen

11. BIRTHPLACE OF FATHER
(State or Country) Denmark

12. MAIDEN NAME OF MOTHER
Not known

13. BIRTHPLACE OF MOTHER
(State or Country) Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Brig. Young
(Address) Grace, Idaho.

15. Filed 9/17/22 191 Ellis Kackley
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
9/17/22 191
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Sep. 17, 1922 191, to Sep. 17, 1922 191,
that I last saw h. 30 P M 191,
and that death occurred on the date stated above, at 3 M.
The CAUSE OF DEATH* was as follows:
Electrocuted, accidentally

(Duration) Instantly yrs. mos. ds.
Contributory 0
(Secondary)

(Duration) _____ yrs. mos. ds.
(Signed) Ellis Kackley M. D.

9/17/22 (Address) Soda Springs

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. mos. days. In the State _____ yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL
Smithfield, Ut. Not Known 191

20. UNDERTAKER ADDRESS
Not known

RECEIVED
BUREAU OF VITALS
CERTIFICATE OF DEATH.State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Caribou Registration District No. 82
City of Sada Springs Registration District No. 2159
St.)If death occurs away from
usual residence, give facts
called for under special
information.

2. FULL NAME

Infant WisemanFile No. **39312**Registered No. 413If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.Single
(Write the word.)

6. DATE OF BIRTH.

August 17 1922
(Month) (Day) (Year)

7. AGE

Yrs.

Mos.

21 hours 5 min. 2]IF LESS than 1 day
how many hrs. or

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
(b) General nature of in-
dustry, business, or estab-
lishment in which employ-
ed (or employer)Infant

9. BIRTHPLACE

(State or Country)

Idaho10. NAME OF
FATHERAndrew L. Wiseman11. BIRTHPLACE
OF FATHER

(State or Country)

N. C.12. MAIDEN NAME
OF MOTHERAlma Watson13. BIRTHPLACE
OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Russell T. Fugert
Sada Springs, Idaho

15.

Filed

Sept 3019122Dee K. Kees

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

August 18 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug. 17 1922 to Aug. 18 1922
that I last saw her alive on Aug. 18 1922and that death occurred on the date stated above; at 2:05 P. M.

The CAUSE OF DEATH* was as follows:

Atelectasis

(Duration)

Yrs.

21 hours 5 min. 2 ds.Contributory
(Secondary)Pneumonia

(Duration)

Yrs.

21 hrs. 5 min. 2 ds.

(Signed)

Russell T. Fugert M. D.

19. (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place

of death

Where was disease contracted
if not at place of death?Former or
usual residence

In the

State

yrs. mos. days

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sada Springs IdahoAug 19 1922

20. UNDERTAKER

ADDRESS

None

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS
should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement
of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH

County of *Cassia*City of *Malta*

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
SEP 10 1922
BURRegistration District No. *119*Primary Registration District No. *2198*

(No. St.)

2. FULL NAME

Vida Lounsbury

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39313**
Registered No.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single

Write the word.)

6. DATE OF BIRTH.

*Feb.**19**1922*

(Month)

(Day)

(Year)

7. AGE

10 Yrs. *4* Mos. *21* ds.IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

In School.

9. BIRTHPLACE

(State or Country)

Malta Ida.

10. NAME OF FATHER

Roepp A. Lounsbury

11. BIRTHPLACE OF FATHER

(State or Country)

Font Look Out Utah.

12. MAIDEN NAME OF MOTHER

Sarah E. Wake.

13. BIRTHPLACE OF MOTHER

(State or Country)

Almo Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Roepp A. Lounsbury

(Address)

Malta Ida.

15.

Filed

*Sept 10 1922**C. J. Sater*

Local Registrar.

CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

*July**10**1922*

(Month)

(Day)

(Year)

17.

I HEREBY CERTIFY, That I attended deceased from

*September**1914**to July 10**1922*that I last saw him alive on *July 1* *1922*and that death occurred on the date stated above, at *4* A.M.

The CAUSE OF DEATH* was as follows:

Hodgkins Disease

(Duration)

Yrs.

mos.

ds.

Contributory

(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

C. J. Sater

M. D.

Sept 10

(Address)

Malta Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death *10* yrs. *4* mos. *21* daysIn the State *10* yrs. *4* mos. *21* days

Where was disease contracted if not at place of death?

at place of death

Former or

usual residence

Same

19. PLACE OF BURIAL OR REMOVAL

Albion Ida.

DATE OF BURIAL

Sept 12 1922

20. UNDERTAKER

Bishop Loveland

ADDRESS

Albion Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17

RECEIVED
SEP 15 1922
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39314**
Registered No. **612**
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of **Cassia**
City of **Burley**
If death occurs away from usual residence, give facts called for under special information.
Registration District No. **117**
Primary Registration District No. **2196**
(No. St.)

2. FULL NAME **Louis Jay Bullock**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Single**
(Write the word.)

6. DATE OF BIRTH **June 8 1914**
(Month) (Day) (Year)

7. AGE **8 Yrs. 7 Mos. 11 ds.**
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work **At Home**
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) **Rupert Idaho**

10. NAME OF FATHER **Russell Bullock**

11. BIRTHPLACE OF FATHER
(State or Country) **Texas**

12. MAIDEN NAME OF MOTHER **Lottie Haggerty**

13. BIRTHPLACE OF MOTHER
(State or Country) **Kansas**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) **Russell Bullock**
(Address) **Burley Ida**

15. Filed **Aug 31 1922** **R. J. Patterson**
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **Aug 19 1922**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Aug 14 1922** to **Aug 19 1922**
that I last saw her alive on **Aug 19 1922**
and that death occurred on the date stated above, at **9 A.M.**

The CAUSE OF DEATH* was as follows:
Tuberculosis of meninges

(Duration) **untreated** mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) **J. C. Patterson** M. D.
Aug 19 1922 (Address) **Burley Ida**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days, State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **Burley Ida**

DATE OF BURIAL **Aug 21 1922**

20. UNDERTAKER **L. B. Gregory**

ADDRESS **Burley Ida**

Smith
State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39315**
Registered No. **609**
If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

1. PLACE OF DEATH
County of Cassia Registration District No. 117
City of Burley Primary Registration District No. 2196
If death occurs away from
usual residence, give facts
called for under special
information. (No. St.)
BUREAU STATE

2. FULL NAME Charles August Johnson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH. Unknown
(Month) (Day) (Year)

7. AGE 59 Yrs. Mos. ds. IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of in-
dustry, business, or estab-
lishment in which em-
ployed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Sweden

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Hageman
(Address) R. F. A. # 3, Burley, Ida.

15. Filed Aug 31 1922 Aug C. Patterson
Local Registrar.

MEDICAL CERTIFICATE OF DEATH 28

16. DATE OF DEATH Aug 9 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
August 1st 1922 to August 9 1922
that I last saw him alive on August 9 1922
and that death occurred on the date stated above, at 3 A. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(Duration) 3 Yrs. mos. ds.Contributory
(Secondary)myocardial Degeneration(Duration) 14 Yrs. mos. ds.

(Signed)

H. P. Smith M. D.Aug 9 1922 (Address) Burley, Idaho

State the Disease Causing Death; or in deaths from Violent
Causes, state (1) Means of Injury; and (2) whether Accidental,
Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place In the
of death yrs. mos. days, State yrs. mos. days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Burley, Ida.

DATE OF BURIAL

Aug 10 - 1922

20. UNDERTAKER

L. B. Tallopy

ADDRESS

Burley, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS
should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement
of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39316**
Registered No. **610**
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of *Cassia* Registration District No. *117*
City of *Burley* Primary Registration District No. *2196*
If death occurs away from usual residence, give facts called for under special information. (No. St.)

2. FULL NAME *Elma Myrtle Bingham*

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. *Single*
(Write the word.)

16. DATE OF DEATH

6. DATE OF BIRTH.

April 24 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Aug 21 1922* to *Aug 22 1922*

7. AGE

1 Yrs. 3 Mos. 28 ds.

IF LESS than 1 day
how many hrs. or
..... min.?

that I last saw her alive on *August 22 1922*
and that death occurred on the date stated above, at *9:30 P.M.*

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

The CAUSE OF DEATH* was as follows:

Accidental swallowing of lye followed by violent infection of the mouth

(Duration) Yrs. mos. 1 ds.

9. BIRTHPLACE

(State or Country)

Burley Ida.

10. NAME OF FATHER

Chas. J. Bingham

11. BIRTHPLACE OF FATHER

(State or Country)

Ogden Utah.

12. MAIDEN NAME OF MOTHER

Myrtle Maria Silcox

13. BIRTHPLACE OF MOTHER

(State or Country)

Riverton Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Chas. J. Bingham

(Address)

R. F. D. #3 Burley Ida.

15.

Filed *Aug 23 1922*

Dr. J. C. Patterson
Local Registrar.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) *C. A. Rich* M. D.

8-23-1922 (Address) *Burley Ida.*

*State the Disease Causing Death; in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days, State yrs. mos. days

Where was disease contracted
if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Ogden Utah.

DATE OF BURIAL

Aug 24 1922

20. UNDERTAKER

L. B. Gallogly

ADDRESS

Burley Ida.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Cassia Registration District No. 117
 City of Burley Primary Registration District No. 2196
 If death occurs away from usual residence, give facts called for under special information. (No. St.)

2. FULL NAME Jesse Allen Bateman

State of Idaho
 BOARD OF HEALTH

Bureau of Vital Statistics

File No. 39317Registered No. 611

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
 (Write the word.)

6. DATE OF BIRTH. March 2 1922
 (Month) (Day) (Year)

7. AGE 7 Yrs. 5 Mos. 13 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work None
 (b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Burley Ida.

10. NAME OF FATHER

Joseph Allen Bateman

11. BIRTHPLACE OF FATHER

(State or Country) Burley Idaho

12. MAIDEN NAME OF MOTHER

Wm. Lyons

13. BIRTHPLACE OF MOTHER

(State or Country) St. Anthony Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. A. Bateman(Address) Burley Ida.15. Filed Aug. 31 1922 P. J. Patterson

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug. 15 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug. 14 1922 to Aug. 15 1922

that I last saw him alive on Aug. 15 1922and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage

(Duration) Yrs. mos. ds.

Contributory (Secondary) Infantile Convulsions

(Duration) Yrs. mos. ds.

(Signed) J. A. Bateman M. D.19. (Address) Burley Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
 of death yrs. mos. days, State yrs. mos. days

Where was disease contracted
 if not at place of death?

Former or
 usual residence

19. PLACE OF BURIAL OR REMOVAL

Burley Ida

DATE OF BURIAL

Aug. 15 1922

20. UNDERTAKER

None

ADDRESS

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED

SEP 13 1922

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No.

Registration District No.

125

2203

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 39318

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw her alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

8/27/1922

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39319**
Registered No. **59**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of **Clearwater, RECEIVED** Registration District No. **70**
City of **Orofino, SEP 1 1922** Registration District No. **2108** (No. **103**) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **JACOB J. LEMM,**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Divorced,**
(Write the word.)

6. DATE OF BIRTH **About 1884**
(Month) (Day) (Year)

7. AGE **38** Yrs. Mos. ds. IF LESS than 1 day how many mos. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work **Contractor,**
(b) General nature of industry, business or establishment in which employed (or employer) **Engineering.**

9. BIRTHPLACE

(State or Country) **Switzerland,**

10. NAME OF FATHER

Lemm,

11. BIRTHPLACE OF FATHER

(State or Country) **Kloster, Switzerland,**

12. MAIDEN NAME OF MOTHER

Unknown,

13. BIRTHPLACE OF MOTHER

(State or Country) **Zurich, Switzerland,**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **John W. Givens**

(Address) **Orofino, Idaho.**

15.

Filed **Sept 1 1922** **J. M. Givens** Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

August Nineteenth 1922,
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **June 26th 1922** to **August 19th 1922,** that I last saw him alive on **August 18th 1922** and that death occurred on the date stated above, at **7:30 A.M.**

The CAUSE OF DEATH* was as follows:

Arterio sclerosis

Unknown,

(Duration) Yrs. mos. ds.

Contributory **Insanity.**
(Secondary)

Unknown,

(Duration) Yrs. mos. ds.

(Signed) **John W. Givens** M. D.

Aug 19 1922 (Address) **John W. Givens**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) Whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

Unknown,
At place of death **0** yrs. **1** mos. **25** days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Also Saint John,

Former or usual residence **Wallace, Idaho, Oregon.**

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Hamilton, Mont **Aug 25 1922**

20. UNDERTAKER ADDRESS

Bobo **Orofino, Idaho**

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39320**Registered No. **40**1. PLACE OF DEATH
County of **Clatsop** Registration District No. **90**
City of **Dent** Primary Registration District No. **2168**
BUREAU (No. **1022**) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Amanda Belle Taylor

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Single**
(Write the word.)6. DATE OF BIRTH **Aug 25 1922**
(Month) (Day) (Year)7. AGE **✓** If LESS than 1 day how many **6** hrs. or **?** min.?
Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).**none**

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Ira Taylor

11. BIRTHPLACE OF FATHER

(State or Country)

Mo.

12. MAIDEN NAME OF MOTHER

Clady Blanchard

13. BIRTHPLACE OF MOTHER

(State or Country)

D.C.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ira Taylor

(Address)

Dent, Ida

15.

Filed

Aug 28 1922**J. M. Fairly**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **Aug 25 1922**
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from **Aug 25 1922** to **Aug 25 1922** that I last saw him alive on **Aug 25 1922** and that death occurred on the date stated above, at **5 P.M.**

The CAUSE OF DEATH* was as follows:

Permeation(Duration) Yrs. **6 1/2** mos. ds.Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Dent Ida**Aug 16 1922**

20. UNDERTAKER

ADDRESS

None

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39321**
Registered No. **71**

1. PLACE OF DEATH

County of Clearwater Registration District No. 90
City of Orfino Primary Registration District No. 2168
(No.) (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Chris W. Roth

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

male white single
(Write the word.)

6. DATE OF BIRTH

1897
(Month) (Day) (Year)

7. AGE

25 Yrs. — Mos. — ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Laborer

9. BIRTHPLACE

(State or Country)

W.S.

10. NAME OF FATHER

John Roth

11. BIRTHPLACE OF FATHER

(State or Country)

Austria

12. MAIDEN NAME OF MOTHER

?

13. BIRTHPLACE OF MOTHER

(State or Country)

Austria

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. W. Atteberry

(Address)

Orfino, Ida

15.

Filed

Sept 11 1922

J. M. Gaily
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug. 31 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 20 1922 to Aug 31 1922

that I last saw him alive on Aug 31 1922

and that death occurred on the date stated above, at 6:00 P.M.

The CAUSE OF DEATH* was as follows:

Exhaustion of acute mania

(Duration) — Yrs. — mos. — ds.

Contributory
(Secondary)

Insanity

(Duration) — yrs. — mos. — ds.

(Signed)

John W. Atteberry M. D.

Sept 1st 1922

(Address) Orfino, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death — yrs. — mos. 11 days. In the State — yrs. — mos. — days

Where was disease contracted if not at place of death? I do not know

Former or usual residence Castle Rock, W. Va

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

N.S. Sanitarium Cemetery Sept 3 1922

20. UNDERTAKER

ADDRESS

J. W. Atteberry Orfino, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39323**
Registered No. **97**

1. PLACE OF DEATH
County of **Clearwater** Registration District No. **90**
City of **Orofino** Registration District No. **2157** St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME **BERTHA GRIFFITH**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Single**
(Write the word.)

6. DATE OF BIRTH **March Sixteenth, 1895**
(Month) (Day) (Year)

7. AGE **27** Yrs. **5** Mos. **1** ds. IF LESS than 1 day how many..... hrs. or..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work **Farmer's Daughter,**
(b) General nature of industry, business or establishment in which employed (or employer) **Helping at Farm and House Work,**

9. BIRTHPLACE **Idaho,**
(State or Country)

10. NAME OF FATHER **Jesse Griffith,**

11. BIRTHPLACE OF FATHER **Unknown,**
(State or Country)

12. MAIDEN NAME OF MOTHER **Lillian**

13. BIRTHPLACE OF MOTHER **Unknown,**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) **John W. Burns**
(Address) **Orofino, Idaho.**

15. Filed **Sept 1** 19**22** Local Registrar **John Gandy**

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **August Sixteenth, 1922**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Febry 12th, 1919** to **August 16th 1922**, that I last saw her alive on **August 15th 1922**, and that death occurred on the date stated above, at **12:50 AM**. The CAUSE OF DEATH* was as follows: **Epilepsy.**

About 18 Yrs. mos. ds. (Duration)
Contributory (Secondary) **Insanity,**
Unknown,
(Signed) **John W. Burns** M. D.
Aug. 16, 1922 (Address) **Orofino, Idaho.**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death **3** yrs. **6** mos. **5** days. In the State **27** yrs. **5** mos. **1** days
Where was disease contracted if not at place of death?
Former or usual residence **Moscow, Idaho, R. F. D. Two.**

19. PLACE OF BURIAL OR REMOVAL **The Northorn Idaho Sanitarium Cemetery** DATE OF BURIAL **August 18, 1922**
20. UNDERTAKER **P.M. Johnson** ADDRESS **Orofino, Idaho**

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11 **CERTIFICATE OF DEATH**

1. PLACE OF DEATH. *Charm City* Registration District No. *91*
County of *Charm City* Registration District No. *2168*
City of *Elk River* (No. _____, St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39324**
Registered No. *1*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Jim Sultos*

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *Greek* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. *Single*
(Write the word.)

6. DATE OF BIRTH _____
(Month) (Day) (Year)

7. AGE *32* yrs. _____ mos. _____ ds. IF LESS than 1 day
how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. *Lumberjack*
(b) General nature of industry business or establishment in which employed (or employer) *Woods sawyer*

9. BIRTHPLACE *Greece*
(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *R. W. Jones*
(Address) *Elk River Ida*

15. Filed *Sept. 28 1922* *Mildred Hambley*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *9 25 1922*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *9-25 1922* to *9-25 1922*
that I last saw him alive on *9-25 1922*
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Accidental, Fractured skull from a falling tree

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory *none*
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) *M. A. Holmes* M. D.
9-25 1922 (Address) *Elk River*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence *Spokane Wash*

19. PLACE OF BURIAL OR REMOVAL *Elk River Ida* DATE OF BURIAL *9/27 1922*

20. UNDERTAKER *None* ADDRESS _____

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39325**
Registered No. **2**

1. PLACE OF DEATH. **OCT 4 1922** Registration District No. **91**
County of **Clearwater** Primary Registration District No. **2168**
City of **Paris** (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Wilma Powell Thompson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Married**
(Write the word.)

6. DATE OF BIRTH **Jan 22 1880**
(Month) (Day) (Year)

7. AGE **42** yrs. **9** mos. **7** ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. **Housewife**
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) **Spring River Tenn**

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **W. J. Jones**

(Address) **Elk River Ida**

15.

Filed **Sept. 28 1922**

Mildred Hambley
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

9 27 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **9-27-1922** to **9-27-1922**

that I last saw her alive on **9-27-1922**

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) **M. A. Holmes** M. D.
9-27-1922 (Address) **Elk River**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. In the _____ State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Elk River Idaho

9/29 1922

20. UNDERTAKER

ADDRESS

None

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH **RECEIVED**
 County of *Cesar* Registration District No. *76*
 City of *Mackay* Primary Registration District No. *2153*
BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Patrick McLaughlin

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. **39326**
 Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *m* 4. COLOR OR RACE *wh* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*
 (Write the word.)

6. DATE OF BIRTH *Dec. 6*
 (Month) (Day) (Year)

7. AGE *31* Yrs. *8* Mos. *24* ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION *Produce business*
 (a) Trade, profession or particular kind of work *salesman*
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE *Hebron, Neb.*
 (State or Country)

10. NAME OF FATHER *Henry M. McLaughlin*

11. BIRTHPLACE OF FATHER *Ireland*
 (State or Country)

12. MAIDEN NAME OF MOTHER *Katherine Gallagher*

13. BIRTHPLACE OF MOTHER *Ireland*
 (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *E. A. Milton Wagner*
 (Address) *Pocatello, Idaho*

15. Filed *Aug. 31 1922* *Rose Nowacki*
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

8 *30* *1922*
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19....., to 19.....

that I last saw him alive on 19.....

and that death occurred on the date stated above, at.....M.

The CAUSE OF DEATH* was as follows:

Drowning - accidental -

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) *J. P. Richards* - M. D.*8/31 1922* (Address) *Mackay, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Pocatello, Idaho 19.....

20. UNDERTAKER

ADDRESS

W. J. McFarlan, Pocatello, Idaho

FORM V. S. No. 5-25 M. 1-19.

RECEIVED CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39327**

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Custer Registration District No. 76
City of Sessie Primary Registration District No. 2153 (State) Idaho

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mrs. Eudine Bruno

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female white married
(Write the word.)

6. DATE OF BIRTH

May 7 1860
(Month) (Day) (Year)

7. AGE

62 Yrs. 3 Mos. 6 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)Housewife

9. BIRTHPLACE

(State or Country)

Spanish Fork, Utah

10. NAME OF FATHER

Erastus Curtis

11. BIRTHPLACE OF FATHER

(State or Country)

Brownstown, Ohio

12. MAIDEN NAME OF MOTHER

Mary Barton

13. BIRTHPLACE OF MOTHER

(State or Country)

Wilmington, Del.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Eliza Fullmer

(Address)

Mackay, Idaho

15.

Filed

Aug. 31 1922Rose Nawalki
Local Registrar

16. DATE OF DEATH

8 13 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 2 1922, to Aug 13 1922that I last saw her alive on Aug 11 1922,and that death occurred on the date stated above, at 1 a M.

The CAUSE OF DEATH* was as follows:

Chr Endocarditis

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Carroll A. Jensen M. D.5/14 1922 (Address) Mackay, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

1. PLACE OF DEATH

County of *Conston*
City of *MacKay*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Hanna Hemovich

CERTIFICATE OF DEATH

Registration District No. *76*Primary Registration District No. *2153*

(No. St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *39328*

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

wh

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

(Write the word.)

6. DATE OF BIRTH

1 (Month) *19* (Day) *1922* (Year)

7. AGE

6 Yrs. *14* Mos. *14* ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

White Horse, Idaho

10. NAME OF FATHER

Miss Hanna Hemovich

11. BIRTHPLACE OF FATHER

(State or Country)

Montana

12. MAIDEN NAME OF MOTHER

Annis Matule

13. BIRTHPLACE OF MOTHER

(State or Country)

Montana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mrs. Annis Hemovich*(Address) *MacKay, Idaho*

15.

Filed *9/14* *1922* *Rae Nowack*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

91

16. DATE OF DEATH

8 (Month) *5* (Day) *1922* (Year)17. I HEREBY CERTIFY, That I attended deceased from *8/24* *1922*, to *8/5* *1922*that I last saw her alive on *8/5* *1922*and that death occurred on the date stated above, at *10 A.* M.

The CAUSE OF DEATH* was as follows:

Bronchitis - Pneumonia(Duration) Yrs. mos. *5* ds.Contributory
(Secondary)*Pneumonia*(Duration) yrs. mos. *2* ds.

(Signed)

8/4 *1922*

(Address) M. D.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 76

County of Custer

Primary Registration District No. 2153

City of Chilly

(No. 122)

(St.)

File No. 39329

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant Nielson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Infant
(Write the word.)

6. DATE OF BIRTH

8 - 3 - 1922
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day
how many 4 hrs.
or min.?

Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Christian Nielson

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Harry Nielson

13. BIRTHPLACE OF MOTHER

(State or Country)

Ut.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Christian Nielson
Chilly Idaho

(Address)

15.

Filed

9/14

1922

R. Nowacki

Local Registrar

16. DATE OF DEATH

8 3 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

8-3-1922 to 8-3-1922

that I last saw him alive on 8-3-1922

and that death occurred on the date stated above, at 8:20 P.M.

The CAUSE OF DEATH* was as follows:

Premature birth
(Seven months)

(Duration) Yrs. mos. 4 hours

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Carol A. Jensen M. D.

9/4/1922 (Address) Moscow Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Elmore
City of Mountain Home

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No. 36Primary Registration District No. 2020

(No. _____) (St. _____)

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 39330Registered No. 21

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
(Write the word.)6. DATE OF BIRTH May, 31, 1869
(Month) (Day) (Year)7. AGE 53 Yrs. 2 Mos. 1 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Housewife

9. BIRTHPLACE

(State or Country)

Mo.

10. NAME OF FATHER

Isaac Fountain

11. BIRTHPLACE OF FATHER

(State or Country)

Indiana

12. MAIDEN NAME OF MOTHER

Rhoda Barlow

13. BIRTHPLACE OF MOTHER

(State or Country)

Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. W. Fountain(Address) Mountain Home, Idaho15. Filed Aug 3 1922 J. E. Elmore
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug - 2 - 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from 8-2-1922 to 8-2-1922
that I last saw her alive on 8-2-1922
and that death occurred on the date stated above, at 12 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

8/3 1922 (Address) Mountain Home, Idaho M. D.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Mountain Home Cemetery

DATE OF BURIAL

8/5 1922

20. UNDERTAKER

W. M. Bratney

ADDRESS

BoiseIdaho

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39331**
Registered No. **22**

1. PLACE OF DEATH

County of Elmore Registration District No. 34
City of Mt. Home Primary Registration District No. 20 20
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Fred Cooper

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH

Don't know
(Month) (Day) (Year)

7. AGE

73 Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Retired Rancher

9. BIRTHPLACE

(State or Country)

New York N.Y.

10. NAME OF FATHER

Don't know

11. BIRTHPLACE OF FATHER

(State or Country)

Don't know

12. MAIDEN NAME OF MOTHER

" "

13. BIRTHPLACE OF MOTHER

(State or Country)

" "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed 8-11-1922

J. E. Evans
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 9 19 22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19

that I last saw him alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Heart Failure

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

8/9 1922 (Address) W. D. Tally E-198. Mt. Home

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

City Em. Mt. Home

DATE OF BURIAL

8/11 1922

20. UNDERTAKER

W. D. Tally E-198.

ADDRESS

Mt. Home

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Elmore
City of Prairie

REC'D

SEP 1 1922

Registration District No. 34Primary Registration District No. 2020(No. 34)

St.)

File No. 39332Registered No. 23

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

J. P. Marker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widowed
(Write the word!)

6. DATE OF BIRTH

Feb 11 1830
(Month) (Day) (Year)

7. AGE

92 Yrs. 6 Mos. 11 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Stonemason

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Denmark

10. NAME OF FATHER

Jens P. Marker

11. BIRTHPLACE OF FATHER

(State or Country)

Denmark

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed 8-24 1922J. E. Evans
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug. 22, 1922
Do not know
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 18, 1922 to July 18, 1922
that I last saw him alive on July 18, 1922
and that death occurred on the date stated above, at ? M.

The CAUSE OF DEATH* was as follows:

Cancer of liver.(Duration) 2 Yrs. _____ mos. _____ ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

M. H. Tallman M. D.7/18 1922

(Address)

Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. 1 mos. 15 days. In the State 20 yrs. _____ mos. _____ daysWhere was disease contracted if not at place of death? Emmett, IdahoFormer or usual residence Emmett, Idaho

19. PLACE OF BURIAL OR REMOVAL

Smith's Prairie, Ida.

DATE OF BURIAL

8-24-1922

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39333**Registered No. **24**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of **Elmore**
City of **Butte**Registration District No. **34**
Primary Registration District No. **2020**
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Manuel Chavez

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX **M** 4. COLOR OR RACE **brown** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **single**
(Write the word.)

6. DATE OF BIRTH

Not known
(Month) (Day) (Year)

7. AGE

23 Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)**laborer**

9. BIRTHPLACE

(State or Country)

Guerrero Michuacan

10. NAME OF FATHER

Josefa Chavez

11. BIRTHPLACE OF FATHER

(State or Country)

Mexico

12. MAIDEN NAME OF MOTHER

Jovita Arellano

13. BIRTHPLACE OF MOTHER

(State or Country)

Guerrero Michuacan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Jose Zambrano

(Address)

Glenns Ferry, Ida

15.

Filed **8-28-1922****J. E. Evans**
Local Registrar

16. DATE OF DEATH

Aug 27 19**22**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to **19**that I last saw him alive on **19**and that death occurred on the date stated above, at **8:45 A.M.**The CAUSE OF DEATH* was as follows: **accidental****Killed by train No. 24 at Hammett station**

(Duration) Yrs. mos. ds.

Contributory (Secondary) **accidental**

(Duration) yrs. mos. ds.

(Signed) **J. H. Kistner****Aug 27, 1922** (Address) **1110 1st Ave**

State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence **Los Angeles, Cal**

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Butte Cemetery**8-27-1922**

20. UNDERTAKER

ADDRESS

John Fally**Butte**

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39334**Registered No. **25**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

Registration District No. **34**County of **Emure**Primary Registration District No. **2020**City of **Butte**(No. **14** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Edw Carl E Johnson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED
(Write the word.)**Male****White****Married**

6. DATE OF BIRTH

March 18 1896
(Month) (Day) (Year)

7. AGE

36 Yrs. 5 Mos. 8 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Farmer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Sweden

10. NAME OF FATHER

John T. Fox

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME OF MOTHER

Merry Olsen

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs Ed Johnson

(Address)

Stammetts Dela.

15.

Filed

9-1-1922**J E Evans**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

August 26th 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19..... to 19.....

that I last saw h..... alive on..... 19.....

and that death occurred on the date stated above, at **7:30 PM**

The CAUSE OF DEATH* was as follows:

Accidental - Killed by lightning

(Duration) Yrs..... mos..... ds.

Contributory
(Secondary)

(Duration) yrs..... mos..... ds.

(Signed)

St. H. Eaton, coroner**8/26/1922** (Address) **Stammetts Dela.**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place **Sweden** In the
of death yrs..... mos..... days. State yrs..... mos..... daysWhere was disease contracted
if not at place of death?Former or
usual residence**Emmett, Dela.**

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Emmett Dela.**8/27 1922**

20. UNDERTAKER

ADDRESS

Wm D. Bailey

OCT 4 1922

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of ElmoreCity of Elmer's Ferry

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

(No. _____) (St. _____)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 39335

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male White not known
(Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE about
45 Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dr. J. W. Dows(Address) Elmer's Ferry

15.

Filed Sept. 7 1922J. W. Dows
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

When found
Sept 5 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19____, to 19____
that I last saw him alive on 19____
and that death occurred on the date stated above, at ____ M.

The CAUSE OF DEATH* was as follows:

Unknown plaster
in back of head
(Duration) Yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. W. Dows9/5/22 (Address) Elmer's Ferry

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Elmer's Ferry 9/5 1922

20. UNDERTAKER

ADDRESS

J. W. Dows Elmer's Ferry

1. PLACE OF DEATH

County of Franklin Registration District No. 1822
 City of Miner Creek Primary Registration District No. 1822
 (No. 1822 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ingrid E. Persson

CERTIFICATE OF DEATH

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 39336

Registered No. 40

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED widow
 (Write the word.)

6. DATE OF BIRTH

Mar 18 1857
 (Month) (Day) (Year)

7. AGE

65 Yrs. 6 Mos. 11 ds. IF LESS than 1 day
 how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country) Sweden

10. NAME OF FATHER

Lars Larsen

11. BIRTHPLACE OF FATHER

(State or Country) Sweden

12. MAIDEN NAME OF MOTHER

Christina Persson

13. BIRTHPLACE OF MOTHER

(State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Olga Johnson
 (Address) Miner Creek, Ida.

15. Filed Oct. 4 1922 Mrs. Ida Lippert
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 29 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 6 - 1922 to Sept 30 1922
 that I last saw him alive on 19,
 and that death occurred on the date stated above, at 12 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach
Saw her only few times as she
did not want a physician
 (Duration) 7 Yrs. 7 mos. 7 ds.

Contributory
 (Secondary)

(Duration) 7 yrs. 7 mos. 7 ds.

(Signed) G. W. States M. D.

30 1922 (Address) Preston, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 7 yrs. 7 mos. 7 days. In the State 7 yrs. 7 mos. 7 days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Richmond, Va.

DATE OF BURIAL

Oct. 2 1922

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39337**Registered No. **55**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Franklin Registration District No. 27
City of Mink Creek Primary Registration District No. 2119
No. 3 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

C. J. Christensen

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH

March 31 1869
(Month) (Day) (Year)

7. AGE

63 Yrs. 5 Mos. 23 ds. 23
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Farmer

9. BIRTHPLACE

(State or Country)

Denmark

10. NAME OF FATHER

Christian Larson

11. BIRTHPLACE OF FATHER

(State or Country)

Denmark

12. MAIDEN NAME OF MOTHER

Carm Christensen

13. BIRTHPLACE OF MOTHER

(State or Country)

Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Mrs C. S. Christensen
(Informant)(Address) Mink Creek Ida.

15.

Filed Oct. 4 1922 Mrs Ida Lippert
Local Registrar

16. DATE OF DEATH

9 - 23 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 20 1922 to 9-23 1922
that I last saw him alive on 9-21 1922
and that death occurred on the date stated above, at 6 A.M.
The CAUSE OF DEATH* was as follows:Angina Pectoris(Duration) 8 Yrs. mos ds.Contributory Arteriosclerosis - Hypertension
(Secondary)(Duration) 10 yrs. mos ds.(Signed) J. R. Cutler M. D.9-25 1922 (Address) Preston Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Richmond Mt. Sep 25, 22

20. UNDERTAKER

ADDRESS

W. A. Skidmore Preston Ida.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39338**
Registered No. **54**

1. PLACE OF DEATH **RECEIVED**
County of **Franklin** Registration District No. **27**
City of **Preston** Registration District No. **219**
St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Meriam H. Monson-Elliott

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **7** 4. COLOR OR RACE **W.** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **(Write the word.)**

6. DATE OF BIRTH

Nov-8-86 1890
(Month) (Day) (Year)

7. AGE

31 Yrs. **10** Mos. **26** ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Whitney Idaho

10. NAME OF FATHER

Christiam Monson

11. BIRTHPLACE OF FATHER

(State or Country)

Lehi Utah
Franklin Idaho

12. MAIDEN NAME OF MOTHER

Lorina Hansen

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

James W. Elliott
Preston Idaho

15.

Filed

Oct 4 19**22**

1922

Mrs. Ida Lippert
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept - 14 - 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 29 1922 to **Sept 14** 1922
that I last saw her alive on **Sept 14** 1922
and that death occurred on the date stated above, at **1:45 p.m.**
The CAUSE OF DEATH* was as follows:

Mitral disease - Heart.

(Duration) **6** Yrs. **6** mos. **6** ds.
Contributory (Secondary) **Stroke Apoplexy**

(Duration) **3** yrs. **15** mos. **15** ds.
(Signed) **J. W. States** M. D.

Oct 16 1922 (Address) **Preston Ida.**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Franklin Ida.

DATE OF BURIAL

Sept. 17 1922

20. UNDERTAKER

W. A. Skidmore

ADDRESS

Preston Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 27
County of Franklton Primary Registration District No. 2119
City of Preston (No. St.)

File No. 39339

Registered No. 51

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Agnes Giddes Peterson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE wh. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH Aug. 11 1857
(Month) (Day) (Year)

7. AGE 65 yrs. 1 mos. 1 ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE Utah
(State or Country)

10. NAME OF FATHER Wm Giddes

11. BIRTHPLACE OF FATHER Scotland
(State or Country)

12. MAIDEN NAME OF MOTHER Martha Stewart

13. BIRTHPLACE OF MOTHER Scotland
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Preston Peterson
(Address) Logan Utah

15. Filed Oct. 4 1912 Mrs. H. Lippert
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 12 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 5 1922 to Sept 12 1922
that I last saw her alive on Sept 12 1922
and that death occurred on the date stated above, at 9:55 P.M.
The CAUSE OF DEATH* was as follows:

Aortic degeneration from Arterio Sclerosis.
(Duration) 5 yrs. 2 mos. 4 ds.

Contributory Arterio Sclerosis (Secondary)
(Duration) 5 yrs. 2 mos. 4 ds.

(Signed) G. W. States M. D.
Sept. 14 1922 (Address) Preston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death... yrs... mos... days. In the State... yrs... mos... days.

Where was disease contracted if not at place of death?

Former or usual residence...

19. PLACE OF BURIAL OR REMOVAL Preston Idaho DATE OF BURIAL Sept. 15 1922

20. UNDERTAKER G. H. Lundquist ADDRESS Logan Utah

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39340**
Registered No. **52**

1. PLACE OF DEATH

County of Franklin Registration District No. 27
City of Glendale Primary Registration District No. 2119
(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Melba Auger

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH

Sept 1 1922
(Month) (Day) (Year)

7. AGE

0 Yrs. 0 Mos. 0 ds.

IF LESS than 1 day
how many 7 hrs.
or 3 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

William Henry Auger

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Alta Jensen

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. H. Auger

(Address)

Preston, Idaho

15.

Filed

Oct. 4

19

22

Mrs. Ida Lippel

Local Registrar

MEDICAL CERTIFICATE OF DEATH

157-6

16. DATE OF DEATH

Sept 1 1922
(Month) (Day) (Year)

17. HEREBY CERTIFY, That I attended deceased from

Sept 1 1922 to Sept 1 1922
that I last saw him alive on Sept 1 1922
and that death occurred on the date stated above, at 9:30 A.M.

The CAUSE OF DEATH* was as follows:

Asphyxia Nervorum due to congenital debility

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Lurtis Blander M. D.

9/2/22 (Address) Preston, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Glendale

DATE OF BURIAL

9-2 1922

20. UNDERTAKER

ADDRESS

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Franklin Registration District No. 27
 City of Glendale Primary Registration District No. 2119
 (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Elva Auger

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. **39341**Registered No. 52

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
 (Write the word.)

6. DATE OF BIRTH

Sept. 1 1922
 (Month) (Day) (Year)

7. AGE

0 Yrs. 0 Mos. 0 ds.

IF LESS than 1 day
 how many 3 hrs.
 or 30 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

William Henry Auger

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Alta Jensen

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wm H Auger

(Address)

Preston, Idaho

15.

Filed

Oct. 41922Max H. Lippert

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept. 1 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept. 1 1922, to Sept. 1 1922
 that I last saw h. in alive on Sept. 1 1922
 and that death occurred on the date stated above, at 5:45 A.

The CAUSE OF DEATH* was as follows:

asphyxia neonatorum — due to congenital feebleness.

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Curtis Bland M. D.

9/1/22 (Address) Preston, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Glendale, Id.Sept. 2, 1922

20. UNDERTAKER

ADDRESS

RECEIVED
SEP 21 1922
BUREAU

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39342**

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Fremont Registration District No. 99
City of St. Anthony (No.) St. (No.) Registration District No. 2177

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Maria Louise Wonders

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-OWED OR DIVORCED

Female White

(Write the word.)

6. DATE OF BIRTH

April 9th 1840
(Month) (Day) (Year)

7. AGE

82 Yrs. 4 Mos. 17 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

None

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Eastland, Mich.

10. NAME OF FATHER

Abram Seaman

11. BIRTHPLACE OF FATHER

(State or Country)

New York

12. MAIDEN NAME OF MOTHER

Martha Albright

13. BIRTHPLACE OF MOTHER

(State or Country)

New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Viola A. McIntyre

(Address)

St. Anthony, Idaho

15.

Filed

Sept 10 1922 W. S. W. W.

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

August 26th 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 1922 to Aug 1922
that I last saw her alive on Aug 15 1922
and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

General Debility, Senility(Duration) 10 Yrs. mos. ds.Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

Frank Backus M. D.(Address) St. Anthony

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Overview St. Anthony Ida Aug 27 1922

20. UNDERTAKER

St. M. Hansen

ADDRESS

St. Anthony Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39343**

1. PLACE OF DEATH **RECEIVED SEP 21 1922**
Registration District No. _____
County of **Fremont** Primary Registration District No. _____
City of **St. Anthony** (No. _____) St. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Reed LeRoy Anderson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Single**
(Write the word.)
6. DATE OF BIRTH **April 4th 1920**
(Month) (Day) (Year)
7. AGE **2 Yrs. 3 Mos. 5 ds.** IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

none

9. BIRTHPLACE

(State or Country)

Wilford Idaho

10. NAME OF FATHER

William L. Anderson

11. BIRTHPLACE OF FATHER

(State or Country)

Salem Idaho

12. MAIDEN NAME OF MOTHER

Pearl McArthur

13. BIRTHPLACE OF MOTHER

(State or Country)

Wilford Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

William L. Anderson
St. Anthony R.D. 1 Idaho

15.

Filed

8 10

19 **22**

W. Sweet

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 9th
(Month) (Day)

19 **22**
(Year)

17. I HEREBY CERTIFY, That I attended deceased from **July 1 1922** to **July 9 1922**
that I last saw him alive on **July 9 1922**
and that death occurred on the date stated above, at **8 A.M.**

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(Duration) _____ Yrs. _____ mos. **14** ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

J. Frank Watkins

M. D.

(Address) **St. Anthony Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Wilford Cemetery

DATE OF BURIAL

July 11 1922

20. UNDERTAKER

W. M. Hansen

ADDRESS

St. Anthony Idaho

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

(No.)

St.)

File No.

Registered No.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

39344

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15. Filed

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from
that I last saw her alive on
and that death occurred on the date stated above, at.

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Signed)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Fremont Registration District No. 99
 City of St. Anthony Idaho Primary Registration District No. 2177
 (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Chappell Arlena Brown

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. **39345**

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female White married
 (Write the word.)

6. DATE OF BIRTH

Jan. 25th 1883
 (Month) (Day) (Year)

7. AGE

39 Yrs. 5 Mos. 8 ds. IF LESS than 1 day
 how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Alabama

10. NAME OF FATHER

James Gilbert

11. BIRTHPLACE OF FATHER

(State or Country)

Pennisssee

12. MAIDEN NAME OF MOTHER

Roda Stewash

13. BIRTHPLACE OF MOTHER

(State or Country)

Pennisssee

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

George Brown

(Address)

Chubb, Idaho

15.

Filed

8 10

1972

W B WEX

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 3rd 1972
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 1921, to July 1921
 that I last saw him alive on 1922

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Diabetes insipides

(Duration) Several Yrs. mos. ds.

Contributory
 (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. Frank Backus M. D.

1922 (Address) St Anthony Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Below

July 5th 1972

20. UNDERTAKER

ADDRESS

W M Hansen

St. Anthony Ida

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Fremont
City of St. Anthony

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
SEP 2 1922
BUREAU
STA

CERTIFICATE OF DEATH

Registration District No. 99Primary Registration District No. 217

(No. _____)

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39346**

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Francis Lee Quinn

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDmarried

(Write the word.)

6. DATE OF BIRTH

March 20th

(Month)

(Day)

1881

(Year)

7. AGE

41

Yrs.

3

Mos.

9

ds.

IF LESS than 1 day

how many _____ hrs.

or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Housewife

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Rosita Colo

10. NAME OF FATHER

John L. Blomer

11. BIRTHPLACE OF FATHER

(State or Country)

Penn.

12. MAIDEN NAME OF MOTHER

Matta Mitchell

13. BIRTHPLACE OF MOTHER

(State or Country)

Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Off Quinn

(Address)

St. Anthony

15.

Filed

7, 10,1922W. M. H. H. H.

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June

(Month)

29th

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

4/28/1922 to 6-29 1922that I last saw her alive on 4/29/1922and that death occurred on the date stated above, at 3 am

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis(Duration) 7 Yrs. — mos. — ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

James H. H.

M. D.

4/29 1922 (Address) St. Anthony, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

St. Anthony, (Riverview)

DATE OF BURIAL

June 30, 1922

20. UNDERTAKER

W. M. H. H.

ADDRESS

St. Anthony, Ida

RECEIVED
SEP 2 1922

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Fremont Registration District No. 19
City of St. Anthony Registration District No. 2177 St.)

File No. 39347
Registered No. 39347

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Charles Frederick Park

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-OWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH

August 15th 1922
(Month) (Day) (Year)

7. AGE

34 Yrs. 10 Mos. 8 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Rancher

9. BIRTHPLACE

(State or Country)

Plattsburg N. Y.

10. NAME OF FATHER

Charles N. Parks.

11. BIRTHPLACE OF FATHER

(State or Country)

Vermont

12. MAIDEN NAME OF MOTHER

Julia Monly

13. BIRTHPLACE OF MOTHER

(State or Country)

New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Janet E. Duffies
W. Blunt

15.

Filed

7 101922W. Blunt

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 23 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 23 1922 to June 23 1922
that I last saw h. alive on 19

and that death occurred on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

apoplexy

Sudden (Duration) 1 Yrs. 0 mos. 0 ds.

Contributory (Secondary)

none

0 (Duration) 0 yrs. 0 mos. 0 ds.

(Signed)

J. E. Melton M. D.

6-24 1922 (Address) St. Anthony Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 0 yrs. 0 mos. 0 days. In the State 0 yrs. 0 mos. 0 days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Missoula, Mont

DATE OF BURIAL

June 26 1922

20. UNDERTAKER

H. M. Hansen

ADDRESS

St. Anthony Idaho

File No. **39348**

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of _____

City of _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No. **44**Primary Registration District No. **2177**

St.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

6. DATE OF BIRTH.

7. AGE

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15.

Filed

1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

(Duration) 2 Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. P. Davis M. D.

(Address) Ashton, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

1. PLACE OF DEATH

County of *Bremont*City of *St. Anthony Idaho*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED CERTIFICATE OF DEATH

Registration District No. *94*Primary Registration District No. *2177*

BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *39349*

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

*White*5. SINGLE, MARRIED, WID-
OWED OR DIVORCED*Child*

(Write the word.)

6. DATE OF BIRTH

June 18 1917
(Month) (Day) (Year)

7. AGE

4 Yrs. *11* Mos. *16* ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

St. Anthony Idaho

10. NAME OF FATHER

Walter C. Moreton

11. BIRTHPLACE OF FATHER

(State or Country)

Salt Lake City, Utah

12. MAIDEN NAME OF MOTHER

Lilias Arnold.

13. BIRTHPLACE OF MOTHER

(State or Country)

Verdon, Nebr.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Frances Ellen Arnold

(Address)

St. Anthony Idaho

15.

*7 10**22**W. D. WEST*

Filed

*19**22**W. D. WEST*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 5th 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

*Dec 20 1921, to June 5 1922*that I last saw him alive on *June 5 1922*and that death occurred on the date stated above, at *10 P.M.*

The CAUSE OF DEATH* was as follows:

Drabules(Duration) Yrs. *5* mos. ds.Contributory
(Secondary)*in 1921*

(Duration) yrs. mos. ds.

(Signed)

*R. L. Maxwell M.D.**June 5 1922* (Address) *St. Anthony Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

St. Anthony Ida. (Riverview)

DATE OF BURIAL

June 8th 1922

20. UNDERTAKER

W. M. Hansen

ADDRESS

St. Anthony Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39350**
Registered No.

1. PLACE OF DEATH

County of Fremont Registration District No. 99
City of St. Anthony Primary Registration District No. 1177 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Cassie Countryman Hutchinson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH

May 4th 1877
(Month) (Day) (Year)

7. AGE

45 Yrs. 1 Mos. 2 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country) Canada

10. NAME OF FATHER

Jacob Countryman

11. BIRTHPLACE OF FATHER

(State or Country) Canada

12. MAIDEN NAME OF MOTHER

Eliza Wells

13. BIRTHPLACE OF MOTHER

(State or Country) Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Fred Hutchinson
(Address) Rexburg, Idaho

15.

Filled 7 10 1922 W. Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 6 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 11 1922 to June 6 1922
that I last saw her alive on June 6 1922
and that death occurred on the date stated above, at 243 M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) Yrs. 3 mos. 1 ds.

Contributory
(Secondary)

apoplexy

(Duration) yrs. 1 mos. 5 ds.

(Signed)

J. E. Mellon

M. D.

6-6 1922 (Address) St. Anthony, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. 16 mos. 24 days. In the State yrs. 2 mos. 2 days

Where was disease contracted if not at place of death?

Moody Creek

Former or usual residence

Rexburg, Idaho

19. PLACE OF BURIAL OR REMOVAL

Ogdensburg, New York.

DATE OF BURIAL

6/12 1922

20. UNDERTAKER

DAVID R. YOUNG

ADDRESS

REXBURG, ID

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Fremont
City of St. Anthony

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 49
County Registration District No. 2177
(Notarial)
BUREAU OF STATISTICS2. FULL NAME Martha Anna EmbreeState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 39351

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widow
(Write the word.)

6. DATE OF BIRTH

December 29th, 1842
(Month) (Day) (Year)

7. AGE

79 Yrs. 5 Mos. 6 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

None

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Berry, Mo.

10. NAME OF FATHER

Mr Bell

11. BIRTHPLACE OF FATHER

(State or Country) Tenn.

12. MAIDEN NAME OF MOTHER

Not Known

13. BIRTHPLACE OF MOTHER

(State or Country) Tenn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Della Leffler(Address) St. Anthony, Idaho15. 7 10 22Filed 7 10 2219W. D. West

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 4th, 1922 19____
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from 6-3- 1922, to June 4- 1922
that I last saw her alive on June 4 1922
and that death occurred on the date stated above, at 7 P. M.
The CAUSE OF DEATH* was as follows:Pneumonia(Duration) Yrs. 5 mos. 5 ds.Contributory
(Secondary)(Duration) yrs. 5 mos. 5 ds.(Signed) J. E. Mett

M. D.

June 6th 1922 (Address) St. Anthony, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Pueblo, Colo.

DATE OF BURIAL

June 9th 1922

20. UNDERTAKER

W. M. Hansen

ADDRESS

St. Anthony, Ida.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39352**Registered No. **57**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Franklin Registration District No. 27
City of Preston Registration District No. 2119
BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elma Carol

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F4. COLOR OR RACE W5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Single
(Write the word.)

6. DATE OF BIRTH

Feb. 15 1922
(Month) (Day) (Year)

7. AGE

6 Yrs. 7 Mos. 7 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Preston Ida

10. NAME OF FATHER

George M. Condie

11. BIRTHPLACE OF FATHER

(State or Country) Croydon Utah

12. MAIDEN NAME OF MOTHER

Caroline Johnson

13. BIRTHPLACE OF MOTHER

(State or Country) Preston Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) George M. Condie(Address) Preston Ida

15.

Filed Sept 4 1922 Mrs Ida Lippert
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

8 21 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

8-10 1922, to 8-21 1922
that I last saw her alive on 8-21 1922
and that death occurred on the date stated above, at 8:30 A.M.

The CAUSE OF DEATH* was as follows:

Branches pneumonia

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) A. R. Cullin M. D.19 (Address) Preston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Preston Idaho

DATE OF BURIAL

Aug 22 1922

20. UNDERTAKER

W. C. Hickmore

ADDRESS

Preston IdaWRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 27
County of Franklin Primary Registration District No. 2119
City of Preston (St.)
BUREAU OF VITAL STATISTICS

File No. 39353
Registered No. 49

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hans Nelson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH April - 14 - 1850
(Month) (Day) (Year)

7. AGE 72 yrs. 2 mos. 28 ds.
IF LESS than 1 day how many hrs. or min?

8. OCCUPATION Farmer
(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Island of Tyn, Denmark
(State or Country)

10. NAME OF FATHER Christian Nelson

11. BIRTHPLACE OF FATHER Denmark
(State or Country)

12. MAIDEN NAME OF MOTHER Cathrine Jensen

13. BIRTHPLACE OF MOTHER Denmark
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. E. Nelson
(Address) Mink Creek, Idaho

15. Filed Sept 4 1922 Mrs. Ida Lippert
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH July 12 - 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 11 1922, to July 12 1922
that I last saw him alive on July 12 - 1922
and that death occurred on the date stated above, at 8:10 P.M.
The CAUSE OF DEATH* was as follows:

Chronic Brights disease

(Duration) 4 yrs. 1 mos. 4 ds.
Contributory (Secondary) Bronchitis Chronic
(Duration) 3 yrs. 1 mos. 4 ds.
(Signed) G. W. States M. D.
July 13 1922 (Address) Preston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Mink Creek Idaho July 15 1922
20. UNDERTAKER ADDRESS
W. A. Skidmore Preston Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39354**
Registered No. **48**1. PLACE OF DEATH
County of Franklin Registration District No. 27
City of Franklin Primary Registration District No. 2119
St. Idaho

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Bernella Nelson Bergquist

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH 120

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widowed
(Word.)

6. DATE OF BIRTH

Nov 1 1841
(Month) (Day) (Year)

7. AGE

71 Yrs. 9 Mos. 17 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Housewife

9. BIRTHPLACE

(State or Country)

Sweden

10. NAME OF FATHER

Nels Nelson

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Edwaged Bergquist

(Address)

Preston Idaho

15.

Filed Sept 4 1922Mrs. H. Lippert
Local Registrar

16. DATE OF DEATH

Aug 15 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 1 1921, to Aug 15 1922
that I last saw him alive on Aug 15 1922
and that death occurred on the date stated above, at 6 A.M.
The CAUSE OF DEATH* was as follows:
Myocardial Infarction(Duration) 8-10 yrs. 14 mos. 14 ds.
Contributory (Secondary) Ovarian tumor(Duration) 8-10 yrs. 14 mos. 14 ds.
(Signed) A. P. Cutler M. D.8-10 1922 (Address) Preston, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Prink Creek IdaAug 20 1922

20. UNDERTAKER

ADDRESS

W. C. SkidmorePreston Ida

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of

City of

Registration District No.

BUREAU Primary Registration District No.

STA (No.)

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 39355

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William H. Bills

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

male white

married

(Write the word.)

6. DATE OF BIRTH

Nov 26 1876
(Month) (Day) (Year)

7. AGE

45 yrs. 8 mos. 25 ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

Farmer

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Alexander Bills

11. BIRTHPLACE OF FATHER

(State or Country)

not known

12. MAIDEN NAME OF MOTHER

Emily Beckstead

13. BIRTHPLACE OF MOTHER

(State or Country)

Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Edwin Hope

(Address)

Emmett Idaho

15.

Filed 9/2 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 21 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 17 1922 to Aug 21 1922

that I last saw him alive on Aug 19 1922

and that death occurred on the date stated above, at 8 A. M.

The CAUSE OF DEATH was as follows:

Chronic Endocarditis

(Duration) Yrs. mos. ds.

Contributory (Secondary)

Pneumonia

(Duration) yrs. mos. ds.

(Signed)

Bertin O. Clark M. D.

(Address) Emmett Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Emmett Idaho

DATE OF BURIAL

8/24 1922

20. UNDERTAKER

Ed Bucknum

ADDRESS

Emmett Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39356**
Registered No.

1. PLACE OF DEATH

County of *Emmett* Registration District No.
City of *Emmett* Primary Registration District No.
St.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Arthur Peterson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

single
(Write the word.)

6. DATE OF BIRTH

1885
(Month) (Day) (Year)

7. AGE

about 37 yrs
Yrs. Mos. ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Robber

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

Henry Peterson

11. BIRTHPLACE OF FATHER

(State or Country)

Missouri

12. MAIDEN NAME OF MOTHER

Dolcina Crawford

13. BIRTHPLACE OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ray Peterson

(Address)

Emmett Idaho

15.

Filed *9 22* 19 *21*

J. W. Peterson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 14 19 *22*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

..... 19....., to 19.....
that I last saw him..... alive on..... 19.....
and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Spastic paraplegia

..... (Duration) *12* Yrs. mos. ds.

Contributory
(Secondary)

..... (Duration) yrs. mos. ds.

(Signed) *R. N. Emmett* M. D.

7/15 1922 (Address) *Emmett*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Emmett Ida

DATE OF BURIAL

7/15 1922

20. UNDERTAKER

C. D. Bucknum

ADDRESS

Emmett Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39357**
Registered No. _____

1. PLACE OF DEATH

Registration District No. _____
County of *Gern* Primary Registration District No. *6*
City of *Emmett* _____ (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

J. Samuel Wilson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED *widower*
(Write the word.)

6. DATE OF BIRTH

not known
(Month) (Day) (Year)

7. AGE

about 60 yrs
Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

not known

11. BIRTHPLACE OF FATHER

(State or Country)

" "

12. MAIDEN NAME OF MOTHER

" "

13. BIRTHPLACE OF MOTHER

(State or Country)

" "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. H. Lewis
(Address) *Strang, Okla.*

15.

Filed *9/17* 19 *22*

J. H. Reynolds
Local Registrar

16. DATE OF DEATH

Sept 2 19 *22*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Sept 2* 19 *22*, to *Sept 3* 19 *22*, that I last saw him alive on *Sept 2* 19 *22*, and that death occurred on the date stated above, at *11 A.M.*

The CAUSE OF DEATH* was as follows:

uremia

(Duration) Yrs. mos. ds.
Contributory *Chronic nephritis*
(Secondary)

(Duration) *several* mos. ds.
(Signed) *J. H. Reynolds* M. D.

7/17 19 *22* (Address) *Emmett Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Emmett Ida

DATE OF BURIAL

9/6 19 *22*

20. UNDERTAKER

W. Beckman

ADDRESS

Emmett

Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Gem* Registration District No. *6*
City of *Emmett* Primary Registration District No. *6* (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Anna Katherine Baisch*File No. *39358*
Registered No. *39358*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *female* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *married*
(Write the word.)

6. DATE OF BIRTH

Nov 10 1874
(Month) (Day) (Year)

7. AGE

47 Yrs. *9* Mos. *26* ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)*Housewife*

9. BIRTHPLACE

(State or Country)

Illinois

10. NAME OF FATHER

Fred Hottes

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Barbara Dathan

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Fred Baisch

(Address)

Emmett Idaho

15.

Filed

9/14 1922

Local Registrar

J. L. Reynolds

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 6 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *Aug 21 1922* to *Sept 6 1922* that I last saw him alive on *Sept 5 1922* and that death occurred on the date stated above, at *6 P. M.*

The CAUSE OF DEATH* was as follows:

*Hypostatic Pneumonia*Contributory (Secondary) *about* *myocardial insufficiency*
(Duration) Yrs. mos. *20* ds.
(Duration) Yrs. mos. ds.(Signed) *R. N. Cunningham* M. D.9/7/1922 (Address) *Emmett Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Emmett Idaho

DATE OF BURIAL

9/9 1922

20. UNDERTAKER

O. L. Buckman

ADDRESS

Emmett Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39359**

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Gooding
City of Gooding

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Robert Burke

RECEIVED

SEP 13 1922

BUREAU OF VITAL STATISTICS

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDmalewhitesingle
(Write in word.)

6. DATE OF BIRTH

1854

(Month)

(Day)

(Year)

7. AGE

68

Yrs.

Mos.

ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Laborer

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Ireland

10. NAME OF FATHER

not known

11. BIRTHPLACE OF FATHER

(State or Country)

X

12. MAIDEN NAME OF MOTHER

not known

13. BIRTHPLACE OF MOTHER

(State or Country)

X

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. C. Moyes

(Address)

Ogden, Utah

15.

Filed

8-12-1922J. C. Moyes

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug.12, 1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug. 5, 1922

to

Aug. 12, 1922that I last saw him alive on Aug. 12, 1922and that death occurred on the date stated above, at 3 AM.

The CAUSE OF DEATH* was as follows:

AcidosisArterio-sclerosisUremia

(Duration) ? Yrs. mos. ds.

Contributory
(Secondary)X

(Duration) ? yrs. mos. ds.

(Signed)

J. E. Lamb M. D.8/12/22(Address) Gooding, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

..... 19.....

20. UNDERTAKER

A. E. Thompson

ADDRESS

Gooding, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Gooding
City of GoodingRegistration District No. 24Primary Registration District No. 24File No. 39360Registered No. 39360

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Flossie Bell Rogers

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married

(Write the word.)

6. DATE OF BIRTH.

Oct. 14, 1896
(Month) (Day) (Year)

7. AGE

25 Yrs. 10 Mos. 7 ds.IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).housewife

9. BIRTHPLACE

(State or Country) Kansas

10. NAME OF FATHER

W. S. Brown

11. BIRTHPLACE OF FATHER

(State or Country) U.S.

12. MAIDEN NAME OF MOTHER

Minnie May Hason

13. BIRTHPLACE OF MOTHER

(State or Country) Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dean Rogers(Address) Gooding, Idaho.

15.

Filed 8/119122

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

August 7, 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from July 19, 1922 to Aug. 8, 1922that I last saw him er alive on August 8, 1922and that death occurred on the date stated above, at 11 A. M.

The CAUSE OF DEATH* was as follows:

Tuberculosis(Duration) 2 Yrs. 1 mos. 14 ds.Contributory (Secondary) Influenza(Duration) 2 Yrs. 1 mos. 14 ds.(Signed) H. E. Lamb M. D.8/7/22 (Address) Gooding, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mason House 8-80 19122

20. UNDERTAKER

ADDRESS

O. E. Thompson Gooding, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

RECEIVED CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.

County of

Primary Registration District No.

City of

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Halla B Rice

File No. 39361

Registered No.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

May - 12 1872
(Month) (Day) (Year)

7. AGE

50 yrs. 2 mos. 29 ds.

IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

Wm. H. Rimesha

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Italy & Spain

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. S. Rice

(Address)

Gooding, Ida

15.

Filed

8-12-1922

W. Raymo

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug - 9 - 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 1, 1922 to Aug 9 - 1922
that I last saw her alive on Aug 7 - 1922

and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast and liver

(Duration) yrs. 10 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

8/13 1922 (Address) Gooding

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death... yrs... mos... ds. State... yrs... mos... ds.

Where was disease contracted.

If not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Gooding

8/13 - 1922

20. UNDERTAKER

ADDRESS

A. E. Thompson Gooding, Ida

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Gooding* Registration District No. *24*
City of *Bliss* Registration District No. *24*
State of *ID*File No. *39362*
Registered No. *39362*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Sarah Jane Ayres

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

*20*3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*

6. DATE OF BIRTH

Dec 23 1905
(Month) (Day) (Year)

7. AGE

20 Yrs. *7* Mos. *23* ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).*None*

9. BIRTHPLACE

(State or Country)

Kansas

10. NAME OF FATHER

Emery B Ayers

11. BIRTHPLACE OF FATHER

(State or Country)

Kansas

12. MAIDEN NAME OF MOTHER

Lanie Hallaton

13. BIRTHPLACE OF MOTHER

(State or Country)

Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

E. S. Ayers
*Gooding Ida*15. Filed *8-19-1922**Haynes*
Local Registrar

16. DATE OF DEATH

August 16 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 15 1922 to Aug 16 1922
that I last saw him alive on *Aug. 13 1922*
and that death occurred on the date stated above, at *11 P. M.*

The CAUSE OF DEATH* was as follows:

Septicemia + Imp
for infection
Caries of iliac & sacrum
(Duration) Yrs. mos. ds.Contributory
(Secondary)*Tuberculosis of Imp*
(Duration) yrs. mos. ds.

(Signed)

J. H. Cromwell

M. D.

Aug 22 1922 (Address) *Gooding Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Gooding Ida

DATE OF BURIAL

8-19-1922

20. UNDERTAKER

A. E. Thompson

ADDRESS

Gooding Ida

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39364**

1. PLACE OF DEATH

County of Idaho
City of Suite

Registration District No. 106Primary Registration District No. 2184

(No.)

(St.)

Registered No. 128

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Robert Taggart

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

M

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Feb 7 1882
(Month) (Day) (Year)

7. AGE

30

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Engineer

9. BIRTHPLACE

(State or Country)

Michigan

10. NAME OF FATHER

Charles Taggart

11. BIRTHPLACE OF FATHER

(State or Country)

Ontario Canada

12. MAIDEN NAME OF MOTHER

Hulda Matthews

13. BIRTHPLACE OF MOTHER

(State or Country)

Michigan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John Grantham
(Address) Suite Idaho

15.

Filed Aug 29 1922

James H. Kears
Local Registrar

16. DATE OF DEATH

Aug 26 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 26 1922 to Aug 26 1922
that I last saw him alive on Aug 26 1922
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Traumatism. Crushed between traction engine & separator while making coupling.

(Duration) Yrs. mos. ds.

Contributory (Secondary)

Accidental

(Duration) yrs. mos. ds.

(Signed)

A. J. Mangg coronor M. D.

Aug 26 1922 (Address) Grandwell

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Robertson Malibu

DATE OF BURIAL

Sept 4 1922

20. UNDERTAKER

A. J. Mangg

ADDRESS

Grandwell

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. *Idaho* Registration District No. *103*
County of *Idaho* Primary Registration District No. *2181*
City of *Shangwile* (No. *1* St.)

File No. **39365**
Registered No. *23*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

STATIST

William Swords

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M* 4. COLOR OR RACE *N* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. *Single*
(Write the word.)

6. DATE OF BIRTH.

Not Known

7. AGE

63

Yrs. Mos. ds.

If LESS than 1 day
how many hrs. or
min. 2

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...

Rancher

9. BIRTHPLACE

(State or Country)

Kentucky

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Albert Swords

(Address)

Whitebird Idaho

15.

Filed

Oct 1

1922

388 Station

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

About Sept 17

(Month)

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191

to

191

that I last saw *alive* on 191and that death occurred on the *date* above, at M.

The CAUSE OF DEATH* was as follows:

*Success
Stychnine poison*

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

A. J. Mung

9/18/1922 (Address)

Shangwile Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death....yrs....mos....days

State....yrs....mos....days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Knott Ferry

DATE OF BURIAL

Sept 17 1922

20. UNDERTAKER

A. J. Mung

ADDRESS

Shangwile

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Idaho
City of GrangevilleRegistration District No. 103Primary Registration District No. 1001

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Caroline Von. BergenState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 39366Registered No. 23

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

married

(Write the word.)

6. DATE OF BIRTH

Sept 1

(Month)

(Day)

1862
(Year)

7. AGE

60

Yrs.

Mos.

7

ds.

IF LESS than 1 day

how many _____ hrs.

or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

House wif

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

France

10. NAME OF FATHER

Wohl Kenter

11. BIRTHPLACE OF FATHER

(State or Country)

France

12. MAIDEN NAME OF MOTHER

2

13. BIRTHPLACE OF MOTHER

(State or Country)

France

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Julius von. Bergen
Grangeville Idaho

15.

Filed

Oct 1 1922G. S. Stockton

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 5

(Month)

1922

(Day)

1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 1 1922 to Sept 5 1922that I last saw her alive on Sept 4 1922and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) G. S. Stockton M. D.19. (Address) Grangeville Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Denver Idaho

DATE OF BURIAL

9/10 1922

20. UNDERTAKER

E. S. Hancock

ADDRESS

Grangeville

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Idaho Registration District No. 103
County of Idaho Registration District No. 1001
City of Grangerville (No. _____ St.)

File No. **39367**Registered No. 24

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Marshall Series

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED. Don't know
(Write the word.)

6. DATE OF BIRTH.

Don't know
(Month) (Day) (Year)

7. AGE

81 Yrs. _____ Mos. _____ ds.
IF LESS than 1 day
how many _____ hrs. or
_____ min. >|

8. OCCUPATION

(a) Trade, profession or particular kind of work... miner
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country) Liberty, Mo -

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country) ?

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country) ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M. W. Dwyer
(Address) Grangerville, Ida

15.

Filed Oct 1 1922

98 Stockton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 23 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 3 1922 to Sept 23 1922 that I last saw h. alive on Sept 22 1922 and that death occurred on the date stated above, at 2:40 P. M.

The CAUSE OF DEATH* was as follows:

Senile decay

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory Arterio Sclerosis
(Secondary)

(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed) G. S. Stockton M. D.

9/24 1922 (Address) Grangerville, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rainie View Sept 23 1922

20. UNDERTAKER

ADDRESS

Ed Hancock Grangerville

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39368**
Registered No. **37**

1. PLACE OF DEATH

County of *Jefferson*
City of *Rigby, ID #3*

Registration District No. *98*
Primary Registration District No. *2176*
St. *STATISTICS*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Thos Harry Tree

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-OWED OR DIVORCED

Male White (Write the word.)

6. DATE OF BIRTH

5 11 1922
(Month) (Day) (Year)

7. AGE

3 Yrs. *12* Mos. *12* ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) *Rigby ID #3*

10. NAME OF FATHER

Harry Tree

11. BIRTHPLACE OF FATHER

(State or Country) *England*

12. MAIDEN NAME OF MOTHER

Viola Shultz

13. BIRTHPLACE OF MOTHER

(State or Country) *Teton City Idaho*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Harry Tree*

(Address)

15. Filed *Sept 10th 1922*

Ray H. Fish
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 23 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 5th 1922 to *Aug 23rd 1922*
that I last saw him alive on *Aug 20th 1922*
and that death occurred on the date stated above, at *99* M.

The CAUSE OF DEATH* was as follows:

Umbilical infection
Local peritonitis

(Duration) Yrs. mos. ds.

Contributory (Secondary) *Malnutrition*

(Duration) yrs. mos. ds.

(Signed) *Ray H. Fish* M. D.

Aug 24 1922 (Address) *Rigby, Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Rigby

DATE OF BURIAL

8 1924

20. UNDERTAKER

E. D. Lillie

ADDRESS

Rigby Ida

RECEIVED CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39369**Registered No. **5-2**

1. PLACE OF DEATH

County of *Jefferson*City of *Rigby*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Register District No. *98*Primary Registration District No. *2176*

St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widowed
(Write the word.)

6. DATE OF BIRTH

Dec. 17 1844
(Month) (Day) (Year)

7. AGE

77 Yrs. *8* Mos. *14* ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Housewife.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Nauvoo, Illinois.

10. NAME OF FATHER

Elam Luddington

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Ann Brown
Mary Clark

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Lawrence Bush

(Address)

Rigby, Ida

15. Filed

Sept. 10 1922
Ray H. Fisher
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 1 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 25 1922 to *Sept 1 1922*
that I last saw him alive on *Aug 31 1922*
and that death occurred on the date stated above, at *1:30 P.M.*

The CAUSE OF DEATH* was as follows:

Senility.

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *Ray H. Fisher* M. D.19..... (Address) *Rigby, Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Rigby, Ida *114* 1922

20. UNDERTAKER

ADDRESS

E. D. Galtner *Rigby, Ida*

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39370**
Registered No. **50**

1. PLACE OF DEATH
County of Jefferson
City of Rigby - #3
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 98
Primary Registration District No. 2176
No. 3 St.

2. FULL NAME

Lawford Wells Summers
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED
(Write the word.)

6. DATE OF BIRTH January 5 1910
(Month) (Day) (Year)

7. AGE 12 Yrs. 7 Mos. 29 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Rigby ID#3

10. NAME OF FATHER Wm M Summers

11. BIRTHPLACE OF FATHER
(State or Country) South Wales

12. MAIDEN NAME OF MOTHER Alma Weas

13. BIRTHPLACE OF MOTHER
(State or Country) Wyoming

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm M Summers
(Address) Rigby ID#3

15. Filed 9-10 1922 Ray H Fisher
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH September 7 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 30 1922 to Sept 5 1922
that I last saw him alive on Sept 4 1922
and that death occurred on the date stated above, at 7 M.
The CAUSE OF DEATH* was as follows:

Cardio-renal insufficiency

(Duration) 2 Yrs. 0 mos. 0 ds.

Contributory (Secondary)

(Duration) 0 yrs. 0 mos. 0 ds.

(Signed) O. F. Ball M. D.

19. (Address) Rigby Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Rigby Cemetery DATE OF BURIAL Sept 9 1922

20. UNDERTAKER O. F. Ball ADDRESS Rigby

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-18-19

RECEIVED

CERTIFICATE OF DEATH.

1. PLACE OF DEATH. **SEP 9 1922**
County of *Kootenai* Registration District No.
City of *Black Lake* Registration District No.
City of *Black Lake* (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Charles Ernest Allen

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. **39372**

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

male *white* *married*
(Write the word.)

6. DATE OF BIRTH.

Sept. 10 1859
(Month) (Day) (Year)

7. AGE

62 Yrs. *11* Mos. *29* ds.

IF LESS than 1 day
how many.....hrs. or
.....min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

Farmer

9. BIRTHPLACE

(State or Country)

Illinois (Calhoun County)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

Lancaster, Penn.

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Lancaster, Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. C. E. Allen

(Address)

Black Lake

15.

Filed

9-1

1922

notary
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 9 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Aug 8 1922, to *Aug 9 1922*,
that I last saw him alive on *Aug 8 1922*
and that death occurred on the date stated above, at *9:30 AM*.

The CAUSE OF DEATH* was as follows:

*peritonitis most likely from
a ruptured appendix*

(Duration) Yrs. mos. *3* ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed)

L. J. Stauffer M. D.
Aug 9 1922 (Address) *Rose Lake, Ida*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

8-1 1922

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Kootenai*
City of *Coeur d'Alene*Registration District No. *30*Primary Registration District No. *1051*(No. *702 Lakeside One* St.)File No. *39374*Registered No. *1208*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Nathaniel B. Stonestreet

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*
(Write the word.)

6. DATE OF BIRTH

March 25 1890
(Month) (Day) (Year)

7. AGE

33 Yrs. *4* Mos. *24* ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).*Lumberman*

9. BIRTHPLACE

(State or Country)

West Virginia

10. NAME OF FATHER

Thomas J. Stonestreet

11. BIRTHPLACE OF FATHER

(State or Country)

West Virginia

12. MAIDEN NAME OF MOTHER

Ester Germig

13. BIRTHPLACE OF MOTHER

(State or Country)

West Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *J. J. Stonestreet*
(Address) *Coeur d'Alene, Ida.*15. Filed *9/7* 19 *22* *DD Penner*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

August 16 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 20 1922 to *Aug. 16 1922*
that I last saw him alive on *Aug. 16 1922*and that death occurred on the date stated above, at *9 A. M.*

The CAUSE OF DEATH* was as follows:

Fracture of spine - Accidental

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

Aug 16 22 (Address) *Coeur d'Alene, Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State *23* yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Forest Cemetery**Aug 16 1922*

20. UNDERTAKER

ADDRESS

W B Nooney *Coeur d'Alene, Ida.*WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M.

CERTIFICATE OF DEATH

1. PLACE OF DEATH *Roosburg, Mont.* Registration District No. *30*
 County of *Roosburg* Primary Registration District No. *1051*
 City of *Coeur d'Alene* (No. *708*, *Indiana* St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jos. Archert

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. **39375**Registered No. *1107*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M.* 4. COLOR OR RACE *W.* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *married*
 (Write the word.)

6. DATE OF BIRTH *June 10 1834*
 (Month) (Day) (Year)

7. AGE *88* Yrs. *2* Mos. *2* ds. IF LESS than 1 day how many..... hrs. or..... min.?

8. OCCUPATION *Retired*
 (a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE *Ohio*
 (State or Country)

10. NAME OF FATHER *Jos. Archert*

11. BIRTHPLACE OF FATHER *Germany*
 (State or Country)

12. MAIDEN NAME OF MOTHER *Eve*

13. BIRTHPLACE OF MOTHER *Germany*
 (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *W. F. Archert*
 (Address) *806-4th St. Coeur d'Alene, Ida.*

15. Filed *9/7 1922* *D. D. Dennen*
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 12 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Aug 12 1922* to *19*
 that I last saw him alive on *Aug 12 1922*
 and that death occurred on the date stated above, at *11 P.M.*
 The CAUSE OF DEATH* was as follows:

Pulmonary Embolism

(Duration) Yrs. mos. ds.

Contributory
 (Secondary)

(Duration) yrs. mos. ds.

(Signed) *J. D. Dennen* M. D.

Aug 18 1922 (Address) *Coeur d'Alene, Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Forest Lawn* DATE OF BURIAL *8-20 1922*

20. UNDERTAKER *C. Carrey* ADDRESS *C. Dallen*

RECEIVED

FORM V. S. No. 5-25 M. 1-19.

SEP 13 1922 CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 39376

Registered No. 1109

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

1. PLACE OF DEATH

County of Kootenai
City of GarwoodBUREAU OF VITAL STATISTICS
Registration District No. 130
Statistical District No. 1051
(No. _____ St.)If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Nels Johnson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WID-

OWED OR DIVORCED

married
(Write the word.)

6. DATE OF BIRTH

6 (Month) 11 (Day) 1871 (Year)

7. AGE

27 Yrs. 1 Mos. 20 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of workFarmer(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country)

Sweden10. NAME OF
FATHER11. BIRTHPLACE
OF FATHER

(State or Country)

Sweden12. MAIDEN NAME
OF MOTHER13. BIRTHPLACE
OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Mrs. Frieda Johnson

15.

Filed

9/719 22

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

August 1 19 22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 1 19 22 to Aug 1 19 22

that I last saw h. _____ alive on _____ 19 _____

and that death occurred on the date stated above, at 8:00 M.

The CAUSE OF DEATH* was as follows:

poisoning by Trinitrophenol
(Picric Acid) found in
bottom of well few moments
(Duration) _____ yrs. _____ mos. _____ ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Frank H. Hays M. D.8/1 19 22 (Address) Pocatello, Idaho*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Pimrock Cem. Idaho 8-3 19 22

20. UNDERTAKER

Carsted

ADDRESS

Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH

County of Hot Springs
City of Garwood

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED
SEP 13 1922
BUREAU OF VITAL STATISTICS
Registration District No. B. O.
Registration District No. 1067
St.)State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 39377
Registered No. 1104

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WID-OWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH

Feb. 19 1896
(Month) (Day) (Year)

7. AGE

26 Yrs. 5 Mos. 12 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Farmer

9. BIRTHPLACE

(State or Country) Wash.

10. NAME OF FATHER

Henry J. Beneke

11. BIRTHPLACE OF FATHER

(State or Country) Minnesota

12. MAIDEN NAME OF MOTHER

Minerva Lehman

13. BIRTHPLACE OF MOTHER

(State or Country) Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H. J. Beneke(Address) 2113 E. 5th Ave.

15.

Filed 9/719 22D. D. Hennan
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

August 1 22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 1 1922, to Aug 1 1922
that I last saw him alive on 19
and that death occurred on the date stated above, at 8:00 M.

The CAUSE OF DEATH* was as follows:

Prisoning by Indians -
phrenal (Pichie Creek)
found in bottom of well
(Duration) yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Frank Wenz M. D.8/1 1922 (Address) Rockaway, Id.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. 2 mos. 2 days. In the State 2 yrs. 2 mos. 2 days

Where was disease contracted if not at place of death?

Former or usual residence Garwood, Wash.

19. PLACE OF BURIAL OR REMOVAL

Greenwood

DATE OF BURIAL

Aug 3 1922

20. UNDERTAKER

ADDRESS

Spokane, Wash.
Undertaking Co.

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Kootenai Registration District No. 30
City of Pocatello Primary Registration District No. 1051
(No. 1108 Sherman St.)

If death occurs away from usual residence, give facts called for under special information.

File No. 39378
Registered No. 1105

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Hannah Thompson

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widow
(Write the word.)

6. DATE OF BIRTH

April 24 1883
(Month) (Day) (Year)

7. AGE

87 Yrs. 3 Mos. 8 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Retired

9. BIRTHPLACE

(State or Country)

Michigan

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

Penn

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Mich

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. J. L. McClear

(Address)

Pocatello, Ida.

15.

Filed

9/7

19

22W. D. Drennan
Local Registrar

16. DATE OF DEATH

August 2nd 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 26 1922, to Aug. 1 1922
that I last saw h. lv alive on Aug. 1 1922
and that death occurred on the date stated above, at 10 A. M.
The CAUSE OF DEATH* was as follows:Apoplexy(Duration) _____ Yrs. _____ mos. 7 ds.Contributory
(Secondary)Arteriosclerosis

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

W. D. Drennan

M. D.

Aug 7, 1922

(Address)

Pocatello, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State Ida. yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Forest Cemetery

DATE OF BURIAL

8/2 1922

20. UNDERTAKER

R. B. Mooney Pocatello

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39379**Registered No. **1109**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of **Kootenai**
City of **Coeur d'Alene**Registration District No. **30**Primary Registration District No. **1067**No. **6th + Montana** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Theodore Maas

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widowed
(Write the word.)

6. DATE OF BIRTH

Nov. 24 1881
(Month) (Day) (Year)

7. AGE

40 Yrs. 8 Mos. 25 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

Labr

9. BIRTHPLACE

(State or Country)

Minn.

10. NAME OF FATHER

Christian Maas

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Hennrich Eggers

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

At Maas
Munich, Minn.

15.

Filed **Sept 8 1922** **D.D. Arena**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug. 19 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug. 19 1922 to **Aug. 19 1922**
that I last saw him alive on **Aug. 19 1922**
and that death occurred on the date stated above, at **10 A. M.**

The CAUSE OF DEATH* was as follows:

Fracture of skull and internal injuries from railroad accident

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

Aug 22 1922 (Address) **Coeur d'Alene, Ida.**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Forest Cem.

DATE OF BURIAL

8-24 1922

20. UNDERTAKER

Carsey

ADDRESS

C. Valene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. **39380**

Registered No. **1106**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of **Kootenai** Registration District No. **31**
City of **Coeur d'Alene** Primary Registration District No. **1051**
City of **St. Robert** (No. **937**, **W. Garden** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **F.** 4. COLOR OR RACE **W.** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **single**
(Write the word.)

6. DATE OF BIRTH **Aug. 8 1922**
(Month) (Day) (Year)

7. AGE **0** Yrs. **0** Mos. **0** ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE **Idaho**
(State or Country)

10. NAME OF FATHER **John G. Ott**

11. BIRTHPLACE OF FATHER **Russia**
(State or Country)

12. MAIDEN NAME OF MOTHER **Bessie Smith**

13. BIRTHPLACE OF MOTHER **Wash.**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **John G. Ott**
(Address)

15. Filed **9/9 1922** **D. D. Drennon**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug. 8 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **19** to **19**, that I last saw him alive on **19**, and that death occurred on the date stated above, at **M.** The CAUSE OF DEATH* was as follows:

(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) M. D.
(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **Forest-Cem. Co. Id.** DATE OF BURIAL **8-9 1922**

20. UNDERTAKER **Carsey** ADDRESS **Chalco**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

39381

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 122
County of Kootenai Primary Registration District No. 2306
City of Lone (St.)

File No. 3
Registered No. 6

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William James Goodson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

widowed
(Write the word.)

6. DATE OF BIRTH.

Dec 25 1844
(Month) (Day) (Year)

7. AGE

77 8 18
Yrs. Mos. ds.

If LESS than 1 day
how many hrs. or
min. 2)

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Retired

9. BIRTHPLACE

(State or Country)

Georgesville
Madison County, Ohio

10. NAME OF FATHER

Wilson Goodson

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Nancy Walker

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

W. A. Goodson

(Address)

Lone, Idaho

15.

Filed

10-1

1922

W. A. Goodson

Local Registrar

MEDICAL CERTIFICATE OF DEATH

1574

16. DATE OF DEATH

Sept. 13 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 8 1922, to Sept 13 1922,
that I last saw him alive on Sept 12 1922
and that death occurred on the date stated above, at 5:00 AM

The CAUSE OF DEATH* was as follows:

Senility

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) L. J. Stauffer M. D.

9-13 1922 (Address) Rose Lake, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Home

DATE OF BURIAL

9-14 1922

20. UNDERTAKER

Home

ADDRESS

CERTIFICATE OF DEATH

39382

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Kootenai*
City of *Harrison*Registration District No. *124*Primary Registration District No. *2204*File No. *3*Registered No. *7*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Michael C. Roholt

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

February 75 19*25*
(Month) (Day) (Year)

7. AGE

67 Yrs. *7* Mos. *✓* ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Millwright

(b) General nature of industry, business or establishment in which employed (or employer).

Saw Mill

9. BIRTHPLACE

(State or Country)

Norway

10. NAME OF FATHER

Christopher Roholt

11. BIRTHPLACE OF FATHER

(State or Country)

Norway

12. MAIDEN NAME OF MOTHER

Anne Aikland

13. BIRTHPLACE OF MOTHER

(State or Country)

Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs M C Roholt

(Address)

Harrison Ida

15.

Filed *10-1**22**W. H. M. M. M.*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

39

16. DATE OF DEATH

Sept 27 19*22*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19..... to *9-27* 19*22*that I last saw him alive on *9-26* 19*22*and that death occurred on the date stated above, at *12* M.

The CAUSE OF DEATH* was as follows:

Carcinoma of left lower jaw.(Duration) *2* Yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. H. M. M. M. M. D.(Address) *Harrison Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Harrison *9-28* 19*22*

20. UNDERTAKER

*C. Cassady**M. Kitchum*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

 State of Idaho
BOARD OF HEALTH
 Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 126 **39383**
 County of Kootenai Primary Registration District No. 2285 File No. 5
 City of Harrison (St.) Registered No. 8
 If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Deed before 6 Mr old
 If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
 (Write the word.)

6. DATE OF BIRTH.

9 30 1922
 (Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
 how many 4 hrs. or
 min. 2)

8. OCCUPATION

(a) Trade, profession or particular kind of work...
 (b) General nature of industry, business, or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15.

Filed

10-1-22 1922
Mr. J. W. McHenry
 Local Registrar

16. DATE OF DEATH

9 30 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191... to 9-30 192...
 that I last saw her alive on 9-30 192...
 and that death occurred on the date stated above, at ... M.

The CAUSE OF DEATH* was as follows:

arm presentation
injuries received at
delivery
 (Duration) Yrs. mos. ds.

Contributory (Secondary)

(Signed) Mr. J. W. McHenry M. D.
 930 22 (Address) Harrison

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Harrison 10-1-22
 20. UNDERTAKER Swine ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH **RECEIVED**
 County of *Hooten* Registration District No. *30*
 City of *Rathdrum* Registration District No. *1051*
 State of *Idaho*

File No. **39384**
 Registered No. *1140*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Catherine Esch

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *female* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED *Married*
 (Write the word.)

6. DATE OF BIRTH *Sept 2 1836*
 (Month) (Day) (Year)

7. AGE *86* Yrs. *10* Mos. *ds.*
 IF LESS than 1 day
 how many _____ hrs.
 or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

Retired

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

Michael Homderich

11. BIRTHPLACE OF FATHER

(State or Country)

Switzerland

12. MAIDEN NAME OF MOTHER

Elizabeth Stutzman

13. BIRTHPLACE OF MOTHER

(State or Country)

Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Elizabeth Esch

(Address)

15.

Filed

Ohio 19 22

Local Registrar

16. DATE OF DEATH

September 12 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 8 1920 to *Sept 12 1922*
 that I last saw her alive on *Sept 11 1922*
 and that death occurred on the date stated above, at *1:00 P.M.*

The CAUSE OF DEATH* was as follows:

*Carcinoma of breast**6 3* Yrs. mos. ds.
 (Duration)

Contributory (Secondary)

*old age**7 1 1922* Yrs. mos. ds.
 (Duration)

(Signed)

*Frank Wenz M. D.**9/14/1922* (Address) *Rathdrum Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Rathdrum Idaho**9/15 1922*

20. UNDERTAKER

Ed Carey

ADDRESS

Rathdrum

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39385**Registered No. **1111**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of *Hortland*City of *Conrad*

If death occurs away from usual residence, give facts called for under special information.

Registration District No. *30*Primary Registration District No. *1057*(No. *316*)*Wallace*

(St.)

BUREAU
STATE

2. FULL NAME

Ruth Minetta Hahn

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F.

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

single

(Write the word.)

6. DATE OF BIRTH

June

(Month)

11

(Day)

1896

(Year)

7. AGE

26 Yrs. *2* Mos. *25* ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Stenographer

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Wis.

10. NAME OF FATHER

Theo. Hahn

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

M. Eva Dodge

13. BIRTHPLACE OF MOTHER

(State or Country)

Wis.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

M. Eva Hahn

(Address)

316 Wallace St.

15.

Filed

Oct 6

19

*22**DD Orduna*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept.

(Month)

6

(Day)

22

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 3 19*27* to *Sept 6* 19*27*that I last saw him alive on *Sept 6* 19*27*and that death occurred on the date stated above, at *7:30 P.M.*

The CAUSE OF DEATH* was as follows:

Pulm. Tuberculosis(Duration) *3* Yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Sept 7 1927

(Address)

Conrad Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Forest-Cem.

DATE OF BURIAL

9-8-1927

20. UNDERTAKER

Carsey

ADDRESS

Conrad

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39386**Registered No. **1112**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of **Portland**
City of **Corvallis, Oregon**Registration District No. **30**Primary Registration District No. **1057**

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Thorstein Strand

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

widowed

(Write the word.)

6. DATE OF BIRTH

11 (Month) **13** (Day) **1844** (Year)

7. AGE

77 Yrs. **9** Mos. **24** ds.

IF LESS than 1 day

how many _____ hrs.

or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Retired

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Norway

10. NAME OF FATHER

Arne Strand

11. BIRTHPLACE OF FATHER

(State or Country)

Norway

12. MAIDEN NAME OF MOTHER

Carrie Strand

13. BIRTHPLACE OF MOTHER

(State or Country)

Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

H. Stolee
(Address) **Corvallis, Ida.**

15.

Filed **Oct 6** 19**22** **DD Drennan**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept. 7 19**22**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 28 19**22** to **Sept. 6** 19**22**that I last saw him alive on **6** 19**22**and that death occurred on the date stated above, at **3:09** M.

The CAUSE OF DEATH* was as follows:

Paralysis

(Duration) _____ Yrs. _____ mos. _____ ds.

Contagious
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) **DD Drennan** M. D.**9/7** 19**22** (Address) **Corvallis, Ida.**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Silverton Ore. **9/8** 19**22**

20. UNDERTAKER

C. L. Carney

ADDRESS

Corvallis

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Kootenai*
City of *Boeur d'Alene*Registration District No. *30*
Primary Registration District No. *1051*
(No. St.)File No. *39387*
Registered No. *1113*

If death occurs away from usual residence, give facts called for under special information.

BUREAU

2. FULL NAME

Armine Rayment

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*
(Write the word.)6. DATE OF BIRTH *Jan. 19 1922*
(Month) (Day) (Year)7. AGE *7* Yrs. *20* Mos. *20* ds.
IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)*None*

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Earl Rayment

11. BIRTHPLACE OF FATHER

(State or Country)

Wisconsin

12. MAIDEN NAME OF MOTHER

Pearl Pettis

13. BIRTHPLACE OF MOTHER

(State or Country)

Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Earl Rayment

(Address)

*Route 1 Boeur d'Alene*15. *Oct. 6. 1922* *DD Drama*
Filed Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 8 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *Sept 1 1922* to *Sept 8 1922*
that I last saw her alive on *Sept 8 1922*
and that death occurred on the date stated above, at *10:08 A.M.*
The CAUSE OF DEATH* was as follows:*Cholera Infantum*(Duration) *6* Yrs. *6* mos. *12* ds.Contributory
(Secondary)(Duration) *6* Yrs. *6* mos. *12* ds.(Signed) *J.H. Hooten* M. D.*9/9 1922* (Address) *Boeur d'Alene*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Forest Cem. Boeur d'Alene *Sept 10 1922*

20. UNDERTAKER ADDRESS

Mrs. C. Cassidy *Boeur d'Alene*

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Dr. Hooten.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Boone
City of Boone STATE (No. _____ St.)Registration District No. 30
Primary Registration District No. 1037File No. 39388Registered No. 1114

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Isabella Mallert

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE N. 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED single
(Write the word.)

6. DATE OF BIRTH

9 (Month) 9 (Day) 1922 (Year)

7. AGE

Yrs. 8 Mos. 8 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Alex Mallert

11. BIRTHPLACE OF FATHER

(State or Country) Iowa

12. MAIDEN NAME OF MOTHER

Margaret Heath

13. BIRTHPLACE OF MOTHER

(State or Country) Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Alex Mallert

(Address)

Boone Idaho

15. Filed

Oct 61922D. D. Drenna

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

9 (Month) 10 (Day) 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

9-9-1922 to 9-10-1922
that I last saw h. _____ alive on 9-10-1922

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Infection

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) D. D. Drenna M. D.9-17-1922 (Address) Boone

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Forest Cem

DATE OF BURIAL

9-18-1922

20. UNDERTAKER

C. Carney

ADDRESS

C. Carney

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39389**
Registered No. **1116**

1. PLACE OF DEATH
County of **Portland** Registration District No. **30**
City of **Portland** Primary Registration District No. **1037**
City of **Portland** State No. **816** **Garden** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Margaret M Main**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Married**
(Write the word.)

6. DATE OF BIRTH **Oct 27 18**
(Month) (Day) (Year)

7. AGE **75** Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION **Retired**
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE **Scotland**
(State or Country)

10. NAME OF FATHER **James M. Cairn**

11. BIRTHPLACE OF FATHER **Scotland**
(State or Country)

12. MAIDEN NAME OF MOTHER **Lusson Godfrey**

13. BIRTHPLACE OF MOTHER **Scotland**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) **Mr J Roy Gates**
(Address) **Porter & Adams? Dr.**

15. Filed **Oct 6 1922** **J. S. Brennan**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **Sept 9 1922**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Jan. 15 1922** to **Sept 9 1922**
that I last saw him alive on **Sept 8 1922**
and that death occurred on the date stated above, at **2:30 P.M.**

The CAUSE OF DEATH* was as follows:

Myocardial degeneration
(Duration) **Not known** mos. ds.
Contributory (Secondary) **Arterio-sclerosis**
(Duration) **10 years** yrs. mos. ds.
(Signed) **J. W. Gates** M. D.
Sept 11 1922 (Address) **Chambers Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State **29** yrs. mos. days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **Franklin** DATE OF BURIAL **9/11/22**

20. UNDERTAKER **P. B. Mooney** ADDRESS **Portland**

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bozeman
City of BozemanRegistration District No. 30Primary Registration District No. 1051(No. 15 and Montana St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Charles BedellState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 39390Registered No. 1116

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDMale White Widower

6. DATE OF BIRTH

Oct 9 84
(Month) (Day) (Year)

7. AGE

76 Yrs. 11 Mos. 3 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

Retired

9. BIRTHPLACE

(State or Country)

Mo

10. NAME OF FATHER

John Bedell

11. BIRTHPLACE OF FATHER

(State or Country)

New York

12. MAIDEN NAME OF MOTHER

Etherine Hoffman

13. BIRTHPLACE OF MOTHER

(State or Country)

U. S.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs Ida Bedell

(Address)

Bozeman & Bozeman, Ida

15.

Filed

Oct 6 1922A. D. Dreman

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 12 22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 11 1922, to Sept 11 1922that I last saw him alive on Sept 11 1922

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed)

Alexander Barclay M. D.9-14 1922(Address) Bozeman & Bozeman, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State 18 Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Forest Cemetery 9/14/22

20. UNDERTAKER

ADDRESS

R. B. Morgan Bozeman

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Kootenai
City of Paer d'AleneRegistration District No. 30Primary Registration District No. 1051(No. 818 Government Hwy.)State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 39391Registered No. 1117

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Sarah Adeline Thomas

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widow (with the word.)

6. DATE OF BIRTH

Sept 10 1899
(Month) (Day) (Year)

7. AGE

83 Yrs. 0 Mos. 4 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Retired

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Mo.

10. NAME OF FATHER

Thomas Allen

11. BIRTHPLACE OF FATHER

(State or Country) Tenn.

12. MAIDEN NAME OF MOTHER

Channon George

13. BIRTHPLACE OF MOTHER

(State or Country) Ken

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Claude Thomas(Address) Paer d'Alene, Ida.

15.

Filed Oct 6 1922 St. Thomas

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 14 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept. 13 1922, to Sept. 14 1922that I last saw him ex. alive on Sept. 10 1922and that death occurred on the date stated above, at M.

The CAUSE OF DEATH was as follows:

Cerebral hemorrhage.(Duration) Yrs. mos. 1 ds.Contributory
(Secondary)(Duration) Yrs. mos. ds.

(Signed)

John Wood, M.D.
Sept. 10 1922 (Address) Paer d'Alene, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State 22 yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Forest Cemetery

DATE OF BURIAL

9/15 1922

20. UNDERTAKER

R.B. Mooney Paer d'Alene

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39392**
Registered No. **1118**

1. PLACE OF DEATH

County **Boonville**
City of **Boonville**

Registration District No. **30**Primary Registration District No. **1051**(No. **708 Fourth** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Elizabeth J Hoffman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married

(Write the word.)

6. DATE OF BIRTH

July 19 1867
(Month) (Day) (Year)

7. AGE

55 Yrs. **1** Mos. **16** ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

House Wife

9. BIRTHPLACE

(State or Country)

Ind.

10. NAME OF FATHER

John Whiting

11. BIRTHPLACE OF FATHER

(State or Country)

Ind.

12. MAIDEN NAME OF MOTHER

Miss Craig

13. BIRTHPLACE OF MOTHER

(State or Country)

Ind.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **N P Hoffman**(Address) **Boonville 2nd**

15.

Filed **Oct 6** 19 **22** **S D Shuman**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 13 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19..... to 19.....

that I last saw him..... alive on 19.....

and that death occurred on the date stated above, at **9:30 A.M.**

The CAUSE OF DEATH* was as follows:

Cancer

..... (Duration) Yrs. mos. ds.

Contributory
(Secondary)

..... (Duration) yrs. mos. ds.

(Signed) **S D Shuman** M. D.

19..... (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State **2** yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Forest Cemetery **Sept 17 1922**

20. UNDERTAKER

R B Mooney **Boonville**

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Routenay*
City of *Carlin Bay*Registration District No. *30*
Primary Registration District No. *1057*
(No. _____ St.)State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *39393*Registered No. *7777*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Margaret M. Copsey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *F* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*
(Write the word.)

6. DATE OF BIRTH

Jan 13 1918
(Month) (Day) (Year)

7. AGE

3 Yrs. *8* Mos. *3* ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Henry Copsey

11. BIRTHPLACE OF FATHER

(State or Country)

W

12. MAIDEN NAME OF MOTHER

Bessie Cowin

13. BIRTHPLACE OF MOTHER

(State or Country)

Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Henry Copsey

(Address)

Carlin Bay

15.

Filed

*Oct 6 1922**J. J. Drennon*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

September 16 1922
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from *Sep. 2 1922* to *Sep. 16 1922*
that I last saw him alive on *Sep. 15 1922*
and that death occurred on the date stated above, at *3 A.* M.
The CAUSE OF DEATH* was as follows:*Encephalitis lethargica.*(Duration) Yrs. mos. *14?* ds.
Contributory (Secondary) *Conjunctivitis & pneumonia.*(Duration) Yrs. mos. *?* ds.(Signed) *J. J. Drennon* M. D.*Sep. 16 1922* (Address) *Carlin Bay, Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Forest Cem. Ida.

DATE OF BURIAL

9-17 1922

20. UNDERTAKER

Carney

ADDRESS

Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 30

County of Kootenai

Primary Registration District No. 1051

City of Pocatello

(No. Noodlawn Crossing St.)

File No.

39394

Registered No.

1150

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Horace H Bailey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

male white married (Write the word.)

6. DATE OF BIRTH

mch 31 1884
(Month) (Day) (Year)

7. AGE

38 Yrs. 4 Mos. 18 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Carpenter

9. BIRTHPLACE

(State or Country)

Minn

10. NAME OF FATHER

Herbert Bailey

11. BIRTHPLACE OF FATHER

(State or Country)

U.S.

12. MAIDEN NAME OF MOTHER

Nelly Tyler

13. BIRTHPLACE OF MOTHER

(State or Country)

U.S.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs H H Bailey

(Address)

Pocatello Idaho

15.

Filed

Oct 6 1922

1922

D P Phema

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

aug 19 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19

that I last saw him alive on 19

and that death occurred on the date stated above, at 8:45 M.

The CAUSE OF DEATH* was as follows:

accidentally killed by Electric Train, Noodlawn Crossing
(Skull Fracture)

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

R B Mowrey, M.D.

19

(Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State 15 yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

Pocatello Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Forest Cemetery

8/22 1922

20. UNDERTAKER

ADDRESS

R B Mowrey Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

DISINTERMENT PERMIT

OCT 30 1956

STATE OF IDAHO
DEPARTMENT OF PUBLIC HEALTH
BOISE, IDAHO

APPLICATION HAVING BEEN MADE for the disinterment of the body of Horace H. Bailey
now lying buried in Forest Cemetery, in the city or Town of Coeur d'Alene
County of Kootenai State of Idaho, who died on the 19th day of August, 1922, Aged 38 years 4 months
18 days, the cause of death being Train Accident and
not directly or indirectly by diphtheria; (membranous croup); scarlet fever; smallpox; leprosy; asiatic cholera; typhus fever;
or yellow fever as shown by the certificate of death of said deceased, given by
R. B. Mooney, Coroner attending physician

THIS IS TO CERTIFY that permission is hereby given for such disinterment and removal by Private
to Restlawn Memorial Park Cemetery in the City or Town of Coeur d'Alene county of Kootenai
State of Idaho to take effect upon the approval by the local board of health of the City, Town, or County of

Coeur d'Alene it being understood and provided that nothing herein shall be deemed as contravening or in
anywise modifying or releasing the Regulations of the Department of public health governing the Transportation of
Corpses or the requirements for a Transportation permit, and all Transportation Companies and Common Carriers will be
governed accordingly; and provided further, that where the disinterment is for the purpose of reinterment in another
part of the same cemetery, or in a contiguous cemetery, the removal shall not be made by any public conveyance. The
disinterment and removal must be done under the personal supervision of a licensed Embalmer in good standing. If the
remains are to be removed from the cemetery they (including the disinterred casket), must be enclosed in a new metallic
lined outer case before removal.

Given under my hand and Seal of the Department of public health at Boise, Idaho,
permit issued to: this 10th day of November, A.D. 1955.

W. W. Benson

by [Signature] Director, Division of vital Statistics

The foregoing application for disinterment and removal is hereby approved by the local Board of health of the City,
Town or County of Kootenai State of Idaho, this 22 day of June, 1956.

C. F. Bain Acting Director
PUBLIC HEALTH OFFICER
COEUR D'ALENE, IDAHO

Disinterment permit sent to:

Restlawn Memorial Park, Inc.
123 Sherman Ave.
Coeur d'Alene, Idaho

11-7-55

Date

11-10-55

Department of Public Health
Boise, Idaho

I hereby give authorization for the disinterment of: _____

NAME OF DECEASED Horace H. Bailey

DATE OF DEATH Aug 19, 1922

CAUSE OF DEATH Train Accident

ATTENDING PHYSICIAN _____

BURIED IN Forest Cemetery

CEMETERY

TO BE REMOVED TO Rest Lawn Memorial Park

CEMETERY

RELATIONSHIP TO PERSON REQUESTING PERMIT Husband

NAME OF LICENSED EMBALMER Mooney

REASON FOR DISINTERMENT Family Burial Estate

Very truly yours,

Maud A. Bailey

Signature of relative or person
requesting permit.

1216 - 4th

C. D. A. Ida.

Address

- * * * * *

State of Idaho)
County of _____) ss

On this 24th day of Nov, 1955, before me Robt. Wilson
a Notary Public in and for the within county and state personally appeared Maud A. Bailey
known to me (or proved by the oath of _____)
to be the person whose name is subscribed to the foregoing instrument, and acknow-
ledged to me that he executed the same.

In Witness whereof I have hereunto set my hand and affixed my official seal
this the day and year first above written.

(Seal)

Robt. Wilson
Notary Public, residing at _____, Idaho
My commission expires 1-25-57

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39395**
Registered No. **1721**

1. PLACE OF DEATH
County of **Power & Idaho**
City of **Power**
Registration District No. **30**
Primary Registration District No. **1051**
(No. **518** **Fourth** St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Ellen Hark**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female**
4. COLOR OR RACE **White**
5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Married**
(Write the word.)
6. DATE OF BIRTH **Nov 29 1847**
(Month) (Day) (Year)
7. AGE **79** Yrs. **10** Mos. **0** ds.
IF LESS than 1 day how many min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. **Retired**
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE
(State or Country) **Ireland**

10. NAME OF FATHER **John Finn**

11. BIRTHPLACE OF FATHER
(State or Country) **Ireland**

12. MAIDEN NAME OF MOTHER **Budget Reagan**

13. BIRTHPLACE OF MOTHER
(State or Country) **Ireland**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) **Frank Hark**
(Address) **Power & Idaho**

15. Filed **Oct 6 1922** **D. D. Spenn**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **Sept 29 1922**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Oct 27 1921** to **Sept 29 1922**
that I last saw her alive on **Sept. 29 1922**
and that death occurred on the date stated above, at **8 P. M.**
The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) Yrs. mos. ds.
(Signed) **J. D. Spenn** M. D.
Oct 2 1922 (Address) **Power & Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death Yrs. mos. days. In the State 37 yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **Forest Cemetery**
DATE OF BURIAL **10/1 1922**
20. UNDERTAKER **J. D. Spenn**
ADDRESS **Power & Idaho**

CERTIFICATE OF DEATH

1. PLACE OF DEATH *RECORD* Registration District No. *64*
 County of *Latah* Primary Registration District No. *2144*
 City of *Troy* (No. *100*) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Praval Charlie Cummings

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. *39399*
 Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *married*
 6. DATE OF BIRTH *July 8 1900*
 (Month) (Day) (Year)
 7. AGE *22* Yrs. *2* Mos. *15* ds. IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

Laborer

9. BIRTHPLACE

(State or Country)

Butte, Idaho

10. NAME OF FATHER

Charles F. Cummings

11. BIRTHPLACE OF FATHER

(State or Country)

Michigan

12. MAIDEN NAME OF MOTHER

Mattie B. Reed

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Hilla C. Carlson*
 (Address) *Nooska, Idaho*

15. Filed *Sept 30 1922* *Lucy M. Pick*
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *Sept 23 1922*
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 19____ to _____ 19____
 that I last saw him _____ alive on _____ 19____
 and that death occurred on the date stated above, at *3 P. M.*

The CAUSE OF DEATH* was as follows:

Accidental Discharge of Shot Gun

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) *H. E. Wilson* M. D.

925 1922 (Address) *Troy, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Moscow, Idaho

DATE OF BURIAL

Sept 23 1922

20. UNDERTAKER

John J. Pickard

ADDRESS

Troy, Idaho

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH La Caba Registration District No. 64
 County of Troy Primary Registration District No. 2144
 City of Troy (No. _____) (St.) _____

If death occurs away from usual residence, give called for under special information.

2. FULL NAME

Glen Jewel Draper

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 39400
 Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
 (White or Colored.)

6. DATE OF BIRTH April 2 1922
 (Month) (Day) (Year)

7. AGE 6 yrs. 20 mos. 20 ds. IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

Nothing

9. BIRTHPLACE

(State or Country)

Troy Ida

10. NAME OF FATHER

Ira Clinton Draper

11. BIRTHPLACE OF FATHER

(State or Country)

Missouri

12. MAIDEN NAME OF MOTHER

Clarina Gene Parr

13. BIRTHPLACE OF MOTHER

(State or Country)

Troy Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ira Draper

(Address)

Troy Ida

15.

Filed Sept 30 1922 Lucy M. Pickard
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 22 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 23 1922 to Sept 22 1922
 that I last saw him alive on Sept 22 1922

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Ileo-colitis

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
 (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

9/23 1922 (Address) Troy Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Moscow Ida Sept 23 1922

20. UNDERTAKER

ADDRESS

John J. Pickard

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Lemhi
 City of Carmen

If death occurs away from
 usual residence, give facts
 called for under special in-
 formation.

REC

Registration District No. 41Primary Registration District No. 2116(No. 41)

(St.)

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 39401

Registered No. _____

If death occurred in a hos-
 pital, institution or camp,
 give its NAME instead of
 street and number.

2. FULL NAME

Edgar Meade Neal

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDSingle

(Write the word.)

6. DATE OF BIRTH

November 25th 1922
 (Month) (Day) (Year)

7. AGE

26 Yrs. 9 Mos. 22 ds.

IF LESS than 1 day
 how many..... hrs.
 or..... min.?

8. OCCUPATION

(a) Trade, profession or
 particular kind of work

Farmer

(b) General nature of in-
 dustry, business or estab-
 lishment in which employ-
 ed (or employer)

9. BIRTHPLACE

(State or Country)

Iowa10. NAME OF
FATHERMeade M. Neal11. BIRTHPLACE
OF FATHER

(State or Country)

Ohio.12. MAIDEN NAME
OF MOTHERJessie Long13. BIRTHPLACE
OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Meade M. Neal

(Address)

Carmen Idaho.

15.

Filed

9/10 -1922

C. B. Bellamy
shy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

September 7th 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 5th 1922 to Sept. 7th 1922
 that I last saw him alive on Sept. 7th 1922
 and that death occurred on the date stated above, at 2:00 P.M.

The CAUSE OF DEATH* was as follows:

Typhoid fever(Duration) Yrs. 2 mos. ds.Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

(Address)

C. B. Stratton M. D.
9/8/22 Sahman, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state
 (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted
 if not at place of death?

Former or
 usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sahman Cemetery9-9th 1922

20. UNDERTAKER

ADDRESS

W. C. DoeblerSahman, Ida.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Lemhi
City of Salmon, Ida.Registration District No. 4/1Primary Registration District No. 2116(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Bowen HornState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 39402Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

November 26 1867
(Month) (Day) (Year)

7. AGE

53 Yrs. 8 Mos. 17 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Mail contractor

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Illinois

10. NAME OF FATHER

Robert A Horn

11. BIRTHPLACE OF FATHER

(State or Country)

United States

12. MAIDEN NAME OF MOTHER

Lucinda McManus

13. BIRTHPLACE OF MOTHER

(State or Country)

United States

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs Edith Horn

(Address)

Salmon, Idaho

15.

Filed

9/10 - 1922Chas Bellamy
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

August 13 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar. 9th 1922 to Aug 12, 1922that I last saw him alive on Aug 12 1922and that death occurred on the date stated above, at 12:30 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration)

6 Yrs. 6 mos.Contributory
(Secondary)Chronic nephritis

(Duration)

10 Yrs. 6 mos. 10 ds.

(Signed)

W. H. Stratton M. D.
9/16/22 (Address) Salmon, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Salmon Cemetery

DATE OF BURIAL

8-16 1922

20. UNDERTAKER

W C Dooley

ADDRESS

Salmon, Ida

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39403**
Registered No. **54**

1. PLACE OF DEATH

Registration District No. **100**County of **Madison**Primary Registration District No. **2178**City of **Rexburg**

St.)

If death occurs away from
usual residence, give facts
called for under special in-
formation.

RECEIVED
OCT 5 1922
BUREAU OF VITAL STATISTICS
Chard, Ellwood Poole

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

5. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Child

(Write the word.)

6. DATE OF BIRTH

October

(Month)

20th

(Day)

1922

(Year)

7. AGE

1 Yrs.

10 Mos.

11 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.

Child

(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF
FATHER

Harry L. Poole

11. BIRTHPLACE
OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME
OF MOTHER

Anna Hansen

13. BIRTHPLACE
OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Harry L. Poole

(Address)

Rexburg

15.

Filed

9/2

19

22

J. H. Young

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept

(Month)

1st

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19

to

19

that I last saw him alive on 19

and that death occurred on the date stated above, at 1 M.

The CAUSE OF DEATH* was as follows:

Drowning

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

J. H. Young

M. D.

9-2-1922

(Address)

Rexburg, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place

of death

yrs.

mos.

days

In the

State

yrs.

mos.

days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Memor, Ida.

DATE OF BURIAL

9/2

1922

20. UNDERTAKER

ADDRESS

David Young Rexburg

CERTIFICATE OF DEATH

1. PLACE OF DEATH **RECEIVED**

County of Madison **OCT 5 1922** Registration District No.
 City of Burton **BUREAU OF VITAL STATISTICS** Primary Registration District No.
 (No.) (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Margaret Mary Neeley

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. **39404**
 Registered No. **55**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
 (Write the word.)

6. DATE OF BIRTH June 3 1922
 (Month) (Day) (Year)

7. AGE 10 Yrs. 2 Mos. 28 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION Student
 (a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE Idaho
 (State or Country)

10. NAME OF FATHER Ruben S. Neeley

11. BIRTHPLACE OF FATHER Idaho
 (State or Country)

12. MAIDEN NAME OF MOTHER Myrle A. Heileson

13. BIRTHPLACE OF MOTHER Utah
 (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ruben S. Neeley
 (Address) Rehburg, Idaho

15. Filed 9/2 1922 W. J. Young
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 1st 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 18 1922 to Aug 29 1922
 that I last saw her alive on Aug 29 1922
 and that death occurred on the date stated above, at 12¹⁵ A. M.
 The CAUSE OF DEATH* was as follows:
Myocarditis

(Duration) 2 Yrs. — mos. — ds.
 Contributory (Secondary) Myocarditis

(Duration) — yrs. — mos. — ds.
 (Signed) Loring F. Neeley M. D.
7/2 1922 (Address) Rehburg Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Burton, Ida. DATE OF BURIAL 9/2 1922

20. UNDERTAKER David Young ADDRESS Rehburg

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39405**Registered No. **56**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH **REC'D**
 County of **Madison** **REC'D**
 City of **Sugar** **BUREAU**
 Registration District No. **100**
 Primary Registration District No. **278**
 (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Genara Cardenas

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female Mexican Infant
 (Write the word.)

6. DATE OF BIRTH.

9 **19** **1922**
 (Month) (Day) (Year)

7. AGE

Yrs. Mos. **6** ds.

IF LESS than 1 day
 how many hrs. or
 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work....
 (b) General nature of industry, business, or establishment in which employed (or employer).....

Infant

9. BIRTHPLACE

(State or Country)

Sugar City - Idaho

10. NAME OF FATHER

Bonifacio Cardenas

11. BIRTHPLACE OF FATHER

(State or Country)

Mexico

12. MAIDEN NAME OF MOTHER

Maria Garcia

13. BIRTHPLACE OF MOTHER

(State or Country)

Mexico

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) **George Cardenas**
 (Address) **Sugar City**

15.

Filed

9/26**19122****J. R. King**

Local Registrar

16. DATE OF DEATH

9 **25** **1922**
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **9 - 25** **1922**, to **9 - 25** **1922**, that I last saw her alive on **9 - 25** **1922** and that death occurred on the date stated above, at **9 P.M.**

The CAUSE OF DEATH* was as follows:

Acute peritonitis(Duration) Yrs. mos. **2** ds.

Contributory (Secondary)

Infection of cord

(Duration) Yrs. mos. ds.

(Signed)

M. K. Thierland M. D.**9-26-1922** (Address) **Pexburg Idaho**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

Sugar
J. R. King**9/26** **1922**
Pexburg

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH SEP 1 1922 Registration District No. 96
County of Bozeman Registration District No. 1009
City of Lewiston (No. 1009) St.)

File No. 39406
Registered No. 150

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Leah Blanche Mary Haynes

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Child
(Write the word.)

6. DATE OF BIRTH Feb. 21st 1921
(Month) (Day) (Year)

7. AGE 1 yrs. 6 mos. 0 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

Child

9. BIRTHPLACE

(State or Country)

Lewiston, Ida.

10. NAME OF FATHER

Edman D. Haynes

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Leah G. Bunch

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Edman D. Haynes

(Address)

Lewiston, Ida.

15.

Filed

9/8/1922

F.T. Harris, M.D.

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug. 21st 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1922 to 8-21-1922

that I last saw her alive on 8-21-1922, and that death occurred on the date stated above, at 1050 A.M.

The CAUSE OF DEATH* was as follows:

Dyspnea Intoxication

(Duration) 1 yrs. 0 mos. 0 ds.

Contributory (Secondary)

(Duration) 1 yrs. 0 mos. 0 ds.

(Signed)

W. F. McMahon M. D.
8-21-1922 (Address) Lewiston, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death 1 yrs. 0 mos. 0 ds. State 1 yrs. 0 mos. 0 ds.

Where was Disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lewiston, Idaho

8/23 1922

20. UNDERTAKER

ADDRESS

Vassar and Co

Lewiston, Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39407**Registered No. **149**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of My Perce Registration District No. 96
City of Lehi Primary Registration District No. 1009 St. (No.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

George Henry Cook

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

married
(Write the word.)

6. DATE OF BIRTH

Nov. 21 1858
(Month) (Day) (Year)

7. AGE

63 Yrs. 8 Mos. 26 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Farmer

9. BIRTHPLACE

(State or Country)

Siskiyou Co. California

10. NAME OF FATHER

D. M. Cook

11. BIRTHPLACE OF FATHER

(State or Country)

Stewart Co. Tennessee

12. MAIDEN NAME OF MOTHER

Elizabeth Wisner

13. BIRTHPLACE OF MOTHER

(State or Country)

Oakland Co. Michigan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Mrs. J. H. Cook
Asotin Wash.

15.

Filed

9/8/1922F. T. Harris, M. D.

Local Registrar

MEDICAL CERTIFICATE OF DEATH

81

16. DATE OF DEATH

8 18 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19..... to 19.....
that I last saw him alive on 8/17 1922
and that death occurred on the date stated above, at,..... M.

The CAUSE OF DEATH* was as follows:

Atherosclerosis with cerebral embolism and gangrene of lower extremities.
(Duration) Yrs. mos. ds.Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) McEwan M. D.8/18 19..... (Address) Asotin Wash.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Asotin Wash. 19.....

20. UNDERTAKER

ADDRESS

H. R. McEwan Asotin Wash.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of *Peru*City of *Lewiston*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED CERTIFICATE OF DEATH

SEP 14 1922

Registration District No. 96

BUREAU OF VITAL STATISTICS
Registration District No. 1009

BUREAU OF VITAL STATISTICS

St.)

File No.

39408

Registered No. 144

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female*4. COLOR OR RACE *white*

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

(Year)

7. AGE

24 Yrs.

7 Mos.

11 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

9/8/ 1922

F. T. Harris, M. D.

Local Registrar

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 31 1922 to Aug 9 1922
that I last saw him alive on Aug 9 1922

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(Duration)

Yrs.

2 mos.

ds.

Contributory
(Secondary)

(Duration)

Yrs.

2 mos.

ds.

(Signed)

O. E. Cannon

M. D.

19

(Address)

Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lewiston Ida

9/10 1922

20. UNDERTAKER

ADDRESS

Bassett & Co

Lewiston Ida

1. PLACE OF DEATH

County of They areCity of Lewiston

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

J. Rose Paris

CERTIFICATE OF DEATH

RECEIVED
SEP 13 1922
BUREAU OF VITAL STATISTICSRegistration District No. 96City Registration District No. 1009

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

39409Registered No. 139

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

married
(Write the word.)

6. DATE OF BIRTH

March 20

(Month)

(Day)

1873
(Year)

7. AGE

49 Yrs. 4 Mos. 14 ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

9/8/1922F. T. Harris, M.D.

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 3 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 9 1922, to Aug 3 1922that I last saw h.e.s. alive on Aug 3 1922and that death occurred on the date stated above, at 9:30 A.M.

The CAUSE OF DEATH* was as follows:

Perforation of Intestine (Typhoid)(Duration) Yrs. mos. 2 ds.

Contributory (Secondary)

Typhoid fever(Duration) yrs. 1 mos. ds.

(Signed)

E. S. Braddock

M. D.

Aug 3, 1922

(Address)

Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lewiston Idaho8/5 1922

20. UNDERTAKER

ADDRESS

Vassallo & Co.Lewiston Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH **RECEIVED**
Registration District No. 96
County of **Boyer** SEP 13 1922
City of **Lewiston** Registration District No. 1009
St. ()

File No. **39410**
Registered No. **140**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Anna Martin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Married**
(Write the word.)

6. DATE OF BIRTH

July 28 1856
(Month) (Day) (Year)

7. AGE

66 Yrs. Mos. ds. IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

At Home

9. BIRTHPLACE

(State or Country)

Kansas

10. NAME OF FATHER

Jedediah Olmstead

11. BIRTHPLACE OF FATHER

(State or Country)

Indiana

12. MAIDEN NAME OF MOTHER

Mariah Connor

13. BIRTHPLACE OF MOTHER

(State or Country)

Pa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. B. Martin

(Address)

15. Filed **9/8/1922** **F. T. Harris, M. D.**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 4 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended, deceased from **November 1 1921**, to **August 4 1922**, that I last saw her alive on **Aug 4 1922**, and that death occurred on the date stated above, at **10:45 P. M.**

The CAUSE OF DEATH* was as follows:

Fernicious Anemia

(Duration) **2** Yrs. mos. ds.
Contributory (Secondary) **Pulmonary Edema**

(Duration) **4** yrs. mos. ds.
(Signed) **W. P. Clark** M. D.

Aug 5 1922 (Address) **Lewiston Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lewiston Idaho **8/6 1922**

20. UNDERTAKER

ADDRESS

Wassall and Co **Lewiston Idaho**

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Key Perce* Registration District No. *96*
 City of *Liberton* Primary Registration District No. *1009* St.)
 If death occurs away from usual residence, give facts called for under special information.

RECEIVED
 SEP 13 1922
 BUREAU OF VITAL STATISTICS

Corson
 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. **39411**
 Registered No. *141*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Gerhard Gehring

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *widower*
 (Write the word.)

6. DATE OF BIRTH

July 24 1883
 (Month) (Day) (Year)

7. AGE

69 Yrs. *11* Mos. *11* ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

Farmer

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

Theodore Gehring

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Margaret Rehning

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

O. N. Gehring

(Address)

Kuterville, Ida.

15.

Filed

*9/8/ 19 22**F. T. Harris, M.D.*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 5 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Aug 3rd 1922* to *Aug 5th 1922*
 that I last saw him alive on *Aug 5th 1922*
 and that death occurred on the date stated above, at *5 P.M.*
 The CAUSE OF DEATH* was as follows:

General Peritonitis(Duration) Yrs. *3* mos. *3* ds.

Contributory (Secondary)

Ruptured Appendix(Duration) yrs. *3* mos. *3* ds.

(Signed)

O. C. Carson

M. D.

19

(Address)

Leavitt, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cottonwood, Ida.

19

20. UNDERTAKER

ADDRESS

Vassar and Co. Leavitt, Ida.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics1. PLACE OF DEATH **RECEIVED**
Registration District No. 96
County of Mayhew SEP 13 1922
Primary Registration District No. 1009
City of Butte (No. 1009) St.)File No. **39412**
Registered No. **142**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Allie Deford

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Divorced
(Write the word.)6. DATE OF BIRTH Aug 14 1896
(Month) (Day) (Year)7. AGE 35 Yrs. 11 Mos. 23 ds. IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Farming

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

Albert Collins

11. BIRTHPLACE OF FATHER

(State or Country)

Kansas

12. MAIDEN NAME OF MOTHER

Millie Meyers

13. BIRTHPLACE OF MOTHER

(State or Country)

Nebr.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

F. T. Harris
Butte, Idaho15. Filed 9/8/1922 F. T. Harris, M.D.
Local Registrar

16. DATE OF DEATH

(Month)

(Day)

1922
(Year)17. I HEREBY CERTIFY, That I attended deceased from 8-25 1922 to 8-31 1922
that I last saw h. alive on 8-31 1922
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Septic Parotitis

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

John H. Alley M. D.

19

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Longview, Idaho

19

20. UNDERTAKER

ADDRESS

Butte, Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39413**
Registered No. **143**

1. PLACE OF DEATH **RECEIVED**
County of **Nez Perce** Registration District No. **96**
City of **Lewiston** Primary Registration District No. **1009**
(No. **3**) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Fred Buchsan**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED **Single**
(Write the word.)
6. DATE OF BIRTH **Don't Know**
(Month) (Day) (Year)
7. AGE **About 80 year** IF LESS than 1 day
Yrs. Mos. ds. how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

6

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **H. R. Merchant**
(Address) **Clarkston, Wash.**

15. Filed **9/8/1922** **F. T. Harris, M. D.**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

8 **8** **22**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **8/7** 19**22**, to **8/8** 19**22**
that I last saw him alive on **8/8** 19**22**
and that death occurred on the date stated above, at **5:30 P.**

The CAUSE OF DEATH* was as follows:

Fracture of Skull

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

8/8/1922 (Address) **Clarkston, Wash.**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **Clarkston, Wash.** DATE OF BURIAL **8/10/22**
20. UNDERTAKER **H. R. Merchant** ADDRESS **Clarkston, Wn**

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

SEP 13 1922

Registration District No. 96

County of

Primary Registration District No. 1009

City of

(No.)

St.)

File No.

39414

Registered No. 146

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Agnes Ayers

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female

White

(Write the word.)

6. DATE OF BIRTH

Dec (Month)

11 (Day)

1896 (Year)

7. AGE

25

Yrs.

6

Mos.

29

ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

At home

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Dallas Ore

10. NAME OF FATHER

Willis W Moody

11. BIRTHPLACE OF FATHER

(State or Country)

Maine

12. MAIDEN NAME OF MOTHER

Martha Douglas

13. BIRTHPLACE OF MOTHER

(State or Country)

Boise Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs J A Hallett

(Address)

Clarkston Wash-

Bridges between 13th & 14th

15.

Filed

9/8/19 22

F.T.Harris, M.D.

Local Registrar

16. DATE OF DEATH

(Month)

(Day)

19 22 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 15 19 22 to Aug 10 19 22

that I last saw him alive on Aug 10 19 22

and that death occurred on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

E clamping

(Duration)

Yrs.

mos.

1 ds.

Contributory (Secondary)

acute nephritis of pregnancy

(Duration)

Yrs.

mos.

2.6 ds.

(Signed)

O C Johnson

M. D.

19

(Address)

Leviston 249

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

yrs.

mos.

In the

days.

State

yrs.

mos.

days

Where was disease contracted if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Leviston Idaho

8-12-22 19 22

20. UNDERTAKER

ADDRESS

Jasson & Co

Leviston Idaho

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH

SEP 13 1922

Registration District No. 96

County of

BUREAU OF VITAL STATISTICS

Registration District No. 1009

City of

(No.

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

James Arthur Brown

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

39417

Registered No.

151

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Male

White

Married

6. DATE OF BIRTH

Nov 27

(Day)

1869

(Year)

7. AGE

52 Yrs. 8 Mos. 26 ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

Heavyman

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

James Scott Brown

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Julia Robertson

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. J. Arthur Brown

(Address) 521-15th St.

15.

Filed

9/8/ 19 22

F.T. Harris, M.D.

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 29, 1922 to Aug 22, 1922

that I last saw him alive on Aug 22, 1922

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

The minor cause was as follows:

(Duration) 7 Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. Harris, M. D.

(Address) 521-15th St.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Lowiston, Idaho

DATE OF BURIAL

8/25 19 22

20. UNDERTAKER

WASSAR UNDERTAKING CO.

ADDRESS

Lowiston, Idaho

RECEIVED

CERTIFICATE OF DEATH

White
State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39418**
Registered No. **153**

1. PLACE OF DEATH **Idaho** Registration District No. **96**
County of **Boise** Primary Registration District No. **1009**
City of **Leicester** State (No. _____) St. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mabel P. Watson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Married**
(Write the word.)

6. DATE OF BIRTH **May 21st 1881**
(Month) (Day) (Year)

7. AGE **41** Yrs. **3** Mos. **4** ds. IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. **Housewife**
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE
(State or Country) **Mo**

10. NAME OF FATHER **W. J. Gibson**

11. BIRTHPLACE OF FATHER
(State or Country) **Not Known**

12. MAIDEN NAME OF MOTHER **Lizzie Phillips**

13. BIRTHPLACE OF MOTHER
(State or Country) **Not Known**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **M. Watson**
(Address) **Leicester, Idaho.**

15. Filed **9/8/1922** **F. T. Harris, M.D.**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 20th 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Aug 15th 1922** to **Aug 25th 1922**
that I last saw him alive on **Aug 25th 1922**
and that death occurred on the date stated above, at **2¹⁰ P.M.**

The CAUSE OF DEATH*, was as follows:

Acute Dilatation of Heart

(Duration) _____ Yrs. _____ mos. _____ ds.
Contributory (Secondary) **Toxic Gastric.**

(Duration) _____ Yrs. **3** mos. _____ ds.
(Signed) **E. L. White** M. D.

8-25-1922 (Address) **Leicester, Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL **Leicester, Idaho** DATE OF BURIAL **8/26 1922**

20. UNDERTAKER **Vassar and Co** ADDRESS **Leicester, Idaho**

CERTIFICATE OF DEATH

Carroll
State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39419**
Registered No. **154**

1. PLACE OF DEATH **RECEIVED**
Registration District No. **96**
County of **Payson** Primary Registration District No. **1009**
City of **Leaverton** (No. **VITAL**) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Joseph W. Van Cleor

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Divorced**
(Write the word.)

6. DATE OF BIRTH **March** 1880
(Month) (Day) (Year)

7. AGE **72** Yrs. Mos. ds. IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. **Merchant**
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE
(State or Country) **N. J.**

10. NAME OF FATHER **Van Cleor**

11. BIRTHPLACE OF FATHER
(State or Country) **unknown**

12. MAIDEN NAME OF MOTHER **unknown**

13. BIRTHPLACE OF MOTHER
(State or Country) **unknown**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) **J. W. Van Cleor**
(Address) **Leaverton, Idaho**

15. Filed **9/8/22** **F. T. Harris, M.D.**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 25th 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Aug 14th** 1922 to **Aug 25th** 1922
that I last saw him alive on **Aug 25th** 1922
and that death occurred on the date stated above, at **7 P.M.**
The CAUSE OF DEATH* was as follows:

Gangrene
(Duration) Yrs. **mos. 15** ds.
Contributory **Arteriosclerosis**
(Secondary)
(Duration) **7** yrs. **mos.** ds.
(Signed) **W. C. Pearson** M. D.
Leaverton Idaho
(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **Leaverton Idaho** DATE OF BURIAL **8/27/22**

20. UNDERTAKER **Vassar and Co.** ADDRESS **Leaverton Idaho**

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39420**
Registered No. **2**

1. PLACE OF DEATH **001** Registration District No. **97**
County of **Blaine** Registration District No. **2174**
City of **Shalding** (No. _____ St.)
If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME **Lafayette Platt**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **M** 4. COLOR OR RACE **W** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Married**
(Write the word.)

6. DATE OF BIRTH **Oct 9th 1839**
(Month) (Day) (Year)

7. AGE **82 yrs. 11 mos. 4 ds.**
IF LESS than 1 day how many hrs. or mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work **Farmer**
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE **Indiana**
(State or Country)

10. NAME OF FATHER **Jacob Platt**

11. BIRTHPLACE OF FATHER **Ohio**
(State or Country)

12. MAIDEN NAME OF MOTHER **Jane Thompson**

13. BIRTHPLACE OF MOTHER **Indiana**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Victor Shensler**
(Address) **Shalding Idaho**

15. Filed **Sept 15 1912** **Welfam** Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **September 13 1912**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **July 10 1912** to **Sept 13 1912**
that I last saw him alive on **Sept 13 1912**
and that death occurred on the date stated above, at **2 P. M.**
The CAUSE OF DEATH* was as follows:

Ch. Int. Nephritis
(Duration) **5 yrs. 0 mos. 0 ds.**

Contributory **Legion Hip**
(Secondary)

(Signed) **Welfam** M. D.
(Address) **Lapwai Ida.**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL **Lewiston Ida** DATE OF BURIAL **Sept 15 1912**

20. UNDERTAKER **L. B. Wain** ADDRESS **Lewiston Ida**

RECEIVED

SEP 9 1922

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Oneida
City of Malad

BUREAU OF VITAL STATISTICS

Registration District No. 2069

(No. _____ St.)

File No. 39421Registered No. 25

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John H. Meag

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male White Child (Write the word.)

6. DATE OF BIRTH

Aug 14 1922
(Month) (Day) (Year)

7. AGE

Yrs. 13 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Child

9. BIRTHPLACE

(State or Country)

Paseo Vie Idaho

10. NAME OF FATHER

Joseph J. Meag

11. BIRTHPLACE OF FATHER

(State or Country)

Provo Utah

12. MAIDEN NAME OF MOTHER

Emma Knight

13. BIRTHPLACE OF MOTHER

(State or Country)

Paseo Vie Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. J. MeagFiled Sept 5 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 27 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 14 1922 to Aug 27 1922that I last saw him alive on Aug 27 1922and that death occurred on the date stated above, at 6 a. M.

The CAUSE OF DEATH* was as follows:

Rachischisis and Hydrocephalus(Duration) Yrs. 13 ds.Contributory
(Secondary)

(Duration) Yrs. _____ mos. _____ ds.

(Signed)

R. J. Meag M. D.Aug 27 1922 (Address) Malad

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Paseo Vie Idaho Aug 29 1922

20. UNDERTAKER

ADDRESS

J. J. Benson Malad

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of OneidaCity of Malaga

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John H LewisRegistration District No. 24Primary Registration District No. 2069File No. 39422Registered No. 24

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WID-OWED OR DIVORCED

Single

6. DATE OF BIRTH

July 8

(Month)

(Day)

1922
(Year)

7. AGE

1 Yrs. 23 Mos. 23 ds.

IF LESS than 1 day

how many _____ hrs.

or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

child

9. BIRTHPLACE

(State or Country)

Malaga Ida

10. NAME OF FATHER

Geo Lewis

11. BIRTHPLACE OF FATHER

(State or Country)

St John Idaho

12. MAIDEN NAME OF MOTHER

Jane McKay

13. BIRTHPLACE OF MOTHER

(State or Country)

Malaga Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Sept 5 1922RT Mauer M.D
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 24 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

8/20 1922 to 8/22 1922
that I last saw him alive on 8/21 1922
and that death occurred on the date stated above, at 3 AM

The CAUSE OF DEATH* was as follows:

meningitis(Duration) _____ Yrs. _____ mos. 6 ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

J. M. Tarns, M. D.
8/22 1922 (Address) Malaga Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Malaga

DATE OF BURIAL

8/23 1922

20. UNDERTAKER

Woodland Und Co

ADDRESS

Malaga

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39423**
Registered No. **24**

1. PLACE OF DEATH **RECEIVED**
County of **Blaine** Registration District No. **26**
City of **Malad** Primary Registration District No. **2069**
If death occurs away from usual residence, give facts called for under special information. **BUREAU OF VITAL STATISTICS**
2. FULL NAME **Carroll Davis Jones**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Single**
6. DATE OF BIRTH **Aug 23 1922**
7. AGE **8** yrs. **8** mos. **8** ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

chld.

9. BIRTHPLACE

(State or Country)

Malad Idaho

10. NAME OF FATHER

Joseph P Jones

11. BIRTHPLACE OF FATHER

(State or Country)

Malad Idaho

12. MAIDEN NAME OF MOTHER

Anna Davis

13. BIRTHPLACE OF MOTHER

(State or Country)

Willard Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Barbara Rydley**
(Address) **Malad Ida**

15.

Filled **Sept 5 1922** **R. M. Mauer M.D.**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 31 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Aug 23 1922** to **Aug 31 1922**
that I last saw him alive on **Aug 31 1922**
and that death occurred on the date stated above, at **2 P.M.**

The CAUSE OF DEATH* was as follows:

not fully developed
Inf. nourishment

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) **J. M. Kerns M.D.**

9/1 1922 (Address) **Malad Ida**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Malad Idaho **9-1 1922**

20. UNDERTAKER

ADDRESS

D. C. Johnson **Malad**

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Oreida
City of St John

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED
OCT 4 1922
BUREAU OF STATISTICS
CERTIFICATE OF DEATHRegistration District No. 26Registration District No. 2069

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 39424Registered No. 27

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDChild
(Write the word.)

6. DATE OF BIRTH

May 27 1921
(Month) (Day) (Year)

7. AGE

1 Yrs. 4 Mos. 2 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Child

9. BIRTHPLACE

(State or Country)

St John, Oreida

10. NAME OF FATHER

Andie Dalbot

11. BIRTHPLACE OF FATHER

(State or Country)

Ogden Ut.

12. MAIDEN NAME OF MOTHER

Mariana Monson

13. BIRTHPLACE OF MOTHER

(State or Country)

St John, Oreida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Andie Dalbot

(Address)

St John, Id.

15. Filed

Oct 4 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 29 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 16 1922 to Sept 29 1922
that I last saw her alive on Sept 28 1922
and that death occurred on the date stated above, at 6 9 M.

THE CAUSE OF DEATH* was as follows:

Ileo Colitis(Duration) Yrs. mos. 14 ds.Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

J. L. Alton M. D.

(Address)

Malad

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

St. John, Ida.

DATE OF BURIAL

Oct 1 1922

20. UNDERTAKER

Woodland F. Co

ADDRESS

Malad

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39425**
Registered No. **35**

1. PLACE OF DEATH
County of *Payette*
City of *Payette*
Registration District No. *4*
Primary Registration District No. *1008*
St. *Idaho*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Betty F Bowman*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female*
4. COLOR OR RACE *White*
5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*
(Write the word.)

6. DATE OF BIRTH
Nov 26th 1860
(Month) (Day) (Year)

7. AGE
61 Yrs. *8* Mos. *19* ds.
IF LESS than 1 day how many..... hrs. or..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work *House Wife*
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) *Clinton Co. Missouri*

10. NAME OF FATHER *A. J. Lott*

11. BIRTHPLACE OF FATHER
(State or Country) *Kentucky*

12. MAIDEN NAME OF MOTHER *Elender Newman*

13. BIRTHPLACE OF MOTHER
(State or Country) *Missouri*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *E. F. Bowman*
(Address) *Payette Idaho*

15. Filed *Aug 17 1922*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug 14 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Aug 12 1922* to *Aug 14 1922* that I last saw him alive on *Aug 14 1922* and that death occurred on the date stated above, at *4:30* P. M.
The CAUSE OF DEATH* was as follows:
Draining

(Duration) Yrs. mos. ds.
Contributory (Secondary) *Chronic Nephritis*
(Duration) yrs. mos. ds.
(Signed) *J. C. Woodward* M. P.
Aug 16 1922 (Address) *Payette Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Payette Idaho*
DATE OF BURIAL *Aug 17 1922*
20. UNDERTAKER *J. C. Woodward*
ADDRESS *Payette Idaho*

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

39426

1. PLACE OF DEATH

Registration District No. 4

County of Malheur

Primary Registration District No. 1008.

City of Ontario, Oregon

St.)

File No.

Registered No. 36

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John G. roesbeck

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Widowed

(Write the word.)

6. DATE OF BIRTH

October 18, 1847.

(Month)

(Day)

(Year)

7. AGE

75 Yrs. 10 Mos. 2 ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Farmer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Wisconsin

10. NAME OF FATHER

Unknown.

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Unknown.

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. J. E. Hazlett

(Address)

Fruitland, Idaho

15.

Filed August 22 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

August 20, 1922.

(Month)

(Day)

19

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

August 10, 1922, to August 20 1922

that I last saw him alive on August 20 1922

and that death occurred on the date stated above, at 11.30 P.

The CAUSE OF DEATH* was as follows:

Double Lobar Pneumonia

(Duration)

Yrs.

mos.

12

ds.

Contributory

(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

J. C. Woodward

M. D.

Aug 22 1922 (Address) Payette, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

Yrs.

mos.

In the

days

State

Yrs.

mos.

days

Where was disease contracted if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

Payette, Idaho

DATE OF BURIAL

Aug 23 1922

20. UNDERTAKER

Glenn E. Landon

ADDRESS

Payette, Idaho

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Payette Registration District No. 4
 City of Payette Primary Registration District No. 1008
 (State of Idaho) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Louise Elaine Samuels

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 39428
 Registered No. 38

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

single
 (Write the word.)

6. DATE OF BIRTH

Dec 22 1921
 (Month) (Day) (Year)

7. AGE

9 Yrs. 9 Mos. ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Oregon

10. NAME OF FATHER

Thomas Samuels

11. BIRTHPLACE OF FATHER

(State or Country)

California

12. MAIDEN NAME OF MOTHER

Jennie Hodgson

13. BIRTHPLACE OF MOTHER

(State or Country)

Washington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jennie Samuels
 (Address) Ontario - Ore.

15.

Filed Sep 23 1922 J. B. Woodward
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

104

16. DATE OF DEATH

Sept 22 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept. 20 1922, to Sept 22 1922
 that I last saw her alive on Sept 22 1922,
 and that death occurred on the date stated above, at 100 M.

The CAUSE OF DEATH* was as follows:

Enteric colitis

(Duration) 3 Yrs. 3 mos. ds.

Contributory
 (Secondary)

(Duration) Yrs. mos. ds.

(Signed) O. H. Avery M. D.

9/23/1922 (Address) Payette, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Payette, Idaho

DATE OF BURIAL

Sept 24 1922

20. UNDERTAKER

Glen C. Lundon

ADDRESS

Payette Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39429**
Registered No. **39**

1. PLACE OF DEATH **Payette**
County of **Payette** Registration District No. **4**
City of **Payette** (No. **1008**) St.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Eugene Charles Canier

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **male** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **single**
(Write the word.)

6. DATE OF BIRTH **March 10 1911**
(Month) (Day) (Year)

7. AGE **11** Yrs. **6** Mos. **15** ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Montana

10. NAME OF FATHER

Chas. LeRoy Canier

11. BIRTHPLACE OF FATHER

(State or Country)

Montana

12. MAIDEN NAME OF MOTHER

Ida Bell Lyons

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. E. H. Canier

(Address)

Payette, Idaho

15.

Filed

Sep 25 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sep. 24 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **February 4 1923** to **Sep 24 1922**

that I last saw him alive on **Sep 24 1922** and that death occurred on the date stated above, at **10 P. M.**

The CAUSE OF DEATH was as follows:

Diabetes Mellitus

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed)

J. C. Woodward M. D.

(Address)

Payette, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Payette

DATE OF BURIAL

Sep. 28 1922

20. UNDERTAKER

John C. Lander

ADDRESS

Payette, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

1. PLACE OF DEATH.

County of **Power**City of **American falls, Idaho**

Registration District No.

Primary Registration District No. **2072**

File No.

Registered No. **165**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Jrvey R. Botkin**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single

(Write the word.)

6. DATE OF BIRTH.

April

(Month)

25

(Day)

1921

(Year)

7. AGE

1 Yrs. **4** Mos. **9** ds.

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...

None

9. BIRTHPLACE

(State or Country)

Power Co**Idaho.**

10. NAME OF FATHER

S.O. Botkin

11. BIRTHPLACE OF FATHER

(State or Country)

Kty

12. MAIDEN NAME OF MOTHER

Minnie Hall

13. BIRTHPLACE OF MOTHER

(State or Country)

Kty

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

American Falls, Idaho

15.

Filed

9-15**1922****R. J. Roth**

Local Registrar

16. DATE OF DEATH

August

(Month)

14

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191

to

191

that I last saw h..... alive on

191

and that death occurred on the date stated above, at

M.

The CAUSE OF DEATH* was as follows:

Accidental Drowning By**Falling into a Creek**

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

Rudolph Ceranen D.**8/15/22** (Address)**American Falls, Ida.**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death.....yrs.....mos.....days

State.....yrs.....mos.....days

Where was disease contracted
if not at place of death?.....

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

American Falls, Idaho

DATE OF BURIAL

8/15 22

20. UNDERTAKER

ADDRESS

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No.

Primary Registration District No.

St.)

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

7. AGE

Yrs. Mos. ds.

If LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

19

Local Registrar

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39433**Registered No. **39**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH **NELO** Registration District No. **123**
County of **Shoshone** (Primary Registration District No. **1922**)
City of **Heleppig** (City of **Idaho**) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Lilla Elder**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **F** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Widow**

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

45 Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

Housekeeper

9. BIRTHPLACE

(State or Country)

Wisconsin

10. NAME OF FATHER

Wm Williams

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Agnes Stodden

13. BIRTHPLACE OF MOTHER

(State or Country)

None

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Adrian Cunningham

(Address)

Heleppig, Idaho

15.

Filed

9/20/22

19

22**E. E. Hardy**

Local Registrar

MEDICAL CERTIFICATE OF DEATH **Dr. C. C. C. C.**

16. DATE OF DEATH

Aug (Month)**3** (Day)**22** (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 20 19**22**, to **August 3**, 19**22**,that I last saw him alive on **8/3/1922**and that death occurred on the date stated above, at **9 P. M.**

The CAUSE OF DEATH* was as follows:

Intermittent (Pulmonary)**Myocardial weakness**

(Duration) Yrs. mos. ds.

Contributory **decompensation of heart**

(Secondary) (Duration) Yrs. mos. ds.

(Signed) **Dr. C. C. C. C.** M. D.**8/8/1922** (Address) **Heleppig, Idaho**

*State the Disease Causing Death; or in death from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Heleppig, Idaho

DATE OF BURIAL

Aug 9, 1922

20. UNDERTAKER

M. P. Thornhill Heleppig

ADDRESS

CERTIFICATE OF DEATH

1. PLACE OF DEATH
County of Shoshone Registration District No. 123
City of Bear Gulch Primary Registration District No. Emville (No. 1) St. Idaho

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Frank Macki

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 39434
Registered No. 38

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widowed

6. DATE OF BIRTH April 1. 1 (Month) (Day) (Year)

7. AGE 47 Yrs. — Mos. — ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Miner

9. BIRTHPLACE

(State or Country)

Finland

10. NAME OF FATHER

Mr. Macki

11. BIRTHPLACE OF FATHER

(State or Country)

Finland

12. MAIDEN NAME OF MOTHER

W. M. M.

13. BIRTHPLACE OF MOTHER

(State or Country)

Finland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Elmer Macki
(Address) _____

15. Filed 9/30/22 E. E. Hardy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 7, 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 31, 1922 to Aug 5, 1922
that I last saw him alive on Aug 5, 1922
and that death occurred on the date stated above, at 5:45 P.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonary

(Duration) Several yrs. mos. ds.

Contributory (Secondary) Marasmus

(Duration) _____ yrs. mos. ds.

(Signed) A. S. Macdonald M. D.

8/8/1922 (Address) 1011 1/2 St. Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. mos. days. In the State _____ yrs. mos. days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Stengston, Idaho Aug 9, 1922

20. UNDERTAKER

ADDRESS

M. P. Thornhill Stengston, Idaho

1. PLACE OF DEATH

County of Shoshone
City of WardnerRegistration District No. 133

Primary Registration District No. _____

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William Thomas JonesState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 39435Registered No. 39

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCED
married
(Write the word.)

6. DATE OF BIRTH

January 27 1956
(Month) (Day) (Year)

7. AGE

66 Yrs. 6 Mos. 13 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)miner

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

John Jones

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Sarah Treadway

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Nellie Jones

(Address)

Wardner

15. Filed

7/291956E. E. Hardy

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 9 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 2 1922 to Aug 2 1922
that I last saw him alive on 8/20 1922
and that death occurred on the date stated above, at P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(Duration) 6 Yrs. _____ mos. _____ ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

A. S. Jones M. D.7/29/1922 (Address) Wardner, Idaho

*State the Disease Causing Death; or in death from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Greenwood

DATE OF BURIAL

Aug 13 1922

20. UNDERTAKER

McHardy

ADDRESS

Wardner

CERTIFICATE OF DEATH

1. PLACE OF DEATH *Shoshone* Registration District No. *123*
 County of *Shoshone* Principal Registration District No. *123*
 City of *Kellogg* State *Idaho* (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Edw. A. Kruegel

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. *39436*
 Registered No. *30*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *m* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WID-
~~OWED~~ *married*

6. DATE OF BIRTH

May 19 1858
 (Month) (Day) (Year)

7. AGE

64 Yrs. *2* Mos. *27* ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

Blacksmith

9. BIRTHPLACE

(State or Country)

Wisconsin

10. NAME OF FATHER

no inf.

11. BIRTHPLACE OF FATHER

(State or Country)

W. S.

12. MAIDEN NAME OF MOTHER

no inf.

13. BIRTHPLACE OF MOTHER

(State or Country)

W. S.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. E. Hardy

(Address)

Kellogg, Idaho

15.

Signed

9/30/1922 E. E. Hardy

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

August 15 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 12 1922 to Aug 15 1922

that I last saw him alive on *Aug 15 1922*
 and that death occurred on the date stated above, at *10 A.M.*

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Duration) Yrs. *8* mos. ds.

Contributory (Secondary)

Influenza

(Duration) Yrs. *1* mos. ds.

(Signed)

E. E. Hardy

M. D.

9/14/22 (Address) *Kellogg*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Spokane, Wash.

DATE OF BURIAL

Aug 17 1922

20. UNDERTAKER

M. C. Thornball

ADDRESS

Kellogg, Idaho

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of ShoshoneRegistration District No. 123City of ShoshonePrimary Registration District No. 123

If death occurs away, from usual residence, give facts called for under special information.

2. FULL NAME

John Juhlmas J. HillState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 39437Registered No. 31

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

9/20/221922E. E. Hardy

Local Registrar

16. DATE OF DEATH

Sept 12 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended John Juhlmas J. Hill from Sept 12 1922 to Sept 12 1922that I last saw him alive on Sept 12 1922 and that death occurred on the date stated above, at Shoshone, Idaho M.

The CAUSE OF DEATH* was as follows:

Gunshot wound perforating the heart accidentally inflicted.

(Duration) — Yrs. — mos. — ds.

Contributory
(Secondary)

(Duration) — yrs. — mos. — ds.

(Signed)

E. E. Hardy

M. D.

Sept 14 1922

(Address)

Kellogg Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Shoshone IdahoSept 14 1922

20. UNDERTAKER

ADDRESS

M. C. ThornhillKellogg Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH 0015 1322
 Registration District No. 77
 County of Jefferson Primary Registration District No. 2176
 City of Driggs (No. _____ St.)

File No. **39438**Registered No. 37

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Alma Christensen

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Single (word.)

6. DATE OF BIRTH Sept. 26 1922
 (Month) (Day) (Year)

7. AGE 8 IF LESS than 1 day
 how many _____ hrs.
 Yrs. Mos. da. or min. ?

8. OCCUPATION

(a) Trade, profession or
particular kind of work. Infant.
 (b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer) "

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Neon Christensen

11. BIRTHPLACE OF FATHER

(State or Country) Idaho

12. MAIDEN NAME OF MOTHER

Martha Moulton

13. BIRTHPLACE OF MOTHER

(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Neon Christensen(Address) Driggs, Ida

15.

Filed 10/1st 1922

Martha Marker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept. 27 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Sept 26 1922 to Sept 27 1922

that I last saw him alive on Sept 26 1922

and that death occurred on the date stated above, at 4 PM

The CAUSE OF DEATH* was as follows:

premature

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Chas Mout M. D.

Sept 27 1922 (Address) Driggs Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state
 (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted
 if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Driggs Idaho Sept. 28 1922

20. UNDERTAKER

ADDRESS

Driggs Driggs

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Twin Falls Registration District No. 37
City of Idaho Falls Primary Registration District No. 1085
(No. 1085) Idaho Falls General HospitalFile No. 39440

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Harold Croft

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male white Single
(Write the word.)

6. DATE OF BIRTH

March 4 1919
(Month) (Day) (Year)

7. AGE

3 Yrs. 6 Mos. 22 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Ephraim Croft

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Anna Blankinship

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ephraim Croft

(Address)

445 5th Ave. W. City

15.

Filed Oct. 1 1922John H. Hargrave
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept. 26 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 17 1922 to Sept 25 1922
that I last saw him alive on Sept 25 1922,
and that death occurred on the date stated above, at 1 a. M.

The CAUSE OF DEATH* was as follows:

Bacillary dysentery(Duration) Yrs. mos. 10 ds.Contributory
(Secondary)None

(Duration) yrs. mos. ds.

(Signed)

John W. Visher M. D.Sept 27 1922(Address) Twin Falls, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Twin Falls

DATE OF BURIAL

Sept. 27, 1922

20. UNDERTAKER

J. J. Hargrave

ADDRESS

Twin Falls

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Twin FallsRegistration District No. 37Primary Registration District No. 1883City of "(No. ")

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Henry WiersFile No. 39441Registered No. "

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Don't Know
(Month) (Day) (Year)

7. AGE

About 71 Yrs.

Mos.

ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Home Dealer

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Not Known

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed Oct 119 22John A. Laughlin
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept - (Month) 13th
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19..... to 19.....

that I last saw him..... alive on..... 19.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Heart work -
apical aneurysm of
aorta.

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. Wiers

M. D.

19.....

(Address)

Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Twin Falls Ida9/17 19 22

20. UNDERTAKER

ADDRESS

J. GrossmanTwin Falls Ida

CERTIFICATE OF DEATH

Wilson
State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39442**
Registered No.

1. PLACE OF DEATH

Registration District No. **37**
County of **Twin Falls** Primary Registration District No. **1275**
City of **"** **Bureau County Hospital** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Elezebeth Jordan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female **White** **Married**
(Write the word.)

6. DATE OF BIRTH

Feb 5 1888
(Month) (Day) (Year)

7. AGE

54 Yrs. **7** Mos. **3** ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

House wife

9. BIRTHPLACE

(State or Country)

Russia

10. NAME OF FATHER

Jacob Waggoner

11. BIRTHPLACE OF FATHER

(State or Country)

Russia

12. MAIDEN NAME OF MOTHER

Sophia Waggoner

13. BIRTHPLACE OF MOTHER

(State or Country)

Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Neney Jordan
Resident **Twin Falls Ida**

15.

Filed **Oct. 1 - 1922** **John S. Laughter**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept - 8 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 1 1922 to Sept 8 1922
that I last saw him alive on **Sept 5 1922**
and that death occurred on the date stated above, at **4** M.

The CAUSE OF DEATH* was as follows:

General Streptococcus infection

(Duration) Yrs. **6** mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) **H. Wilson** M. D.

Sept 8 1922 (Address) **Twin Falls, Ida**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Twin Falls **9-10 1922**

20. UNDERTAKER

ADDRESS

W. Grossman **Twin Falls Ida**

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39443**
Registered No.

1. PLACE OF DEATH
County of *Iron* Registration District No. *37*
City of *Iron* Primary Registration District No. *1085*
(No. County General Hospital. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Esther Clementine McDaniel
If death occurred in a hospital, institution or camp, give the NAME, number of bed and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *female* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WID-OWED OR DIVORCED *Married*

6. DATE OF BIRTH

Nov 1 1860
(Month) (Day) (Year)

7. AGE

62 Yrs. *11* Mos. *22* ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

House maid

9. BIRTHPLACE

(State or Country)

Miss

10. NAME OF FATHER

M M Morgan

11. BIRTHPLACE OF FATHER

(State or Country)

Conn

12. MAIDEN NAME OF MOTHER

Eleanor Feigau

13. BIRTHPLACE OF MOTHER

(State or Country)

Miss

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs E L Turner

(Address)

15.

Filed *Oct. 1* 19 *22*

John T. Karpman
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 22 19 *22*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept. 20 19 *22* to *Sept. 21* 19 *22*
that I last saw him alive on *Sept 21* 19 *22*
and that death occurred on the date stated above, at *12* M.

The CAUSE OF DEATH* was as follows:

Ruptured gall bladder.

(Duration) Yrs. mos. *2* ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

Har Wilson M. D.

(Address) *Iron Falls, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Iron Falls, Ida *Sept 26* 19 *22*

20. UNDERTAKER

ADDRESS

E. E. Hart *Iron Falls*

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
OCT 2 1922
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39444**

1. PLACE OF DEATH

County of *Twin Falls*City of *Idaho Falls*Registration District No. *37*Primary Registration District No. *2085*(No. *11*)

St.)

Registered No. *1*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Susan McMillan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female white

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widowed

6. DATE OF BIRTH

Nov. 22 1841
(Month) (Day) (Year)

7. AGE

*80 Yrs. 9 Mos. 21 ds.*IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).*Retired*

9. BIRTHPLACE

(State or Country)

Peru

10. NAME OF FATHER

Thomas Walker

11. BIRTHPLACE OF FATHER

(State or Country)

Pa.

12. MAIDEN NAME OF MOTHER

Bertha Schellenburg

13. BIRTHPLACE OF MOTHER

(State or Country)

Pa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

S. McMillan

(Address)

Idaho Falls, Idaho

15.

Filed *Oct. 1-22* 19*22*

Local Registrar

John J. Leoughlin

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept. 13 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *Sept 12 1922* to *Sept 13 1922*, that I last saw her alive on *Sept 13 1922* and that death occurred on the date stated above, at *9:30 A.M.*
The CAUSE OF DEATH* was as follows:
Internal hemorrhage(Duration) Yrs. mos. ds. *1*
Contributory (Secondary) *Probably Ovarian Cyst*(Duration) Yrs. mos. ds. *5*
(Signed) *John W. Fisher* M. D.*14/9 1922* (Address) *Twin Falls, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Tampa, Fla.

20. UNDERTAKER

ADDRESS

Thos. J. Crossman Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39445**

1. PLACE OF DEATH
County of *Twin Falls* Registration District No. *37*
City of *Idaho Falls* Primary Registration District No. *2085*
(No.) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Leithel B. Meyer*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*

6. DATE OF BIRTH *June 9 1909*
(Month) (Day) (Year)

7. AGE *13 Yrs 2 Mos 18 ds*
IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work *School girl*
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) *Ill.*

10. NAME OF FATHER *Robert Meyer*

11. BIRTHPLACE OF FATHER
(State or Country) *Ill.*

12. MAIDEN NAME OF MOTHER *Mable Claudine*

13. BIRTHPLACE OF MOTHER
(State or Country) *Ill.*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Robert Meyer*
(Address) *Twin Falls R. F. D. 1*

15. Filed *Oct 1 - 1922* *John Houghlin*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *Aug 27 1922*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 19... to 19...
that I last saw him alive on 19...
and that death occurred on the date stated above, at... M.

The CAUSE OF DEATH* was as follows:
Acute Toxic Nephritis
Alcohol & Arsenic in Stomach
The above findings from Post Mortem Examination
Contributory (Secondary) ...
(Duration) yrs. mos. ds.

(Signed) *Chas. R. Scott* M. D.
19... (Address) *Twin Falls - Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Twin Falls* DATE OF BURIAL *Aug 30 - 1922*

20. UNDERTAKER *J. J. Brown* ADDRESS *Twin Falls*

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Twin Falls

Registration District No. 37

Primary Registration District No. 2085

City of _____ (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Anna Lamareau

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 39446

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married

6. DATE OF BIRTH

Feb 4 1986
(Month) (Day) (Year)

7. AGE

56 Yrs. 7 Mos. 19 ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work house wife
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Utah

10. NAME OF FATHER

Ezekiel

11. BIRTHPLACE OF FATHER

(State or Country) Ohio

12. MAIDEN NAME OF MOTHER

Francis Anna Beadleston

13. BIRTHPLACE OF MOTHER

(State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henry G. Lamareau

(Address) _____

15. Filed Oct. 1 1922

John T. Houghlin
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 23 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 20 1922, to Sept 22 1922

that I last saw him alive on Sept 22 1922

and that death occurred on the date stated above, at 6 M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) _____ Yrs. _____ mos. 2 ds.

Contributory (Secondary) Arteriosclerosis

unknown (Duration) _____ Yrs. _____ mos. _____ ds.

(Signed) Hal Biele M. D.

Sept 23 1922 (Address) Twin Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Twin Falls Ida

DATE OF BURIAL

Sept 25 1922

20. UNDERTAKER

J. E. Newell

ADDRESS

Twin Falls

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics1. PLACE OF DEATH
County of Twist Falls Registration District No.
City of Twist Falls (No.) St.
Primary Registration District No. 1085File No. 39447

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married

6. DATE OF BIRTH

Aug 10 1878
(Month) (Day) (Year)

7. AGE

44 Yrs. 20 Mos. 20 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Holland

10. NAME OF FATHER

Peter

11. BIRTHPLACE OF FATHER

(State or Country) Holland

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15. Filed Oct. 1 19 22

Local Registrar

16. DATE OF DEATH

Sept. 10 19 22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept. 10 1922 to Sept. 10 1922
that I last saw him alive on Sept. 10 1922
and that death occurred on the date stated above, at 5:45 P.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed)

9-14-22 (Address) Twist Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Twist FallsSept. 13 1922

20. UNDERTAKER

ADDRESS

J. J. Foreman Twist Falls

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Twin FallsCity of Idaho

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37Primary Registration District No. 1085(No. 4th 200 N. St.)

2. FULL NAME

Frank J. TerrellState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 39448

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married

6. DATE OF BIRTH

Aug. 17 1922
(Month) (Day) (Year)

7. AGE

74 Yrs. 0 Mos. 4 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Stockman

9. BIRTHPLACE

(State or Country)

Tenn.

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

Tenn.

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Tenn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

F. J. Terrell Jr.

(Address)

Twin Falls Idaho

15.

Filed Oct. 1 1922John F. Coughlin
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept. 1 1922
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from Aug 31st 1922 to Sept 1st 1922
that I last saw h. alive on Sept 1st 1922
and that death occurred on the date stated above, at 1304 M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris(Duration) 2 Yrs. _____ mos. _____ ds.Contributory
(Secondary)(Duration) 1 Yrs. _____ mos. _____ ds.

(Signed)

John F. Coughlin M. D.9.5.19.22 (Address) Twin Falls Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Twin Falls

DATE OF BURIAL

Sept 3 1922

20. UNDERTAKER

J. F. Coughlin

ADDRESS

Twin Falls

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39449**

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Twin Falls
City of 11 11001Registration District No. 37
Primary Registration District No. 1085
(No. County Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Frank A. Koch

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single

6. DATE OF BIRTH

Oct. 4 1895
(Month) (Day) (Year)

7. AGE

26 Yrs. 11 Mos. 2 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)School Teacher

9. BIRTHPLACE

(State or Country)

Oregon

10. NAME OF FATHER

John Koch

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Lena Buckner

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Lena Martin
(Address) 1111 Idaho

15.

Filed Oct. 1-22 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept. 6 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Sept 6th 1922 to Sept 6th 1922
that I last saw him alive on Sept 6th 1922
and that death occurred on the date stated above, at 5 p.m.

The CAUSE OF DEATH* was as follows:

Gun shot wound (38 cal. armory)
of head. Fracture skull.
Destruction of brain - substance
(Duration) _____ Yrs. _____ mos. _____ ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Lena Martin M. D.7/3 1922 (Address) Twin Falls, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bull, Ida 1922

20. UNDERTAKER

ADDRESS

J. J. Grassman Twin Falls, Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39450**
Registered No.

1. PLACE OF DEATH *Twin Falls* Registration District No. *37*
County of *Twin Falls* Primary Registration District No. *1085*
City of *Twin Falls* (No.) St.
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Cora E Stiles

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Widowed*
(Write the word.)

6. DATE OF BIRTH *October 10 1863*
(Month) (Day) (Year)

7. AGE *58* Yrs. *10* Mos. *27* ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Retired

9. BIRTHPLACE *Knowlton Wise*
(State or Country)

10. NAME OF FATHER *Mr Oliver E Meigs*

11. BIRTHPLACE OF FATHER *Canada*
(State or Country)

12. MAIDEN NAME OF MOTHER *Maggie Meigs*

13. BIRTHPLACE OF MOTHER *Bradford County Penn*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Cora E Stiles*
(Address) *461 E. Main Ave Twin Falls Idaho*

15. Filled *Oct. 1 - 1922* *John H. Houshlin*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *Sept 7 1922*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Sept 7 1922* to *Sept 7 1922*, that I last saw *her* alive on *Sept 7 1922*, and that death occurred on the date stated above, at *4:00* M. The CAUSE OF DEATH* was as follows:
Pneumonia, anemia

(Duration) Yrs. *6* mos. ds.
Contributory (Secondary)

(Duration) yrs. mos. ds.
(Signed) *W. E. Stiles* M. D.
9/9/22 1922 (Address) *Twin Falls Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Twin Falls Idaho* DATE OF BURIAL *9-10-1922*

20. UNDERTAKER *P. J. Grossman* ADDRESS *Twin Falls Idaho*

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39451**

1. PLACE OF DEATH
County of Lewin Falls
City of Lewin Falls
If death occurs away from usual residence, give facts called for under special information.

RECEIVED
Registration District No. 39
Primary Registration District No. 1085

Registered No. _____
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Harold W. Taylor

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
6. DATE OF BIRTH May 23 1886
(Month) (Day) (Year)

7. AGE 26 Yrs. 3 Mos. 20 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work RR Conductor
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Minnesota

10. NAME OF FATHER Stewart T. Taylor

11. BIRTHPLACE OF FATHER
(State or Country) Ireland

12. MAIDEN NAME OF MOTHER Caroline Hall

13. BIRTHPLACE OF MOTHER
(State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Stewart H. Taylor
(Address) Lewin Falls, Ida

15. Filed Oct. 1-22 19 John J. Broughlin
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 13 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 7 1922 to Sept 12 1922
that I last saw him alive on Sept 7 1922
and that death occurred on the date stated above, at 2 am M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(Duration) _____ Yrs. _____ mos. _____ ds.
Contributory (Secondary) _____
(Duration) 2 yrs. _____ mos. _____ ds.
(Signed) How Wilson M. D.
Sept 14 1922 (Address) Lewin Falls, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Lewin Falls DATE OF BURIAL Sept 14 1922

20. UNDERTAKER J. J. Broughlin ADDRESS Lewin Falls

1. PLACE OF DEATH **RECEIVED** CERTIFICATE OF DEATH
 County of *Idaho Falls* Registration District No. *37*
 City of *Idaho Falls* Primary Registration District No. *1085*
 If death occurs away from *Idaho Falls County Hospital* St.)
 usual residence, give facts
 called for under special
 information.

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. **39452**
 Registered No.
 If death occurred in a hos-
 pital, institution or camp,
 give its NAME instead of
 street and number.

2. FULL NAME *Ida A. Comegys*

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED, *married*
 (Write the word.)

6. DATE OF BIRTH *Aug 09 1864*
 (Month) (Day) (Year)

7. AGE *57* Yrs. *1* Mos. *17* ds.
 IF LESS than 1 day
 how many hrs. or
 min.?

8. OCCUPATION

(a) Trade, profession or
 particular kind of work
 (b) General nature of in-
 dustry, business, or estab-
 lishment in which em-
 ployed (or employer)

Wife

9. BIRTHPLACE

(State or Country)

Penn

10. NAME OF FATHER

Wayne Winter

11. BIRTHPLACE OF FATHER

(State or Country)

Pa.

12. MAIDEN NAME OF MOTHER

Jones

13. BIRTHPLACE OF MOTHER

(State or Country)

Pa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *H. P. Comegys*

(Address) *Filer*

15.

Filed Oct. 1. 1912.

John H. Goughlin
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *Sept 19 1922*
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Sept 5 1922 to *Sept 19 1922*
 that I last saw him alive on *Sept 19 1922*
 and that death occurred on the date stated above, at *5:45 P.M.*
 The CAUSE OF DEATH* was as follows:

Central Lemnorrhage
 (Duration) Yrs. mos. *45 minutes*

Contributory *Arterio-sclerosis*
 (Secondary)

(Duration) *2* Yrs. mos. ds.
 (Signed) *F. A. Wright, M. D.*
Sept 22 1922 (Address) *Filer, Idaho*

*State the Disease Causing Death; or in deaths from Violent
 Causes, state (1) Means of Injury; and (2) whether Accidental,
 Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
 Transients or Recent Residents.)

At place *Twin Falls County Hospital Twin Falls, Idaho*
 of death yrs. mos. *14* days, State yrs. mos. days

Where was disease contracted
 if not at place of death?

Former or
 usual residence *Filer, Idaho*

19. PLACE OF BIRTH OR REMOVAL

Idaho Falls

DATE OF BURIAL

Sept 23 1922

20. UNDERTAKER

H. P. Comegys
H. P. Comegys
 ADDRESS *Filer*

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39453**
Registered No. _____

1. PLACE OF DEATH
County of Dubin Falls Registration District No. 39-
City of Dubin Falls Primary Registration District No. 1085
City of Dubin Falls County Hospital. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME David Henry Dean

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-OWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH Aug 70 1841
(Month) (Day) (Year)

7. AGE 81 Yrs. 0 Mos. 22 ds. IF LESS than 1 day how many _____ hrs. or _____ min. 7

8. OCCUPATION Retired
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE Canada
(State or Country)

10. NAME OF FATHER John Dean

11. BIRTHPLACE OF FATHER Eng.
(State or Country)

12. MAIDEN NAME OF MOTHER Eliza Ellen

13. BIRTHPLACE OF MOTHER Eng.
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Sarah Dean
(Address) Rock Creek

15. Filed Oct. 1- 1922
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 12 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 19 22 to Sept 12 19 22
that I last saw him alive on Sept 12 19 22
and that death occurred on the date stated above, at _____ M.
The CAUSE OF DEATH* was as follows:
Myocarditis

(Duration) _____ Yrs. _____ mos. _____ ds.
Contributory Arterio Sclerosis
(Secondary)
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) Joseph Neal M. D.
(Address) Dubin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days
Where was disease contracted if not at place of death? _____
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Dubin Falls DATE OF BURIAL Sept. 14 19 22
20. UNDERTAKER C. J. Thompson ADDRESS Dubin Falls

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Washington
City of WeiserRegistration District No. 86Primary Registration District No. 2112(No. of MUNICIPAL
STATISTICS)

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Salomon BarnettState of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

39454Registered No. 8

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

— — 1845
(Month) (Day) (Year)

7. AGE

77Yrs. — Mos. — ds. —IF LESS than 1 day
how many — hrs.
or — min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Mississippi

10. NAME OF FATHER

William Barnett

11. BIRTHPLACE OF FATHER

(State or Country)

Alabama

12. MAIDEN NAME OF MOTHER

Litha Johnson

13. BIRTHPLACE OF MOTHER

(State or Country)

So. Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ed. Barnett

(Address)

Weiser Ida

15.

Filed

8/191922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 7 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 1 1922 to Aug 7 1922that I last saw him alive on Aug 7 1922and that death occurred on the date stated above, at 12:15 P. M.

The CAUSE OF DEATH was as follows:

R. M. Spotted feverabout
(Duration) Yrs. — mos. 10 ds.Contributory
(Secondary)(Duration) yrs. — mos. — ds.

(Signed)

J. M. Waterhouse M. D.8/8 1922 (Address) Weiser Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death — yrs. — mos. — days. In the State — yrs. — mos. — days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hillcrest Cemetery 8-9 1922

20. UNDERTAKER

ADDRESS

Northam M. Cam Weiser

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39455**
Registered No. **9**

1. PLACE OF DEATH

County of WashingtonCity of Weiser

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

District No. 86Primary Registration District No. 1010

RECEIVED
SEP 13 1922
BUREAU OF VITAL STATISTICS

STATE OF IDAHO

Walter a Lloyd

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

Wht

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widowed
(Write the word.)

6. DATE OF BIRTH

Oct

4

1849

(Month)

(Day)

(Year)

7. AGE

74

Yrs.

10

Mos.

4

ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Fruit Grower

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Va.

10. NAME OF FATHER

—

11. BIRTHPLACE OF FATHER

(State or Country)

—

12. MAIDEN NAME OF MOTHER

—

13. BIRTHPLACE OF MOTHER

(State or Country)

—

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. C. Lloyd

(Address)

Weiser, Idaho

15.

Filed

8/19

1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

August 8

(Month)

(Day)

1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 22 1922 to Aug 8 1922

that I last saw him alive on Aug 8 1922

and that death occurred on the date stated above, at 9:50 A.M.

The CAUSE OF DEATH* was as follows:

Hemiplegia

(Duration)

Yrs. 3

mos. ✓ ds.

Contributory
(Secondary)

(Duration)

yrs.

mos. ds.

(Signed)

C. C. Gannant

M. D.

8/8

1922

(Address)

Weiser, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)

At place

of death

yrs.

mos.

days.

State

yrs.

mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Provo, Utah

DATE OF BURIAL

8-10-1922

20. UNDERTAKER

Northern

ADDRESS

M. C. Weiser, Id.

RECEIVED

SEP 13 1922

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No.

Primary Registration District No.

(No.)

(St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many.....hrs.

or.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 8

(Month)

(Day)

1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 4 1922, to Aug 8 1922

that I last saw him alive on Aug 7 1922

and that death occurred on the date stated above, at.....M.

The CAUSE OF DEATH was as follows:

Inanition

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

8/9 1922

(Address)

Weiser Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Hillcrest Cemetery

DATE OF BURIAL

8-8-1922

20. UNDERTAKER

Northman & Co.

ADDRESS

Weiser Ida

1. PLACE OF DEATH

County of Washington District No. 86
 City of Wenatch Primary Registration District No. 1010
 (No. STATISTICS St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Robert Chas. Cullen

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 39457
 Registered No. 11

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
 (Write the word.)

6. DATE OF BIRTH May 22 1921
 (Month) (Day) (Year)

7. AGE 1 Yrs. 2 Mos. 19 ds. IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Ida

10. NAME OF FATHER

Walter Cullen

11. BIRTHPLACE OF FATHER

(State or Country)

Ida

12. MAIDEN NAME OF MOTHER

Erma Alice Milligan

13. BIRTHPLACE OF MOTHER

(State or Country)

Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Walter Cullen
 (Address) Wenatch Idaho

15. Filed 8/19 1922 L. J. Smith
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 11 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1 1922 to Aug 11 1922
 that I last saw him alive on Aug 11 1922
 and that death occurred on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Acute enteritis

(Duration) _____ Yrs. _____ mos. 17 ds.

Contributory
 (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

J. M. Waterhouse M. D.
8/13 1922 (Address) Wenatch Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Hillcrest Cemetery
Northam McCann

DATE OF BURIAL

Aug 13 1922

ADDRESS

Wenatch Id

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Washington*City of *Weiser*Registration District No. *86*Primary Registration District No. *1010*

(No. _____ St.)

File No. *39458*Registered No. *12*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Clement Le Roy Savage

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

(Write the word.)

6. DATE OF BIRTH

July

(Month)

25

(Day)

1919

(Year)

7. AGE

3

Yrs.

0

Mos.

18

ds.

IF LESS than 1 day

how many _____ hrs.

or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ida

10. NAME OF FATHER

Walter Savage

11. BIRTHPLACE OF FATHER

(State or Country)

Washington

12. MAIDEN NAME OF MOTHER

Gladys Atteberry

13. BIRTHPLACE OF MOTHER

(State or Country)

Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Walter Savage

(Address)

Weiser, Ida

15.

Filed

*8/19**1919**H. J. Hamilton*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug

(Month)

13

(Day)

22

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 22 19*22* to *Aug 11* 19*22*that I last saw *him* alive on *Aug 11* 19*22*and that death occurred on the date stated above, at *4 a.m.*

The CAUSE OF DEATH* was as follows:

*ant. Polymyositis**about*

(Duration)

Yrs.

mos.

25 ds.Contributory
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

M. Malerhouse

M. D.

8/14 19*22*

(Address)

Weiser, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

yrs.

mos.

In the

days.

State

yrs.

mos.

days

Where was disease contracted if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Hillcrest Cemetery**Aug 14* 19*22*

20. UNDERTAKER

ADDRESS

*Northam McCann**Weiser, Ida*

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH Washingt
 County of Washer
 City of Washer (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Vera a Denning

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 39459
 Registered No. 13

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
 (Write the word.)

6. DATE OF BIRTH Apr 20 1900
 (Month) (Day) (Year)

7. AGE 22 Yrs. 3 Mos. 24 ds.
 IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION Housewife
 (a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE Ida
 (State or Country)

10. NAME OF FATHER L J Clifford

11. BIRTHPLACE OF FATHER Utah
 (State or Country)

12. MAIDEN NAME OF MOTHER Melissa Gifford

13. BIRTHPLACE OF MOTHER Utah
 (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) A J Denning
 (Address) Washer 704 E Court

15. Filed 9/8 1922
A J Hamilton
 Local Registrar

MEDICAL CERTIFICATE OF DEATH 42

16. DATE OF DEATH August 17 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 15 1922 to Aug 17th 1922
 that I last saw him alive on Aug 17 1922
 and that death occurred on the date stated above, at 2:00 P.M.

The CAUSE OF DEATH* was as follows:
Adeno carcinoma
left max.

(Duration) _____ Yrs. 6 mos. _____ ds.
 Contributory (Secondary) _____

(Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) C. G. Gannett M. D.
8/17 1922 (Address) Washer Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
 At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Rigby Ida DATE OF BURIAL Aug 19 1922

20. UNDERTAKER Northam McCann ADDRESS Washer Ida

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

(No.)

(St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

(Month)

(Day)

(Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug - 3rd 1922 to Aug 4 1922

that I last saw him alive on Aug 4 1922

and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Paralysis Hemic plegia.

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

M. D.

8/5 1922 (Address) W. W. Wilson, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mount Vista, Colo

Aug 5 1922

20. UNDERTAKER

ADDRESS

Northman McCon

W. W. Wilson, Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

39461

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada
City of BoiseRegistration District No. 2
Primary Registration District No. 1004
(No. Overland Hotel St.)File No. 39461
Registered No. 130

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Martin S Cobb

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR, DIVORCED married
(Write the word.)

6. DATE OF BIRTH

January 31 - 1844
(Month) (Day) (Year)

7. AGE

72 Yrs. 8 Mos. 17 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Farmer

9. BIRTHPLACE

(State or Country)

Indiana

10. NAME OF FATHER

Ruben Cobb

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

B E Cobb

(Address)

Boise R D # 3

15.

Filed 10 - 18 1922R. H. Rath
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

October 18 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I saw deceased from
Oct. 18 1922, to Oct. 18 1922,
that I last saw him alive on Oct. 18 1922,
and that death occurred on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Chas. E. Summers, M.D.

(Address)

Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Grave Creek Cemetery Oct. 1922

20. UNDERTAKER

ADDRESS

Summers & Tribbs Boise Idaho

CERTIFICATE OF DEATH

State of Idaho
39462 BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of AdaCity of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2Primary Registration District No. 1004(No. 1301, Hayes St.)File No. 39462Registered No. 235

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

John P. Cunningham

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-OWED OR DIVORCED Married

6. DATE OF BIRTH

Feb 18 1862
(Month) (Day) (Year)

7. AGE

60 Yrs. 7 Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Banker

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

David Cunningham

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Laura Phillips

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. John B. Cunningham(Address)

15.

Filed Oct 5 1922R. H. Pax
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 5 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Apr 5 1922 to Oct 5 1922that I last saw him alive on Oct 4 1922
and that death occurred on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH* was as follows:

Acute infection of the
myocardium(Duration) 3 yrs. 3 mos. 12 ds.
Contributory (Secondary) Heart disease, hypertension & diabetes(Duration) 3 yrs. 3 mos. 12 ds.(Signed) James H. Stewart M. D.(Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Leading Ohio19

20. UNDERTAKER

ADDRESS

Summers & WebbBoise Ida

FORM V. S. No. 5-25 M. 1-19.

Froom.
CERTIFICATE OF DEATH

39463

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No.

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

10-2

1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

19. (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 8, 1922, to Sept 30, 1922
that I last saw him alive on Sept 30th, 1922
and that death occurred on the date stated above, at 8:15 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

M. D.

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death..... yrs..... mos..... days.

In the

State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cem.

Oct 1, 1922

20. UNDERTAKER

ADDRESS

Summer St. Boise

Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. 3 miles South Beatty St.)

File No.

Registered No.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

10-9

1922

G. H. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct. 8 1922 to Oct. 8 1922

that I last saw him alive on Oct. 8 1922

and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Convulsion

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

10/9 1922 (Address) Boise, Idaho, M. D.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill

10/10 1922

20. UNDERTAKER

ADDRESS

Wm McBratney

Boise

Idaho

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Ada
City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 8Primary Registration District No. 2008(No. State Boise Idaho St.)

2. FULL NAME

Jemell Terry

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 39465Registered No. 94

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

M White Single (Married or Divorced)

6. DATE OF BIRTH

May 1899
(Month) (Day) (Year)

7. AGE

23 Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Laborer

9. BIRTHPLACE

(State or Country)

Genesee Idaho

10. NAME OF FATHER

Chris J Terry

11. BIRTHPLACE OF FATHER

(State or Country)

Norway

12. MAIDEN NAME OF MOTHER

Jennie Thompson

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Chas J Terry

(Address)

144 S. Main St. Lemhi Idaho

15.

Filed Oct 12 19 22

R. S. Pad
Local Registrar

MEDICAL CERTIFICATE OF DEATH

160

16. DATE OF DEATH

Oct. 11 19 22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I saw deceased from

Oct. 11 19 22 to 19

that I last saw him alive on 19

and that death occurred on the date stated above, at 8:30 am M.

The CAUSE OF DEATH* was as follows:

Suicide. Cut throat with razor

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

Chas E Summers Coroner
Boise Idaho Ada County

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Moscow IdahoOct 14 1922

20. UNDERTAKER

ADDRESS

Summers & Kuts Boise Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39466**
Registered No. **75**

1. PLACE OF DEATH

County of **Ada.**City of **Boise.**

If death occurs away from usual residence, give facts called for under special information.

Registration District No. **8**Primary Registration District No. **2008**(No. **Ada County Hospital** St.)

2. FULL NAME

George McKee.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WID-OWED OR DIVORCED
Single.
(Write the word.)

6. DATE OF BIRTH

July 14, 1838

(Month)

(Day)

(Year)

7. AGE

84 Yrs. **7** Mos. **14** ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

**Cooker on Ships
Government Employ**

9. BIRTHPLACE

(State or Country)

Iowa.

10. NAME OF FATHER

George McKee.

11. BIRTHPLACE OF FATHER

(State or Country)

Iowa.

12. MAIDEN NAME OF MOTHER

Don't Know

13. BIRTHPLACE OF MOTHER

(State or Country)

" "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wm. McBratney

(Address)

Boise, Idaho.

15.

Filed

Oct 1719**22****R. H. Pad**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

120

16. DATE OF DEATH

Oct - 15 - 1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from **Oct 15** 19**22** to **Oct 15** 19**22** that I last saw him alive on **Oct 14** 19**22** and that death occurred on the date stated above, at **2 P.M.** The CAUSE OF DEATH* was as follows:

Chronic Nephritis.(Duration) **5** Yrs. mos. ds.

Contributory (Secondary)

Cerebral Thrombosis(Duration) yrs. mos. **2** ds.

(Signed)

T. N. Bratton M. D.**10/16/22**(Address) **Boise, Idaho.**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the days. State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Morris Hill Cemetery

DATE OF BURIAL

10/17/22

20. UNDERTAKER

W. McBratney

ADDRESS

**Boise
Idaho.**

RECEIVED
NOV 3 1922

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39467**
Registered No. **96**

1. PLACE OF DEATH

County of **Ada**

City of _____

If death occurs away from
usual residence, give facts
called for under special in-
formation.Registration District No. **8**Primary Registration District No. **3008**
(No. **3 miles E of Boise** St.)

2. FULL NAME

Joe ForgesIf death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **m** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED **married**
(Write the word.)

6. DATE OF BIRTH

Feb 28 1897
(Month) (Day) (Year)

7. AGE

25 Yrs 7 Mos 23 dsIF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)**Laborer**

9. BIRTHPLACE

(State or Country)

Italy10. NAME OF
FATHER**Antonia Forges**11. BIRTHPLACE
OF FATHER

(State or Country)

Italy12. MAIDEN NAME
OF MOTHER**Mary Albuigo**13. BIRTHPLACE
OF MOTHER

(State or Country)

Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Melvinia Forges

(Address)

Barber, Idaho

15.

Filed

Oct 24 19 22**R. H. Path**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

175e

16. DATE OF DEATH

Oct 22 19 22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____ 19 _____ to _____ 19 _____
that I last saw h _____ alive on _____ 19 _____
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

**Dead when I arrived. Cause of death
as stated by those in attendance:
Injury by falling lumber**
(Duration) _____ Yrs. _____ mos. _____ ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

R. L. McCall

M. D.

_____ 19 _____ (Address) **Boise, Idaho***State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted
if not at place of death?Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery**Oct 24 1922**

20. UNDERTAKER

ADDRESS

Summers & Wife Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

OCT 31 1922

CERTIFICATE OF DEATH

39468 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics1. PLACE OF DEATH
County of Ada
City of -Registration District No. 124
Primary Registration District No. 2202
(No. - St.)File No. 21
Registered No. 51

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

James S. Rhodes

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH.

May 27 1866
(Month) (Day) (Year)

7. AGE

56 Yrs. 3 Mos. 7 ds.IF LESS than 1 day
how many hrs. or
min. 2

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....Farmer

9. BIRTHPLACE

(State or Country)

Ind -

10. NAME OF FATHER

J W Rhodes -

11. BIRTHPLACE OF FATHER

(State or Country)

Penn -

12. MAIDEN NAME OF MOTHER

Katherine Fazel

13. BIRTHPLACE OF MOTHER

(State or Country)

Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

William Rhodes -
Kuna Idaho

(Address)

15.

Filed

10 - 30, 1922 W. H. Weston

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

9 4 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Aug - 9 - 1922, to Sep - 4 - 1922, that I last saw him alive on Sep 4 1922 and that death occurred on the date stated above, at 12:00 P.M. The CAUSE OF DEATH* was as follows:Streptococcus Bronchitis(Duration) - Yrs. 5 mos. - ds.Contributory
(Secondary)(Duration) - yrs. - mos. - ds.

(Signed)

F. H. Halsey M. D.
Kuna Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Meridian Id. Sept 5 1922

20. UNDERTAKER ADDRESS

W. B. Moler Meridian

1. PLACE OF DEATH

County of Canyon
City of Arden

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED CERTIFICATE OF DEATH.

OCT 31 1922
BUREAU OF VITAL STATISTICSRegistration District No. 124Primary Registration District No. 2202

39469

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 2Registered No. 47

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

widowed
(Write the word.)

6. DATE OF BIRTH.

7 (Month) 1 (Day) 1858 (Year)

7. AGE

65 Yrs. 1 Mos. 14 ds.IF LESS than 1 day
how many.....hrs. or
.....min. 2 1

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)Invalid for about 4 years

9. BIRTHPLACE

(State or Country)

Mich -

10. NAME OF FATHER

Jacob - Inselman

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany -

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Wayne Inselman
Kuna Idaho

15.

Filed 8-17, 1922Westman
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

8 (Month) 15 (Day) 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 1 - 1922 to 8 - 15 - 1922that I last saw him alive on 8 - 11 - 1922and that death occurred on the date stated above, at 8:50 P. M.

The CAUSE OF DEATH* was as follows:

Gangrene of Left foot
& leg - (Paralyzed side)(Duration) Yrs. 8 mos. - ds.

Contributory (Secondary)

Apoplexy(Duration) Yrs. 3 mos. - ds.

(Signed)

W. J. Coleman M. D.8-15-1922 (Address) Kuna Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Kuna Idaho8-16-1922

20. UNDERTAKER

ADDRESS

W. J. RobinsonKampa

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

39470

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH **RECEIVED**
County of **Ada.** Registration District No. **104**
City of **Kuna.** Principal Registration District No. **104**
St.)

File No. **7**
Registered No. **18**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Flora Alice Clark.**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female.** 4. COLOR OR RACE **White.** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Married.**
(Write the word.)

6. DATE OF BIRTH.

Feb. **4.** **1861.**
(Month) (Day) (Year)

7. AGE

61 Yrs. **6** Mos. **19** ds.

IF LESS than 1 day
how many hrs. or
..... min.?)

8. OCCUPATION

(a) Trade, profession or particular kind of work... **House wife.**
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country) **Ind.**

10. NAME OF FATHER

Sol. Loffer.

11. BIRTHPLACE OF FATHER

(State or Country) **Ind.**

12. MAIDEN NAME OF MOTHER

Louisa Rhodes.

13. BIRTHPLACE OF MOTHER

(State or Country) **Ind.**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) **Mrs. Clara Cummings.**

(Address) **Kuna, R.No.1- Idaho.**

15.

Filed **10 - 30 1922** **Westburn**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

August. **23.** **1922.**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Feb. 6 - 1922.** to **Aug. 23 - 1922.**, that I last saw her alive on **8-23 - 1922.** and that death occurred on the date stated above, at **11.30 P.M.** The CAUSE OF DEATH* was as follows:
Carcinoma of urinary bladder.

(Duration) **1** Yrs. **6** mos. **19** ds.

Contributory
(Secondary) **--**

(Duration) yrs. mos. ds.

(Signed)

8-24-1922 (Address) **Kuna, Idaho.** **M. D.**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

124
39471State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of AdaRegistration District No. 124City of IdahoPrimary Registration District No. 124(No. 124)

St.)

File No. 49Registered No. 49

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Leslie P. Range

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

MaleWidowed

6. DATE OF BIRTH

May 26 1850
(Month) (Day) (Year)

7. AGE

74 Yrs. 4 Mos. 10 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

Housewife

9. BIRTHPLACE

(State or Country)

Wis

10. NAME OF FATHER

Simon Walker

11. BIRTHPLACE OF FATHER

(State or Country)

N. Y.

12. MAIDEN NAME OF MOTHER

Sara Noel

13. BIRTHPLACE OF MOTHER

(State or Country)

Wis

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

M. C. Walker

(Address)

Kuna, Idaho

15.

Filed

10-30-22W. C. Walker

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 6 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 1 - 1922 to Oct 6 - 1922
that I last saw her alive on Oct 6 - 1922
and that death occurred on the date stated above, at 10:30 P.M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) Yrs. mos. ds.

Contributory (Secondary) Diabetes mellitus

(Duration) Yrs. mos. ds.

(Signed) F. J. Coleman M. D.10-6-1922 (Address) Kuna

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Kuna, Idaho

DATE OF BURIAL

10-8-1922

20. UNDERTAKER

G. K. R. R.

ADDRESS

Kuna, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Ada
City of Meridian
If death occurs away from usual residence, give facts called for under special information.

RECEIVED
OCT 31 1922
BUREAU OF VITAL STATISTICS

Registration District No. 124
Registration District No. 2202
St. 39472

2. FULL NAME Daniel Weteel Saxton

File No. 2
Registered No. 50

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-OWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH July 16 1857
(Month) (Day) (Year)

7. AGE 71 2 27
Yrs. Mos. ds. IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. mechanic
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE Ohio
(State or Country)

10. NAME OF FATHER Roy Saxton

11. BIRTHPLACE OF FATHER can not tell
(State or Country)

12. MAIDEN NAME OF MOTHER " " "

13. BIRTHPLACE OF MOTHER " " "
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. A. Saxton
(Address) Meridian Ida

15. Filled 10 - 30 1922 W. B. Stevens
Local Registrar

MEDICAL CERTIFICATE OF DEATH 40

16. DATE OF DEATH Oct. 13 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 4 1922 to Oct. 13 1922
that I last saw him alive on 19
and that death occurred on the date stated above, at 7 A. M.
The CAUSE OF DEATH* was as follows:
Carcinoma of stomach

(Duration) 9 yrs. 9 mos. 0 ds.
Contributory (Secondary) Malnutrition
(Duration) 0 yrs. 0 mos. 0 ds.
(Signed) J. E. Froome M. D.
10-13-1922 (Address) Bois Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 0 yrs. 0 mos. 0 days. In the State 0 yrs. 0 mos. 0 days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Meridian cemetery DATE OF BURIAL Oct 15 1922

20. UNDERTAKER W. B. Mateer ADDRESS Meridian Idaho

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH *Ada* RECEIVED
Registration District No. *2*
County of *Ada* NOV 3 1922
City of *Boise* BUREAU OF VITAL STATISTICS
If death occurs away from usual residence, give facts called for under special information.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. *39473*
Registered No. *758*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Thomas D. Combs

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M.* 4. COLOR OR RACE *White.* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*

6. DATE OF BIRTH

Dec 31 1894
(Month) (Day) (Year)

7. AGE

77 Yrs. *9* Mos. *28* ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Retired

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

Alexander Combs

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Nora Dyer

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Harry Schrobo

(Address)

Boise Idaho

15.

Filed

Oct 24 1922

R. H. Park
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 19 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 7 1922 to Oct 19 1922

that I last saw him alive on *Oct 19 1922*

and that death occurred on the date stated above, at *6:15* M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) Yrs. mos. *12* ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

A. H. Hager M. D.

1014 1922 (Address) *Boise Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Morris Hill Cem.

DATE OF BURIAL

Oct 25 1922

20. UNDERTAKER

Sumner & Schrobo

ADDRESS

Boise Idaho

1. PLACE OF DEATH		RECEIVED		CERTIFICATE OF DEATH		State of Idaho	
County of <u>Ada</u>		Registration District No. <u>2</u>		BUREAU		BOARD OF HEALTH	
City of <u>Bonanza</u>		Primary Registration District No. <u>1004</u>				Bureau of Vital Statistics	
		(No. <u>51</u>)				File No. <u>39474</u>	
If death occurs away from usual residence, give facts called for under special information.		2. FULL NAME <u>Albert Hea Liggott</u>				Registered No. <u>1930</u>	

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

PERSONAL AND STATISTICAL PARTICULARS			
3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED <u>Single</u> (Write the word.)	
6. DATE OF BIRTH <u>March 5</u> 19 <u>22</u> (Month) (Day) (Year)			
7. AGE <u>3</u> Yrs. <u>5</u> Mos. <u>5</u> ds.		IF LESS than 1 day how many..... hrs. or..... min.?	
8. OCCUPATION (a) Trade, profession or particular kind of work. <u>none</u> (b) General nature of industry, business or establishment in which employed (or employer).			
9. BIRTHPLACE (State or Country) <u>Cammet</u>			
10. NAME OF FATHER <u>Albert Liggott</u>			
11. BIRTHPLACE OF FATHER <u>Wash.</u>			
12. MAIDEN NAME OF MOTHER <u>Kettie Godsey</u>			
13. BIRTHPLACE OF MOTHER <u>Texas</u>			
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Albert Liggott</u> (Address) <u>Cammet, Ida</u>			
15. Filed <u>8-10</u> 19 <u>22</u> <u>R. W. Pratt</u> Local Registrar			

16. DATE OF DEATH

8 (Month) 10 (Day) 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8/9 1922, to 8/10 1922 that I last saw him alive on 8/9 1922 and that death occurred on the date stated above, at 1200 A.M.
The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) Yrs. mos. ds.
Contributory (Secondary) Acute appendicitis
(Duration) yrs. mos. 3 ds.
(Signed) Fred R. Liggott M. D.
8/10 1922 (Address) Bonanza, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days.
Where was disease contracted if not at place of death?
Former or usual residence Cammet

19. PLACE OF BURIAL OR REMOVAL <u>Middleton, Ida</u>	DATE OF BURIAL <u>8-10</u> 19 <u>22</u>
20. UNDERTAKER <u>Schriber & Lidenfeld, Boise</u>	ADDRESS <u>Boise</u>

CERTIFICATE OF DEATH

1. PLACE OF DEATH *Nov 3*County of *Ida*
City of *Boise*

If death occurs away from usual residence, give facts called for under special information.

Registration District No. *2*Primary Registration District No. *1004*
(No. *Soldiers Name*, St.)State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *39475*Registered No. *233*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Alexander Ineton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M.* 4. COLOR OR RACE *W.* 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED *Single*
(Write the word.)

6. DATE OF BIRTH

July 15, 1839
(Month) (Day) (Year)

7. AGE

83 Yrs. *2* Mos. *17* ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)*Farmer*

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

John Ineton

11. BIRTHPLACE OF FATHER

(State or Country)

New Jersey

12. MAIDEN NAME OF MOTHER

Sarah Hadley

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wm. McBratney

(Address)

Boise, Idaho

15.

Filed

*Oct 3 1922**R. N. Pad*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct - 2 - 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

*Sept 1 1922 to Oct 2 1922*that I last saw him alive on *Oct 1 1922*

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) *Thos. H. Pugh* M. D.*10/2/22* (Address) *Boise, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Morris Hill Cemetery

DATE OF BURIAL

10/4 1922

20. UNDERTAKER

Wm. McBratney

ADDRESS

Boise, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Pittinger
State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
39476
92468

1. PLACE OF DEATH

County of *Ada* RE.
City of *Boise* NU

Registration District No. *2*
Primary Registration District No. *1004*
(No. *4102N* State St.)

Registered No. *226*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Edgar Leroy Harward

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

m *White* *Single*
(Write the word.)

6. DATE OF BIRTH

Aug 2-1867
(Month) (Day) (Year)

7. AGE

5-5 Yrs. *1* Mos. *4* ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. *Journalist*
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) *Iowa*

10. NAME OF FATHER

Leroy S Harward

11. BIRTHPLACE OF FATHER

(State or Country) *Iowa*

12. MAIDEN NAME OF MOTHER

Mary E Lay

13. BIRTHPLACE OF MOTHER

(State or Country) *Iowa*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Geo. S Harward*
(Address) *Irwin Falls, Idaho*

15.

Filed *10-7* 19*22* *R. S. Piatt*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

10 (Month) *7* (Day) 19*22* (Year)

17. I HEREBY CERTIFY, That I attended deceased from

10/4 19*22* to *10/6* 19*22*
that I last saw *him* alive on *10/6* 19*22*
and that death occurred on the date stated above, at *9:20 P.M.*
The CAUSE OF DEATH* was as follows:

Starvation

(Duration) Yrs. mos. ds.

Contributory (Secondary) *Obstruction of Stomach*

(Duration) Yrs. mos. ds.

(Signed) *Frank A. Pittinger* M. D.

10/7 19*22* (Address) *Boise Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Morris Hill Cemetery Oct 8, 1922

UNDERTAKER

Summers & Tribe Boise Idaho

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
NOV 8 1922

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No.

Primary Registration District No.

(No. Mitchell Hotel, St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 39477

Registered No. 238

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at P. M.

The CAUSE OF DEATH* was as follows:

Contributory (Secondary)

Signed

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39478**
Registered No. **239**

1. PLACE OF DEATH

County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. 410 State Idaho St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Charles Richards Veatch

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Boy 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

March 17 1919
(Month) (Day) (Year)

7. AGE

Three Yrs. Six Mos. 23 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Minor
None

9. BIRTHPLACE

(State or Country)

Ada County, Idaho

10. NAME OF FATHER

John W. Veatch

11. BIRTHPLACE OF FATHER

(State or Country)

Salem, Marion County, Oregon

12. MAIDEN NAME OF MOTHER

Emma A. Bauer

13. BIRTHPLACE OF MOTHER

(State or Country)

Pitts County, Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John W. Veatch
(Address) Boise, Ada County, Idaho

15.

Filed 10-11 1922

R. L. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

October 10 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 7, 1922 to Oct 10th 1922 that I last saw him alive on Oct 10, 1922 and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Perforative, gangrenous appendicitis with resulting general peritonitis of streptococcal variety.

(Duration) Yrs. mos. ds.

Contributory (Secondary) Wated too long before having operation.

(Duration) yrs. mos. ds.

(Signed) L. P. McCalla M. D.

10/11, 1922 (Address) Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

Ada County

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Morris Hill Cemetery 10/12, 1922

20. UNDERTAKER

ADDRESS

Shriebo & Sidenpader Boise

D. McCalla

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Ada
City of BoiseRegistration District No. 2Primary Registration District No. 1004(No. 410 State Idaho St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Alice B. SuttonState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 39479Registered No. 240

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH

Nov 1st 1873
(Month) (Day) (Year)

7. AGE

48 Yrs. 11 Mos. 10 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)housewife

9. BIRTHPLACE

(State or Country)

Tenn

10. NAME OF FATHER

Wm Webb

11. BIRTHPLACE OF FATHER

(State or Country)

Tenn

12. MAIDEN NAME OF MOTHER

Sanfrica L. Oys.

13. BIRTHPLACE OF MOTHER

(State or Country)

Tenn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Chas W. Sutton

(Address)

Boise Idaho

15.

Filed 10-11 1922P. H. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 11th 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Oct 9th 1922 to Oct 10th 1922that I last saw her alive on Oct 10th 1922and that death occurred on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy
3d attack in two years(Duration) 2 Yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Jos. R. Newcomb M. D.10/11 1922 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

Ada County

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery 10/13 1922

20. UNDERTAKER

ADDRESS

Schubert & Sidenfaden Boise

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39480**Registered No. **242**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of **Ada**
City of **Boise**

If death occurs away from usual residence, give facts called for under special information.

Registration District No. **2**Primary Registration District No. **1004**(No. **St Lukes Hospital** St.)

2. FULL NAME

Gunder Rogstad

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **M** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED **Single**
(Write the word.)

6. DATE OF BIRTH

1859 1 (Month) (Day) (Year)

7. AGE

63 Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).**Labour**

9. BIRTHPLACE

(State or Country)

Norway

10. NAME OF FATHER

Jens Rogstad

11. BIRTHPLACE OF FATHER

(State or Country)

Norway

12. MAIDEN NAME OF MOTHER

Guren Arnesdatter

13. BIRTHPLACE OF MOTHER

(State or Country)

Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Sverin Rogstad

(Address)

North Bend Oregon

15.

Filed **Oct 11** 19**22****R. N. Prad**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 10 19**22**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 1 19**22** to **Oct 10** 19**22**
that I last saw him alive on **Oct 10** 19**22**
and that death occurred on the date stated above, at **7 P** M.

The CAUSE OF DEATH* was as follows:

Dilatation of heart

(Duration) Yrs. mos. ds.

Contributory
(Secondary)**Asthma - Emphysema**

(Duration) yrs. mos. ds.

(Signed)

L. H. Bank M. D.

19

(Address)

Boise Id

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery Oct 13 1922

20. UNDERTAKER

ADDRESS

Summers & Krebs Boise Idaho

CERTIFICATE OF DEATH

1. PLACE OF DEATH
 County of Ada
 City of Boise

Registration District No. 2
 Primary Registration District No. 1004
 (No. 1507 Broadway St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Helen Cantral

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 39481
 Registered No. 243

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
 (Write the word.)

6. DATE OF BIRTH

Oct-12-1922
 (Month) (Day) (Year)

7. AGE

IF LESS than 1 day
 how many 5 hrs.
 or — min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Boise Idaho

10. NAME OF FATHER

J. H. Cantral

11. BIRTHPLACE OF FATHER

(State or Country)

Arkansas

12. MAIDEN NAME OF MOTHER

Lusie Fulton

13. BIRTHPLACE OF MOTHER

(State or Country)

Arkansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. McBratney

(Address)

Boise Idaho

15.

Filed 10-13 1922

R. H. Galt
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct-12-1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 12 - 1922 to Oct 12 - 1922

that I last saw her alive on Oct 12 - 1922

and that death occurred on the date stated above, at 9:20 M.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) — Yrs. — mos. — ds.

Contributory
 (Secondary)

Immature

(Duration) — yrs. — mos. — ds.

(Signed)

M. Allen Galloway

M. D.

10/12

(Address)

Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death — yrs. — mos. — days. In the State — yrs. — mos. — days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

County Cemetery

DATE OF BURIAL

10/13-22

20. UNDERTAKER

W. McBratney

ADDRESS

Boise, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
NOV 3 1922

CERIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39482**Registered No. **244**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

Registration District No. **2**Primary Registration District No. **1904**(No. **1309 East Jefferson** St.)

2. FULL NAME

Rosecoe P. Jones

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED**M.****White****Married**

6. DATE OF BIRTH

Aug 17

(Month)

(Day)

(Year)

7. AGE

34

Yrs.

1

Mos.

25

ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Lumberman

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Kansas

10. NAME OF FATHER

John W. Jones

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Rosetta Lighnor

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. R. P. Jones

(Address)

1309 E. Jefferson

15.

Filed

Oct 14 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 12

(Month)

(Day)

1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

May - 12 1922 to **Oct 12 1922**that I last saw him alive on **Oct 12 1922**and that death occurred on the date stated above, at **9 A. M.**

THE CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

R. J. Blum M. D.**10-17-1922**

(Address)

Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

yrs.

mos.

days

In the

State

yrs.

mos.

days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery**Oct 15 1922**

20. UNDERTAKER

ADDRESS

Summers & Krebs**Boise Idaho**

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Ida Registration District No. 2
 City of Boise Primary Registration District No. 1004
 (No. 815 Hayes St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

April Nixon

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 39483

Registered No. 245

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE White. 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED Married

6. DATE OF BIRTH

Feb 12 1 857
 (Month) (Day) (Year)

7. AGE

65 Yrs. 8 Mos. 1 ds.

IF LESS than 1 day
 how many..... hrs.
 or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

Draftsman

9. BIRTHPLACE

(State or Country) Sweden.

10. NAME OF FATHER

Unknown.

11. BIRTHPLACE OF FATHER

(State or Country) Sweden

12. MAIDEN NAME OF MOTHER

Unknown.

13. BIRTHPLACE OF MOTHER

(State or Country) Sweden.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harry Stubs

(Address) Boise, Ida.

15.

Filed Oct 14 19 22

R. N. Prady
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 19 22
 (Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from

Oct 9 19 22 to Oct 13 19 22
 that I last saw him alive on Oct 13 19 22
 and that death occurred on the date stated above, at 3:00 M.

The CAUSE OF DEATH* was as follows:

Exhaustion & failure of
Heart - further diagnosis
not able to make

(Duration) Yrs. mos. 4 ds.

Contributory (Secondary) none

(Duration) Yrs. mos. ds.

(Signed) Wm B. Symon M. D.

10/13/1922 (Address) 729 N. Main St

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Moore's Steel Team Oct 15 19 22

20. UNDERTAKER

ADDRESS

Summers & Grebb Boise Idaho.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada
City of BoiseRegistration District No. 2
Primary Registration District No. 1994
(No. Soldiers Home St.)File No. 39484
Registered No. 246

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Henry William Copp

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widower
(Write the word.)

6. DATE OF BIRTH

May 13 1840
(Month) (Day) (Year)

7. AGE

82 Yrs. 5 Mos. 0 ds.

IF LESS than 1 day

how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Salesman

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Mass

10. NAME OF FATHER

Henry W. Copp

11. BIRTHPLACE OF FATHER

(State or Country)

Mass

12. MAIDEN NAME OF MOTHER

Hanna Coombe

13. BIRTHPLACE OF MOTHER

(State or Country)

Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Kalter H. Copp
(Address) 1017 Harrison Blvd

15.

Filed 10-17 19 22 R. V. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct. 15 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Oct. 15 1922 to 19that I last saw him alive on 19
and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Chas. E. Summers M. D.
10/16 1922 (Address) Boise Idaho Ada County

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Portland Ore Oct 18 1922

20. UNDERTAKER

ADDRESS

Summers & Krebs Boise Id.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of IdahoCity of IdahoRegistration District No. 2Primary Registration District No. 1004

(No. _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 39485Registered No. 247

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Alexis Lester

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single

6. DATE OF BIRTH

Oct 27 1922
(Month) (Day) (Year)

7. AGE

19 Yrs. 7 Mos. 24 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Student

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Myron Lester

11. BIRTHPLACE OF FATHER

(State or Country)

Illinois

12. MAIDEN NAME OF MOTHER

Martha Hartnett

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Harry Stebb

(Address)

Regier Idaho

15.

Filed 10-17 1922R. H. Prith
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 20 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct. 15 1922 to 19that I last saw him _____ alive on _____ 1922

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Suicide. Drowned in Boise River

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Chas E Sumner Corcoran
10/16/19 22 Address Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery Oct 17 1922

20. UNDERTAKER

ADDRESS

Summers & Tule Boise Id

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39486**

1. PLACE OF DEATH

County of Ada Registration District No. 2
City of Bonanza Primary Registration District No. 1004
(No. 410 State Idaho) St. Idaho

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Juanita Lucia (Jack) Moore
If death occurred in a hospital, institution or camp, give name instead of number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

10-19 1922R. H. Pratt
Local Registrar

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from Sept. 23 1922 to Sept 24 1922
that I last saw him alive on Sept 24 1922
and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis with hemorrhage.Contributory
(Secondary)

(Signed)

Oct 19 1922

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs mos days In the State yrs mos days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Ada
City of Boise

If death occurs away from usual residence, give facts called for under special information.

RECEIVED CERTIFICATE OF DEATH

NOV 8

Registration District No. 2Primary Registration District No. 1004Primary Registration District No. 1004

ST. JOHNS HOSPITAL

St. John's Hospital St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 39488Registered No. 251

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Augustus S. Whiteway

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

married
(Write the word.)

6. DATE OF BIRTH

Oct 1

(Month)

(Day)

1864
(Year)

7. AGE

38 Yrs. 0 Mos. 18 ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

Building Contractor

9. BIRTHPLACE

(State or Country)

St Johns New Foundland

10. NAME OF FATHER

Robert Whiteway

11. BIRTHPLACE OF FATHER

(State or Country)

New Foundland

12. MAIDEN NAME OF MOTHER

Emma Anne Tuff

13. BIRTHPLACE OF MOTHER

(State or Country)

New Foundland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Augustus S. Whiteway(Address) Bozeman Apt #31 Boise, Id.

15.

Filed 10-20 1922R. W. Pratt

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct

(Month)

19

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 7 1922 to Oct 19 1922that I last saw him alive on Oct 19 1922and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

General PeritonitisChronic Peritonitis

(Duration)

Yrs.

mos.

13 ds.

Contributory (Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

Jacob H. Stewart M. D.

10/19/22

(Address)

1200 Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill CemeteryOct 22 1922

20. UNDERTAKER

ADDRESS

Summers & Krebs Boise Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39489**Registered No. **252**If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

1. PLACE OF DEATH

County of **Ada**City of **Boise**Registration District No. **2**Primary Registration District No. **1004**(No. **St. Alphonsus Hospital** St.)If death occurs away from
usual residence, give facts
called for under special in-
formation.2. FULL NAME **John Frank Nesbitt**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **M.** 4. COLOR OR RACE **W.** 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED **Single**
(Write the word.)

6. DATE OF BIRTH

Oct 18 - 1913.
(Month) (Day) (Year)

7. AGE

9 Yrs. **1** Mos. **1** ds.IF LESS than 1 day
how many..... hr.
or..... min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer).**In School.**

9. BIRTHPLACE

(State or Country)

Idaho.10. NAME OF
FATHER**J. H. Nesbitt.**11. BIRTHPLACE
OF FATHER

(State or Country)

Don't Know12. MAIDEN NAME
OF MOTHER**Martha Beech.**13. BIRTHPLACE
OF MOTHER

(State or Country)

Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wm McBratney

(Address)

Boise Idaho.

15.

Filed **10-20-1922****T. H. Cratt**
Local RegistrarMEDICAL CERTIFICATE OF DEATH **20**

16. DATE OF DEATH

Oct - 19 - 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
Oct 15th 1922 to **Oct 19th 1922**
that I last saw him alive on **Oct 19th 1922**
and that death occurred on the date stated above, at **10 P.M.**

The CAUSE OF DEATH* was as follows:

**Blood Poisoning
following an injury -**

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

(Address) **Boise Idaho***State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Morris Hill Cemetery

DATE OF BURIAL

10/21 1922

20. UNDERTAKER

Wm McBratney

ADDRESS

Boise Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH
in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39490**
Registered No. **253**

1. PLACE OF DEATH **RECEIVED**Registration District No. **2**County of **Ada**Primary Registration District No. **1004**City of **Boise**(No. **617** **Washington** St.)

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Antonio Gabriola

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH **92**

3. SEX

Male

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCED**Single**
(Write the word.)

6. DATE OF BIRTH

Oct 7 1922
(Month) (Day) (Year)

7. AGE

16 Yrs. **—** Mos. **—** ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

none

9. BIRTHPLACE

(State or Country)

Boise Id10. NAME OF
FATHER**Manuel Gabriola**11. BIRTHPLACE
OF FATHER

(State or Country)

Spain12. MAIDEN NAME
OF MOTHER**Dolores Aspieri**13. BIRTHPLACE
OF MOTHER

(State or Country)

Spain

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Manuel Gabriola

(Address)

Boise Id

15.

Filed **10-23 1922****R. L. Pratt**
Local Registrar

16. DATE OF DEATH

Oct. 23 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct. 21 1922 to **Oct 23 1922**that I last saw **him** alive on **Oct 22 1922**

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) **Dr. Campbell** M. D.

.....19..... (Address).....

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St John Cemetery**Oct 24 1922**

20. UNDERTAKER

ADDRESS

Schreiber & Widensader**Boise Id**

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39492**
Registered No. **25**

1. PLACE OF DEATH

County of **Ada**
City of **Baese**

Registration District No. **2**
Primary Registration District No. **1004**
(No. **Winkler Hotel** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Pelle Thinge Myrness

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **M.** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Married**

6. DATE OF BIRTH **Mar 30 1880**
(Month) (Day) (Year)

7. AGE **42 Yrs 6 Mos 25 ds.** IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION **Warehouse man for Construction Co.**

9. BIRTHPLACE **Minnesota**
(State or Country)

10. NAME OF FATHER **Olaf N. Myrness**

11. BIRTHPLACE OF FATHER **Norway**
(State or Country)

12. MAIDEN NAME OF MOTHER **Catherine**

13. BIRTHPLACE OF MOTHER **Norway**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Harry J. G. G. G.**
(Address) **Boise Idaho.**

15. Filed **Oct 26 1922**

R. N. G. G.
Local Registrar

MEDICAL CERTIFICATE OF DEATH **56**

16. DATE OF DEATH **Oct 25 1922**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I **saw** deceased from **October 26 1922** to **19** that I last saw him **alive on** **19** and that death occurred on the date stated above, at **10 P.M.**

The CAUSE OF DEATH* was as follows:

Acute Alcoholism

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) **Chas E. Summers**

10/27 1922 (Address) **Boise Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Morris Nielsen **19**

20. UNDERTAKER ADDRESS

Summers & Sons **Boise Idaho**

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39493**

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of AdaCity of Boise

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No. 2Primary Registration District No. 1004(No. St. Lukes Hospital St.)Henry L. Mulder

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

(Year)

7. AGE

36 Yrs.

— Mos.

— ds.

If LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

Carpenter

9. BIRTHPLACE

(State or Country)

Not Known

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Wm M. BratneyBoise, Ida.

15.

Filed

10-271922R. H. Pratt

Local Registrar

MEDICAL CERTIFICATE OF DEATH

13. DATE OF DEATH

Oct-25-1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

October 17th 1922 to October 25th 1922that I last saw him alive on October 25 1922

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Hemorrhage in Intestinal Capillary

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

John Bratney M. D.
10/27 1922 (Address) Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

County Cemetery10/27 1922

20. UNDERTAKER

ADDRESS

Wm M. BratneyBoiseIdaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada

City of _____

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2Primary Registration District No. 1004(No. Walders Idaho St.)File No. 39494Registered No. 25

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Alexander J. Hofflinger

MEDICAL CERTIFICATE OF DEATH

68

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widower

6. DATE OF BIRTH

1837
(Month) (Day) (Year)

7. AGE

85 Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Machinist

9. BIRTHPLACE

(State or Country)

France

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. B. Mearns
1301 E. Idaho, Walders, Idaho15. Filed Oct 27 1922

Local Registrar

16. DATE OF DEATH

10 (Month) 27 (Day) 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 1 1922 to 10/27 1922
that I last saw him alive on 10/24 1922
and that death occurred on the date stated above, at 7 A M.

The CAUSE OF DEATH* was as follows:

Senile Dementia

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Frederic A. Pugh M. D.10/27 1922 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Washington, D. C. Oct 28, 1922

20. UNDERTAKER

ADDRESS

Sumner & Tref Boise Idaho

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

NOV 3 1922

FALLMAN
CERTIFICATE OF DEATH

1. PLACE OF DEATH Idaho Union District No. 2
 County of Blaine State Idaho Primary Registration District No. 1004
 City of Boise (No. St. Alphonsus Hospitals St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William E. Allen

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 39495
 Registered No. 232

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED Married

6. DATE OF BIRTH Sep 17 1 86
 (Month) (Day) (Year)

7. AGE 61 Yrs. 14 Mos. 14 ds. IF LESS than 1 day
 how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

Farmer

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

John Allen

11. BIRTHPLACE OF FATHER

(State or Country)

Kentucky

12. MAIDEN NAME OF MOTHER

Nannie Doe

13. BIRTHPLACE OF MOTHER

(State or Country)

Florida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Meysers E. Allen

(Address)

15.

Filed 10-2 19 22

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 1 19 22
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Oct 1921 19 to Oct 1 19 22
 that I last saw him alive on Oct 1 19 22
 and that death occurred on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Gangrene of leg due to embolism(Duration) 22 Yrs. 12 mos. 12 ds.

Contributory (Secondary)

Coronary Arteriosclerosis(Duration) 10 yrs. 10 mos. 10 ds.

(Signed)

M. H. Tallman

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Star Cemetery Oct 3 19 22

20. UNDERTAKER

ADDRESS

Seamans & Co. Boise Ida.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada
City of BoiseRegistration District No. 2Primary Registration District No. 1004(No. 1276 E. Jefferson St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

David R. SangFile No. 39496Registered No. 234

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH

Mar. 5 - 1875
(Month) (Day) (Year)

7. AGE

47 Yrs. 6 Mos. 27 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Merchant

9. BIRTHPLACE

(State or Country)

Mich.

10. NAME OF FATHER

Hugh Sang.

11. BIRTHPLACE OF FATHER

(State or Country)

N. C.

12. MAIDEN NAME OF MOTHER

Emma Reynolds.

13. BIRTHPLACE OF MOTHER

(State or Country)

Minn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wm McBratney
Boise Idaho.

(Address)

15.

Filed 10-3 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct - 3 - 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 1 1921 to Oct 3 1922
that I last saw him alive on Oct 2 1922
and that death occurred on the date stated above, at 12:50 M.

The CAUSE OF DEATH* was as follows:

Carcinoma - multiple.(Duration) 0 Yrs. 4 mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. L. Frazer M. D.
1922 (Address) Boise, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Marion Hill Cemetery

DATE OF BURIAL

10/4 1922

20. UNDERTAKER

W. L. Frazer

ADDRESS

Boise Idaho.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Budge,

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada
City of BoiseRegistration District No. 2Primary Registration District No. 1004
(No. 1213 E. Hays, St.)File No. 39497Registered No. 237

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ira May Miller

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the words)

6. DATE OF BIRTH

May 27 1899
(Month) (Day) (Year)

7. AGE

23 Yrs. 4 Mos. 11 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)At Home

9. BIRTHPLACE

(State or Country)

Mo.

10. NAME OF FATHER

E. J. Hargyard

11. BIRTHPLACE OF FATHER

(State or Country)

Mo.

12. MAIDEN NAME OF MOTHER

Amanda Chambers

13. BIRTHPLACE OF MOTHER

(State or Country)

Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wm A Miller

(Address)

1213 E. Hays

15.

Filed 10-9 1922R. H. Pratt
Local Registrar

20. UNDERTAKER

19. PLACE OF BURIAL OR REMOVAL

Morris Hill Lumber
Summers & Truitt Boise Idaho

DATE OF BURIAL

Oct 10 1922

ADDRESS

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 8 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 19 21 to Oct 8 19 22that I last saw her alive on Oct 8 19 22and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

acute gastritis(Duration) Yrs. 2 mos. 2 ds.Contributory
(Secondary)mitral insufficiency(Duration) 2 yrs. 2 mos. 2 ds.(Signed) M. H. Tallman M. D.(Address) Boise, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Ada*
City of *Boise*Registration District No. *2*
Primary Registration District No. *1004*
(No. *410* State *Idaho* St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Eva (Booker) Wander*File No. **39498**Registered No. *241*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*
(Write the word.)

6. DATE OF BIRTH

June 21 1888
(Month) (Day) (Year)

7. AGE

34 Yrs. *20* Mos. *ds.*IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)*Housewife*

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

Samuel B. Booker

11. BIRTHPLACE OF FATHER

(State or Country)

Pa.

12. MAIDEN NAME OF MOTHER

Ella Martin

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Frank Wander*
(Address)

15.

Filed *10-12* 19*22**G. H. Pratt*
Local Registrar

16. DATE OF DEATH

Oct 11 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *Aug 27 1922* to *Oct 11 1922*
that I last saw her alive on *Oct 11 1922*
and that death occurred on the date stated above, at *9:30 PM*

The CAUSE OF DEATH* was as follows:

Puerperal Eclampsia(Duration) Yrs. mos. ds.
Contributory (Secondary) *Pregnancy*(Duration) yrs. mos. ds.
(Signed) *J. Carl Hill* M. D.*10/2 1922* (Address) *Boise Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence *Boise Idaho*

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Harris Hill *10/13 1922*

20. UNDERTAKER ADDRESS

Schreiber & Biddeford *Boise Idaho*

CERTIFICATE OF DEATH

1. PLACE OF DEATH *Ada,*
County of *Boise,*
City of *Boise,*

If death occurs away from usual residence, give facts called for under special information.

Registration District No. *2*
Primary Registration District No. *1094*
(No. *St. Alphonsus Hospital St.*)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. *39499*
Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME *Baby M. Mahone*

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *F* 4. COLOR OR RACE *W.* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*
(Write the word.)

6. DATE OF BIRTH *Oct-28-1922*
(Month) (Day) (Year)

7. AGE *1 hour*
Yrs. Mos. ds. *1* LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

None.

9. BIRTHPLACE *Boise - Idaho,*
(State or Country)

10. NAME OF FATHER *James M. Mahone*

11. BIRTHPLACE OF FATHER *Utah.*
(State or Country)

12. MAIDEN NAME OF MOTHER *Evelyn Harker*

13. BIRTHPLACE OF MOTHER *Utah.*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Wm. M. Bratney*
(Address) *Boise Idaho.*

15. Filed *10-28-1922* *R. H. Pratt*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *Oct-28-1922*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Oct 28* 19 *22* to *Oct 28* 19 *22*
that I last saw her alive on *Oct 28* 19 *22*
and that death occurred on the date stated above, at *5 A.* M.

The CAUSE OF DEATH* was as follows:

Premature separation of placenta. Death was caused by hemorrhage thru cord before birth.
(Duration) Yrs. mos. / ds.

Contributory (Secondary) _____
(Duration) yrs. mos. / ds.

(Signed) *M. H. Tallman* I. M. D.
10/28/22 (Address) *Boise, Idaho.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL *Morris Hill Cemetery* DATE OF BURIAL *10/28/22*

20. UNDERTAKER *W. M. Bratney* ADDRESS *Boise Idaho.*

RECEIVED *Bratt* NOV 3 1922 CERTIFICATE OF DEATH

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Ada*City of *Boise*

If death occurs away from
 usual residence, give facts
 called for under special in-
 formation.

Registration District No. *2*Primary Registration District No. *1004*(No. *Ada County Hospital*)File No. *39500*Registered No. *200*

If death occurred in a hos-
 pital, institution or camp,
 give its NAME instead of
 street and number.

2. FULL NAME *Julia A. Hitching*

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *F*4. COLOR OR RACE *White*5. SINGLE, MARRIED, WID-
OWED OR DIVORCED *Married (w/da)*

6. DATE OF BIRTH

April 30

(Month)

(Day)

(Year)

7. AGE

67 Yrs. *5* Mos. *29* ds.

IF LESS than 1 day
 how many..... hrs.
 or..... min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work *At Home*(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country) *Missouri*10. NAME OF
FATHER *Caldwell*11. BIRTHPLACE
OF FATHER

(State or Country)

12. MAIDEN NAME
OF MOTHER *Mankins*13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Harry S. Grubbs*(Address) *Boise Idaho*

15.

Filed *10-31* *1922*

R. H. Pratt
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 29 *1922*
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Oct 1 *1922* to *Oct 29* *1922*

that I last saw her alive on *Oct 28* *1922*
 and that death occurred on the date stated above, at *4 A* M.

The CAUSE OF DEATH* was as follows:

Chronic Arthritis(Duration) *10* Yrs. mos. ds.Contributory (Secondary) *Myocarditis*(Duration) yrs. *3* mos. ds.(Signed) *J. N. Brattan*

M. D.

19. (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state
 (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
 if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Morris Hill Cem.

DATE OF BURIAL

Oct 30 *1922*

20. UNDERTAKER

Sumner S. Grubbs

ADDRESS

Boise Idaho

FORM V. S. NO. 5-25 M. 1-19.

CERTIFICATE OF DEATH

39501

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of BlaineCity of Pocatello

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No.

Primary Registration District No.

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
19 to 19

that I last saw him alive on 19

and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) M. D.

19 (Address)

*State the Disease Causing Death or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS

CERTIFICATE OF DEATH

39502

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock Registration District No. 1
 City of Poe (St.) St. Anthony Hospital

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Leopold NicoleFile No. 54Registered No. 3923

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH Jan 18 1899
(Month) (Day) (Year)

7. AGE 23 Yrs. 7 Mos. 25 ds.
IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer).

unknown

9. BIRTHPLACE

(State or Country)

Quebec Canada

10. NAME OF FATHER

Alphonse Nicole

11. BIRTHPLACE OF FATHER

(State or Country)

Quebec Canada

12. MAIDEN NAME OF MOTHER

unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Antonio Nicole
Quebec City Canada

15.

Filed

9-25-22

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 13 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Sept 9 1922, to Sept 13 1922
that I last saw him alive on Sept 13 1922
and that death occurred on the date stated above, at 11:45 A.M.

The CAUSE OF DEATH* was as follows:

Encepholitis Lethargica
(Sleeping Sickness)

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Carl W. Clark M. D.

9/29 1922 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mountain ViewSept 26 1922

20. UNDERTAKER

ADDRESS

SchumacherIdaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED
OCT 21 1922

CERTIFICATE OF DEATH

39503

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Bannock* Registration District No. *2*
City of *Castello* (No. *536* W Lewis St.)If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

*Mary Jane Murphy*If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED *Widowed*
(Write the word.)6. DATE OF BIRTH *Apr 21 1862*
(Month) (Day) (Year)7. AGE *60* Yrs *4* Mos *9* ds. IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)*Housekeeper*

9. BIRTHPLACE

(State or Country)

Canada

10. NAME OF FATHER

Charles Furey

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Ann Hughes

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mary Florence Murphy*
(Address) *626 W Lewis*15. Filed *8/1* 1922

Local Registrar

16. DATE OF DEATH

Aug 30 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19
that I last saw h. or alive on *Aug 30 1922*
and that death occurred on the date stated above, at *6 P. M.*
The CAUSE OF DEATH* was as follows:*Chronic Interstitial Nephritis*
Chronic Myocarditis(Duration) Yrs. mos. ds.
Contributory *Acute Cardiac Disturbance*
(Secondary)(Duration) Yrs. mos. ds.
(Signed) *Thos. F. Mullen* M. D.*Exp 19 22* (Address) *Law Bldg.**State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mountain View *Aug 2 1922*

20. UNDERTAKER

ADDRESS

Schumacher & Hay *Castello*

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH
in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED
OCT 21 1922

CERTIFICATE OF DEATH

39504

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County *Bannock* Registration District No. *28*
City *Pocatello* Hospital District No. *2141*
*General Hospital*File No. *53*
Registered No. *3906*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Gasquale Francione
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *Italian* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*
(Write the word.)

6. DATE OF BIRTH

1874
Exact date unknown
(Month) (Day) (Year)

7. AGE

48
Yrs. Mos. ds.
IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).*Boiler Washer*
O.S. L.R.R.

9. BIRTHPLACE

(State or Country)

Italy

10. NAME OF FATHER

Francione

11. BIRTHPLACE OF FATHER

(State or Country)

Italy

12. MAIDEN NAME OF MOTHER

unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Young Francione

(Address)

454 Nor Haven

15.

Filed

9/2 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

9 - 2
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

7 - 15 19*22*, to *7 - 2* 19*22*
that I last saw him alive on *9 - 2* 19*22*,
and that death occurred on the date stated above, at *119 M.*

The CAUSE OF DEATH* was as follows:

Septicaemia
(Duration) Yrs. *2* mos. ds.Contributory
(Secondary)*Wound L. hand*

(Duration) Yrs. mos. ds.

(Signed) *J. J. Young* M. D.*9/2 1922* (Address) *Pocatello*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mountain View *Oct 3 1922*

20. UNDERTAKER

ADDRESS

Schumacher *Pocatello*

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

39505

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH *Home* Registration District No. *28*
 County of *Bannock* Registration District No. *2-16-1*
 City of *Pocatello* (St.)
 If death occurs away from usual residence, give facts called for under special information.
 2. FULL NAME *Marquary Carlisle*
 If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*
 (Write the word)

16. DATE OF DEATH *Sept 5th 1922*
 (Month) (Day) (Year)

6. DATE OF BIRTH *Feb 15 1865*
 (Month) (Day) (Year)

7. AGE *57* Yrs. *6* Mos. *21* ds.
 IF LESS than 1 day how many... hrs. or... min.?

17. I HEREBY CERTIFY That I attended deceased from *Sept 1921* to *Sept 5th 1922*
 that I last saw her alive on *Sept 5th 1922*
 and that death occurred on the date stated above, at *5 p.m.*

The CAUSE OF DEATH* was as follows:

Cancer of uterus

8. OCCUPATION *Nursewife*
 (a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE *Utah*
 (State or Country)

(Duration) *2* Yrs. mos. ds.
 Contributory (Secondary) *metastasis in bladder*
 (Duration) yrs. mos. ds.

10. NAME OF FATHER *Henry Stewart*

(Signed) *Dr. Lynn* M. D.
Sept 6th 1922 (Address) *Pocatello Ida.*

11. BIRTHPLACE OF FATHER (State or Country)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

12. MAIDEN NAME OF MOTHER

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

13. BIRTHPLACE OF MOTHER (State or Country)

At place of death... yrs... mos... days. In the State... yrs... mos... days

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) *Lester Carlisle*
 (Address) *Pocatello*

Where was disease contracted if not at place of death?

Former or usual residence

15. Filed *9-6* 19*22*
 Local Registrar *W. H. H. H.*

19. PLACE OF BURIAL OR REMOVAL *Law Cemetery* DATE OF BURIAL *9-7 1922*
 20. UNDERTAKER *P. H. Walter* ADDRESS *Pocatello*

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

39507

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 53
Registered No. 3910

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

-2. FULL NAME

Registration District No.

Primary Registration District No.

(No.)

(St.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

(Year)

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (for employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 22, 1922, to Sept 6, 1922, that I last saw him alive on Sept 2, 1922, and that death occurred on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

M. D.

9-6 1922 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

RECEIVED
OCT 21 1922

CERTIFICATE OF DEATH

39508

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Barnock Registration District No. 28
City of Pocatello Primary Registration District No. 2161
(St.) St. Anthony's Hosp.File No. 53Registered No. 3911

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Cora Edell Tucker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female white Married

6. DATE OF BIRTH

June 2 1875
(Month) (Day) (Year)

7. AGE

47 Yrs. 3 Mos. 5 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).House wife

9. BIRTHPLACE

(State or Country)

Nebraska

10. NAME OF FATHER

Norace Carr.

11. BIRTHPLACE OF FATHER

(State or Country)

Mo. State

12. MAIDEN NAME OF MOTHER

Laurinda Gorth

13. BIRTHPLACE OF MOTHER

(State or Country)

Ill. S.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Lus. Tucker

(Address)

827, N. Harrison

15.

Filed

Sept 8 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 7 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Sept. 7 1922 to Sept. 7 1922that I last saw her alive on Sept 7 1922
and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Artemia(Duration) Yrs. mos. ds. 1 ds.

Contributory (Secondary)

Cardio-renal(Duration) yrs. mos. ds. 5

(Signed)

W. A. Wright M. D.Sept 8 1922 (Address) Pocatello, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State 9 yrs. mos. days

Where was disease contracted if not at place of death?

Nebraska

Former or usual residence

827, N. Harrison Pocatello

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mt View Cem.Sept 10 1922

20. UNDERTAKER

ADDRESS

McHan. Undertaking Co. Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED

00121 1922 CERTIFICATE OF DEATH.

39509

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Idaho
City of American Falls

BUREAU Registration District No.

Primary Registration District No.

File No.

Registered No. 3912

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Beverly Eugene Johnson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH.

Aug 29 1891
(Month) (Day) (Year)

7. AGE

31 Yrs. — Mos. — ds.

IF LESS than 1 day
how many hrs. or
..... min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).....

RD Clerk

9. BIRTHPLACE

(State or Country)

St Louis Mo

10. NAME OF FATHER

B L Johnson

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Edith H. Burr

13. BIRTHPLACE OF MOTHER

(State or Country)

Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

B L Johnson

(Address)

Idaho Falls

15.

Filed

9-9

19122

J Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 7 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191..... to 191.....
that I last saw h..... alive on 191.....
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH was as follows:

Electrocution in water at American Falls
Idaho

(Duration) Yrs. mos. ds.

Contributory (Secondary).

(Duration) Yrs. mos. ds.

(Signed)

W. J. Baker

19..... (Address)

Coroner American Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho Falls 9/11 1922

20. UNDERTAKER

ADDRESS

W. J. Baker Idaho Falls

39510

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

Registration District No.

Primary Registration District No.

St.)

File No.

Registered No.

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF
FATHER11. BIRTHPLACE
OF FATHER

(State or Country)

12. MAIDEN NAME
OF MOTHER13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

..... 19....., to 19.....

that I last saw h..... alive on..... 19.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

(Duration) Yrs..... mos..... ds.

Contributory
(Secondary)

(Duration) yrs..... mos..... ds.

(Signed)

9/9 1922

(Address) Acting Coronor

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

39511

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 54

Registered No. 3914

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

FORM V. S. No. 5-A-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bannock Registration District No. 28
City of Pocatello Primary Registration District No. 2801
City of Pocatello (St.) General Hospital

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ray Church

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED unknown
(Write the word.)6. DATE OF BIRTH unknown
(Month) (Day) (Year)7. AGE about 40 years IF LESS than 1 day
Yrs. Mos. ds. how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work unknown
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) unknown

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country) Carney case
Pocatello

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Schumacher Hay(Address) Pocatello 2dg

15.

Filed 9-11-1922W. J. Young
Local Registrar

16. DATE OF DEATH

Aug 24 19 22
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from July 10 1922, to Aug 24 1922,
that I last saw him alive on Aug 24 1922,
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(Duration) Yrs. 6 mos. ds.Contributory, Choking with effusion
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Carl W. Clark M. D.9-4-1922 (Address) Pocatello 2dg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Schumacher Hay

DATE OF BURIAL

Sept 12, 1922

20. UNDERTAKER

Mountain View
Chen

ADDRESS

Pocatello
2dg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

39512

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock Registration District No. 28
City of Pocatello Primary Registration District No. 2161
St. N. MainFile No. 54Registered No. 3915

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Perince Middendorf
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)6. DATE OF BIRTH Sept 3rd 1922
(Month) (Day) (Year)7. AGE 9 Yrs. 9 Mos. 9 ds. IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country) Germany

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Fred B. Middendorf
(Address) 1029 N. Main

15.

Filed 9-13 1922 J. H. Hume
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 12th 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Sept 3 1922 to Sept 12 1922
that I last saw her alive on Sept 12 1922
and that death occurred on the date stated above, at 3:30 P. M.
The CAUSE OF DEATH* was as follows:

Contributory (Secondary)

(Signed) W. H. Madden M. D.
13 1922 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs mos days In the State yrs mos days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

39513

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH *Barre, Idaho* Registration District No. *28*
 County of *Blaine* Primary Registration District No. *2nd 2161*
 City of *Barre* (No. *338*) St. *Idaho* File No. *34*
 If death occurs away from usual residence, give facts called for under special information. Registered No. *3916*
 2. FULL NAME *Genal Oswald Clayton* If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*
 (Write the word.)

6. DATE OF BIRTH *Feb. 12th 1917*
 (Month) (Day) (Year)

7. AGE *5* Yrs. *7* Mos. *—* ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE *Idaho*
 (State or Country)

10. NAME OF FATHER *Austin Clayton*

11. BIRTHPLACE OF FATHER *Ohio*
 (State or Country)

12. MAIDEN NAME OF MOTHER *Nannah Hamilton*

13. BIRTHPLACE OF MOTHER *Utah*
 (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) *Austin Clayton*
 (Address) *335 S. 2nd*

15. Filed *9-13* 19*22*

J. Young
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *Sept 12* 19*22*
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Sept 12* 19*22* to *Sept 12* 19*22*
 that I last saw him alive on *Sept 12* 19*22*
 and that death occurred on the date stated above, at *4:50 A.M.*
 The CAUSE OF DEATH* was as follows:

*Pushing injury to lower chest
 (Run over by loaded coal wagon)
 (Accidental)*

(Duration) Yrs. *four* mos. ds.

Contributory (Secondary) *none*

(Duration) yrs. mos. ds.

(Signed) *Carl W. Clark* M. D.

9-13 19*22* (Address) *Bozelle's Shop*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Mountain View *Sept 14* 19*22*

20. UNDERTAKER ADDRESS

Schumacher Hall *City*

CERTIFICATE OF DEATH

39514

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock Registration District No. 28City of Pocatello (No. 1005) M. Garfield St.)File No. 54Registered No. 3917

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Hannie Edith Crist

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married

6. DATE OF BIRTH

Nov 12 1896
(Month) (Day) (Year)

7. AGE

24 Yrs. 10 Mos. — ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)house wife

9. BIRTHPLACE

(State or Country)

Oregon

10. NAME OF FATHER

J. W. Lupton

11. BIRTHPLACE OF FATHER

(State or Country)

Kansas

12. MAIDEN NAME OF MOTHER

Not known

13. BIRTHPLACE OF MOTHER

(State or Country)

" "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

George Crist

(Address)

556 So. 6th avenue

15.

Filed

Sept 14 1922J. Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

September 12 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

11/1 1921, to Aug 22 1922
that I last saw h. alive on Aug 22 1922
and that death occurred on the date stated above, at 8:30 A.M.

The CAUSE OF DEATH* was as follows:

 tumor of brain
(Paralysis of side)

(Duration) Yrs. mos. ds.

Contributory
(Secondary)anemia of brain

(Duration) yrs. mos. ds.

(Signed)

H. C. Lewis

M. D.

Sept 14 1922(Address) Pocatello, Idaho,

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 2 yrs. 10 mos. 10 days. State Idaho yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

Kansas

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

mt View CemSept 16 1922

20. UNDERTAKER

ADDRESS

McHown Undert Co. PocatelloIdaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

39515

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 28
 County of Bannock Primary Registration District No. 2161
 City of Pocatello (No. 522 E Bridges St.)

 File No. 54
 Registered No. 3918

 If death occurs away from
 usual residence, give facts
 called for under special in-
 formation.

 If death occurred in a hos-
 pital, institution or camp,
 give its NAME instead of
 street and number.

2. FULL NAME

Louie Montoya

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Male Mexican Single (Widowed or Divorced.)

6. DATE OF BIRTH

Nov 9 1921
 (Month) (Day) (Year)

7. AGE

— Yrs. 10 Mos. 4 ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or
 particular kind of work
 (b) General nature of in-
 dustry, business or estab-
 lishment in which employ-
 ed (or employer)

none

9. BIRTHPLACE

(State or Country)

Pocatello, Ida10. NAME OF
FATHERFrank Montoya11. BIRTHPLACE
OF FATHER

(State or Country)

New Mexico12. MAIDEN NAME
OF MOTHERMarg Garcia13. BIRTHPLACE
OF MOTHER

(State or Country)

New Mexico

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Frank Montoya

(Address)

522 E Bridges Pocatello

15.

Filed

Sept 14 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

61-a

16. DATE OF DEATH

Sept 15 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

8-31 1922 to Sept 12 1922
 that I last saw him alive on 9-12 1922
 and that death occurred on the date stated above, at 5:50 P.M.

The CAUSE OF DEATH* was as follows:

acute meningitis(Duration) Yrs. mos. 3 ds.Contributory
(Secondary)acute cholecystitis(Duration) Yrs. mos. 15 ds.

(Signed)

D. C. Ray

M. D.

Sept 14 1922 (Address) Pocatello, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state
 (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted
 if not at place of death?

Former or
 usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mt View Cem Sept 15 1922

20. UNDERTAKER

ADDRESS

McHardy & Co. Pocatello
Ida

CERTIFICATE OF DEATH

39516

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics1. PLACE OF DEATH **RECEIVED**
Registration District No. **21**County of **Bannock** Registration District No. **2161**City of **Pocatello** **BUREAU OF VITAL STATISTICS** **122 N. Hayes** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Infant Brower**File No. **54**
Registered No. **3919**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **male** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **single**6. DATE OF BIRTH **Sept 8 1922**
(Month) (Day) (Year)7. AGE **—** Yrs. **—** Mos. **10** ds.IF LESS than 1 day
how many _____ hrs.
or _____ min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work **none**
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) **Pocatello, Ida.**10. NAME OF FATHER **Wilmar Thatcher**11. BIRTHPLACE OF FATHER **Rebin, Idaho**

(State or Country)

12. MAIDEN NAME OF MOTHER **Laura M. Brower**13. BIRTHPLACE OF MOTHER **Idaho**

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **A. Brower**(Address) **Hawkins, Idaho**15. **Sept 18 1922**Filed **J. Young**

Local Registrar

MEDICAL CERTIFICATE OF DEATH **1914**16. DATE OF DEATH **Sept 17 1922**
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from **9-8 1922** to **9-18 1922**that I last saw him alive on **9-18 1922**
and that death occurred on the date stated above, at **2:20** M.

The CAUSE OF DEATH* was as follows:

Patent Foramen ovale(Duration) _____ Yrs. _____ mos. **10** ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) **J. Young** M. D.**9/18 1922** (Address) **Pocatello, Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence **Hawkins Idaho**19. PLACE OF BURIAL OR REMOVAL **Armo, Idaho**DATE OF BURIAL **Sept 18 1922**20. UNDERTAKER **McHann Undertaking Co.**ADDRESS **Pocatello, Idaho**

39517

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 54
Registered No. 3920If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

FORM V. S. No. 5-25-M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Blaine*City of *Pocatello*If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Registration District No.

Primary Registration District No.

(No. *1000*)*Mary Lidauna Hair*

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED*Female**White**Married*
(Write the word.)

6. DATE OF BIRTH

June 10 1858

(Month)

(Day)

(Year)

7. AGE

64 Yrs. *3* Mos. *10* ds.IF LESS than 1 day
how many.....hrs.
or.....min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer).*Nursewife*

9. BIRTHPLACE

(State or Country)

*Iacon Co Mo*10. NAME OF
FATHER*Wm R. James*11. BIRTHPLACE
OF FATHER

(State or Country)

*Mo*12. MAIDEN NAME
OF MOTHER*Martha Richardson*13. BIRTHPLACE
OF MOTHER

(State or Country)

Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. S. Hair
(Address) *Idaho*

15.

Filed

9-21 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 20 1922
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from
Sept 16 1922 to *Sept 20 1922*that I last saw her alive on *Sept 20 1922*
and that death occurred on the date stated above at *12. Midnight*

The CAUSE OF DEATH* was as follows:

*Paralysis following
apoplexy*(Duration) Yrs. mos. *4* ds.Contributory
(Secondary)(Duration) yrs. *8* mos. ds.

(Signed)

J. W. Lynn M. D.*Sept 21 1922* (Address) *Pocatello Ida**State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Louis Cemetery *Sept 22 1922*

20. UNDERTAKER

ADDRESS

H. H. Walker *Pocatello*

MARGIN RESERVED FOR BINDING

WRITE PLAINLY. WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH

County of *Banner*City of *Pocatello*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mayor Andrew F. Caldwell

CERTIFICATE OF DEATH

Registration District No. *229*Primary Registration District No. *229*St. No. *229*St. *So Arthur*

39518

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *57*Registered No. *3921*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

married

(Write the word.)

6. DATE OF BIRTH

June 2
(Month) (Day)*1846*
(Year)

7. AGE

76 Yrs. *3* Mos. *16* ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

*Retired**12 years*

9. BIRTHPLACE

(State or Country)

Illinois

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Fred Caldwell

(Address)

229 So Arthur

15.

Filed

9-21 19*22*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 18 19*22*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept. 11 1922, to *Sept. 18* 1922that I last saw him alive on *Sept 18* 1922and that death occurred on the date stated above, at *9:30* P.M.

The CAUSE OF DEATH* was as follows:

Fractures of fth. hip(Duration) Yrs. mos. *8* ds.Contributory *Acute dilatation of heart*
(Secondary)(Duration) yrs. mos. *1* ds.(Signed) *J. M. Hargrave* M. D.*8-18* 1922 (Address) *Pocatello Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Pocatello Ida.

DATE OF BURIAL

Sept. 22 1922

20. UNDERTAKER

H. F. McMan

ADDRESS

Pocatello

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

39519

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No.

Primary Registration District No.

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

Paraplegia. or Paralysis of Left foot.

(Duration) 1 Yrs. 2 mos. 0 ds.

Contributory (Secondary) Semblity

(Duration) yrs. mos. ds.

(Signed) J. F. Miller M. D.

(Address) 303 N. 7th St.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
OCT 21 1922

CERTIFICATE OF DEATH

39520

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No.

Registration District No.

No.

28

2161

St.)

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

19.22

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY That I attended deceased from
Sept 8 1922 to Sept 20 1922
that I last saw him alive on Sept 20 1922
and that death occurred on the date stated above, at 12 M.
The CAUSE OF DEATH* was as follows:
Hemiplegia and embolism

(Duration) Yrs. mos. 17 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) R. M. Newton M. D.

Sept 26 1922 (Address) Pocatello, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Mt View cemetery Sept 20 1922

20. UNDERTAKER ADDRESS
H. H. Marked Pocatello

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
OCT 21 1922
BUREAU OF STATISTICS

CERTIFICATE OF DEATH

39521

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of BannockCity of PocatelloRegistration District No. 28Registration District No. 2161(No. 1115-92 Hayes St.)File No. 54Registered No. 3925

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Samuel George Thomas

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married

(Write the word.)

6. DATE OF BIRTH

May 10 1882
(Month) (Day) (Year)

7. AGE

40 Yrs. 4 Mos. 17 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Farmer

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Farwest Utah

10. NAME OF FATHER

Elisha J. Thomas

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Elizabeth Lee

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Nathan F. Hancock

(Address)

Pocatello Idaho

15.

Filed

9-29 1922

J. H. Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

September 27 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 5 1922 to Sept 27 1922
that I last saw him alive on Sept 25 1922
and that death occurred on the date stated above, at 11:22 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(Duration) 3 Yrs. 6 mos. ds.

Contributory (Secondary)

Hemorrhage from Lungs(Duration) yrs. 6 mos. ds.

(Signed)

Carl W. Clark M. D.9/29/1922 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Turner Idaho

DATE OF BURIAL

Oct 1 1922

20. UNDERTAKER

Schumacher & Hall

ADDRESS

Pocatello

FORM V. S. No. 5-A—25 "M. 1-19.

RECEIVED
OCT 21 1922

CERTIFICATE OF DEATH

39522
28State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County *Bannock*
City *Pocatello*

Registration District No. _____

Primary Registration District No. _____

(No. _____)

File No. _____

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Caroline Rose Cushman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

*Female White**Single*

(Write the word.)

6. DATE OF BIRTH

Aug 16 - 1922

(Month)

(Day)

(Year)

7. AGE

1 Yrs. *12* Mos. *12* ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)*Child*

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

John Cushman

11. BIRTHPLACE OF FATHER

(State or Country)

unknown

12. MAIDEN NAME OF MOTHER

unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

St Anthony Hospital

(Address)

Pocatello Idaho

15.

Filed

9/29 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 29 1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 26 1922 to *Sept 28 1922*
that I last saw her alive on *Sept 28 1922*
and that death occurred on the date stated above, at *1:20 p.m.*

The CAUSE OF DEATH* was as follows:

Pneumonia(Duration) _____ Yrs. _____ mos. *5* ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Dr. J. H. Hargrave

M. D.

(Address)

Pocatello, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Mountain View**Sept 30 1922*

20. UNDERTAKER

ADDRESS

Schumacher & Sons Pocatello

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
OCT 21 1922

CERTIFICATE OF DEATH

39523

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

District No.

Registration District No.

(No.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

9 30 19 22

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 13 1922 to Oct 29 1922

that I last saw her alive on Oct 29 1922

and that death occurred on the date stated above, at 6:20 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma breast left.

(Duration) 2 Yrs. mos. ds.

Contributory General Carcinomatosis (Secondary)

(Duration) 3 yrs. mos. ds.

(Signed) W. J. Howard M. D.

9/29 1922 (Address) Pocatello, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
OCT 21 1922
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

39524

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. _____

County of Bannock Primary Registration District No. _____City of Pocatello (No. General Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant Hansen

28

2461

File No. _____

Registered No. 3928

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Infant
(Write the word.)

6. DATE OF BIRTH

September 29 1922
(Month) (Day) (Year)

7. AGE

Stillborn
Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work.
-
- (b) General nature of industry, business or establishment in which employed (or employer).

Infant

9. BIRTHPLACE

(State or Country) Pocatello Ida.

10. NAME OF FATHER

Joseph Hansen

11. BIRTHPLACE OF FATHER

(State or Country) Brigham Utah

12. MAIDEN NAME OF MOTHER

Gladie Westerville

13. BIRTHPLACE OF MOTHER

(State or Country) Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Joseph Hansen
Pocatello

15.

Filed

9 20 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

September 29 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
9-29 1922 to 9-29 1922that I last saw him alive on 9-29 1922and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Salent foramen ovale

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

9 30 1922

(Address)

Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Mountain View Bur

DATE OF BURIAL

Sept 30 1922

20. UNDERTAKER

Schumacher & Hall

ADDRESS

Pocatello

CERTIFICATE OF DEATH

39525

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Bannock* Registration District No. *28*
City of *Pocatello* Primary Registration District No. *2161*
(No. St.)File No. *54*
Registered No. *3929*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Law Allen Lafferty

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *married*
(Write the word.)

6. DATE OF BIRTH

Sept 14 1875
(Month) (Day) (Year)

7. AGE

57 Yrs. *0* Mos. *10* ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

Farmer.
(Indiana)

9. BIRTHPLACE

(State or Country)

Indiana

10. NAME OF FATHER

Silas Lafferty

11. BIRTHPLACE OF FATHER

(State or Country)

Indiana

12. MAIDEN NAME OF MOTHER

Rebecca Jones

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs Louis Allen Lafferty
Pres Idaho

(Address)

15.

Filed *9/24* *1922*

Local Registrar

16. DATE OF DEATH

Sept 23 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

....., 19....., to 19.....

that I last saw him alive on 19.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Pres Idaho

DATE OF BURIAL

Sept 24 1922

20. UNDERTAKER

W. F. McLean

ADDRESS

Pocatello
Ida.

CERTIFICATE OF DEATH

State
BOARD
Bureau of
File No.
Registered No.

If death occurred in a hospital, give its name and street address.

1. PLACE OF DEATH

County of Barnstable Registration District No. 12
City of Barnstable (No. 12) Registration District No. 12 (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

STATISTICAL

Jacob Zureifel

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widowed
(Write the word.)

6. DATE OF BIRTH Dec 10-1839
(Month) (Day) (Year)

7. AGE 82 Yrs. 7 Mos. 14 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Retired

9. BIRTHPLACE

(State or Country)

Switzerland

10. NAME OF FATHER

unknown

11. BIRTHPLACE OF FATHER

(State or Country)

unknown

12. MAIDEN NAME OF MOTHER

unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

James Wharton
Barnstable 2d

15.

Filed

10-1 1922

Walter P. Rock
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

9-24
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended from 19 to 19 that I last saw him alive on 19 and that death occurred on the date stated above, at M. The CAUSE OF DEATH* was as follows:

Chronic Glaucoma hepatic

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

19 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Reykning 2d Sept 27, 1922
20. UNDERTAKER Schumacher Hall ADDRESS Locust St

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 84County of BannockPrimary Registration District No. 2161City of Chesterfield

(No. _____, _____ St.)

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME XXXXXXXXXXXX Baby PerkinsFile No. 39527

Registered No. _____

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

F

W

(Write the word.)

6. DATE OF BIRTH

Sept 9 1922

(Month)

(Day)

(Year)

7. AGE

Yrs.

Mos.

1

ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer).

9. BIRTHPLACE

(State or Country)

Bancroft Idaho10. NAME OF
FATHERSpencer Perkins11. BIRTHPLACE
OF FATHER

(State or Country)

M Idaho12. MAIDEN NAME
OF MOTHERRay Steck13. BIRTHPLACE
OF MOTHER

(State or Country)

Colorado

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(Address) _____

15.

Filed 10-1-22 1922Walter Steck
Local Registrar

16. DATE OF DEATH

Sept 10-22

(Month)

(Day)

1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

9-9-221922

to

1922that I last saw h. _____ alive on _____ 1922

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Premature

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed) Walter Steck

M. D.

9-10-22(Address) Bancroft

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place

of death

yrs.

mos.

days.

In the

State

yrs.

mos.

days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

1922

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

39528

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of BenevolenceCity of DesmetRegistration District No. 31

Primary Registration District No. _____

(No. _____, _____ St.)

File No. 2Registered No. 20

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Laurence Belmore

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDM.Indian(Write the word.) Single

6. DATE OF BIRTH

Sept
(Month)8
(Day)1921
(Year)

7. AGE

1 Yrs.1 Mos.9 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

None

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Frank Belmore

11. BIRTHPLACE OF FATHER

(State or Country)

Montana

12. MAIDEN NAME OF MOTHER

Annie Falcon

13. BIRTHPLACE OF MOTHER

(State or Country)

Montana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Frank Belmore

(Address)

Desmet, Idaho

15.

Filed Oct 19 1922J. S. Belmore
Local RegistrarMEDICAL CERTIFICATE OF DEATH W

16. DATE OF DEATH

Oct
(Month)17
(Day)1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 121922

to

Oct 171922

that I last saw him alive on

Oct 161922and that death occurred on the date stated above, at 11:30 P. M.

The CAUSE OF DEATH* was as follows:

Septicemia(Duration) _____ Yrs. _____ mos. 10 ds.Contributory
(Secondary)

(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed)

Fred Belmore

M. D.

10/18/1922 (Address) Desmet, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DesmetIdaho

DATE OF BURIAL

10/20 1922

20. UNDERTAKER

J. Falcon

ADDRESS

Desmet, Idaho

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bonneville Registration District No. 32
City of St. Mary Registration District No. 2049 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Walter Hess

File No. 39529
Registered No. 44

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married

6. DATE OF BIRTH

877
(Month) (Day) (Year)

7. AGE

45 Last Birthday
Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Woodsmen

9. BIRTHPLACE

(State or Country)

West Virginia

10. NAME OF FATHER

Henry Hess

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

not known

13. BIRTHPLACE OF MOTHER

(State or Country)

not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Anna O'Haro
(Address) St. Mary, Ida.

15.

Filed 9-18 1922 Osmerager
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept. 16 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 16 1922, to Sept. 16 1922

that I last saw him alive on Sept. 16 1922
and that death occurred on the date stated above, at 8:00 a.m.

The CAUSE OF DEATH* was as follows:

Accidental drowning while crossing Platte River from Boat house to dock just above Red Collar line dock. (Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) H. H. Halsey C. Coroner
9/18/1922 (Address) St. Mary, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Woodlawn Cemetery

DATE OF BURIAL

9-20 1922

20. UNDERTAKER

Mitchell & Manager

ADDRESS

St. Mary, Ida.

CERTIFICATE OF DEATH

39530

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Benedict
City of BismarckRegistration District No. 2

Primary Registration District No. _____

(No. _____, _____ St.)

File No. 2Registered No. 21

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Barnice M. Arapa

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX _____ 4. COLOR OR RACE _____ 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED _____7.Indian(Write the word.) Single

6. DATE OF BIRTH

Aug121922

(Month)

(Day)

(Year)

7. AGE

Yrs. 2Mos. 9

ds. _____

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

None

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Louis Arapa

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Mary M. George

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mary George

(Address)

Bismarck, Ida.

15.

Filed Oct. 22 1922Y. E. Bilham
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct211922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept. 11922

to

Oct 71922that I last saw her alive on Oct 7 1922,
and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Frank Barker M. D.10/22/1922 (Address) Bismarck, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Bismarck

DATE OF BURIAL

10/22/1922

20. UNDERTAKER

J. Zelen

ADDRESS

Bismarck

1. PLACE OF DEATH

County of Bennett
City of Fernwood

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED
CERTIFICATE OF DEATH
Registration District No. 32
Primary Registration District No. 2049
BUREAU OF VITAL STATISTICSState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 39531
Registered No. 39531

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married

6. DATE OF BIRTH

August 14 1857
(Month) (Day) (Year)

7. AGE

65 Yrs. 29 Mos. 29 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)Rancher
Retired

9. BIRTHPLACE

(State or Country)

Wisconsin

10. NAME OF FATHER

not known

11. BIRTHPLACE OF FATHER

(State or Country)

not known

12. MAIDEN NAME OF MOTHER

not known

13. BIRTHPLACE OF MOTHER

(State or Country)

not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Seymour W. Hayden
(Address) Fernwood Idaho

15.

Filed Sept. 12 1922 Oelmuogen
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

September 12 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from July 21 1921 to Sept 12 1922
that I last saw him alive on Aug 1 1922and that death occurred on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage(Duration) Yrs. 3 mos. 3 ds.Contributory (Secondary) Arteriosclerosis(Duration) 5 yrs. 5 mos. 5 ds.(Signed) Ed Platt M. D.Res. 121922 (Address) St Marcus, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

St Marcus Ida

DATE OF BURIAL

9-14 1922

20. UNDERTAKER

Mitchell & Mearns

ADDRESS

St Marcus

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39532**
Registered No. **45**1. PLACE OF DEATH **Benewah** Registration District No. **32**
County of **Benewah** City Registration District No. **2049**
City of **St. Maries** (No. **Riverdale** Tracts St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Heliah Beatrice McMillian

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **married**
(Write the word.)

6. DATE OF BIRTH

June 6 1876
(Month) (Day) (Year)

7. AGE

46 3 11
Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)**Lounwife**

9. BIRTHPLACE

(State or Country)

Oregon

10. NAME OF FATHER

J. O. Maxwell

11. BIRTHPLACE OF FATHER

(State or Country)

Illinois

12. MAIDEN NAME OF MOTHER

Helen Churchill

13. BIRTHPLACE OF MOTHER

(State or Country)

Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. E. McMillian
St. Maries, Ida.

15.

Filed **9-18 1922** **Osmerager.**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept. 17 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from **Sept 16 1922** to **Sept 17 1922**that I last saw **her** alive on **Sept. 16 1922**and that death occurred on the date stated above, at **4 P.M.**

The CAUSE OF DEATH* was as follows:

Spinal irritation

(Duration) Yrs. mos. ds.

Contributory (Secondary) **Recurrent attacks**

(Duration) yrs. mos. ds.

(Signed) **Dr. Platt** M. D.**Sept 17 1922** (Address) **St. Maries, Ida.**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Woodlawn

DATE OF BURIAL

9-19 1922

20. UNDERTAKER

Mitchell & Meraga

ADDRESS

St. Maries, Ida.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39533**
Registered No. **132**

1. PLACE OF DEATH

County of **Bingham**
City of **Blackfoot**

Registration District No. **121**Primary Registration District No. **2194**

(No. _____ St.)

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Harriet L. Frodeham

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

Caucasian5. SINGLE, MARRIED, WID-
OWED OR DIVORCED**Widowed**
(Write the word.)

6. DATE OF BIRTH

December 12, 1874
(Month) (Day) (Year)

7. AGE

47 Yrs. **10** Mos. **4** ds.

IF LESS than 1 day

how many _____ hrs.

or _____ min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work**Domestic**(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country)

England10. NAME OF
FATHER11. BIRTHPLACE
OF FATHER

(State or Country)

12. MAIDEN NAME
OF MOTHER13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

According to Asylum Records
(Informant) **Martha E. Leigh - Bookkeeper**
(Address) **Idaho Insane Asylum, Belfair**

15.

Filed **Oct. 17, 1922** **Mrs. Hacer E. Pattee**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct. 16, 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb. 29, 1920, to Oct. 16, 1922

that I last saw her alive on **Oct. 16, 1922**

and that death occurred on the date stated above, at **10:25 A.M.**

The CAUSE OF DEATH* was as follows:

**Toxemia from Carcinoma of
The Liver**

(Duration) **1** Yrs. _____ mos. _____ ds.Contributory **Paraphrenia Depressive**

(Secondary)

(Duration) **7** Yrs. _____ mos. _____ ds.(Signed) **C. H. Hooper** M. D.

Oct. 16, 1922 (Address) **Blackfoot, Ida**

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death **2** yrs. **7** mos. **18** days. In the State **22** yrs. _____ mos. _____ days

Where was disease contracted
if not at place of death? **Unknown**

Former or
usual residence **Blackfoot, Idaho**

19. PLACE OF BURIAL OR REMOVAL

Blackfoot, Ida

DATE OF BURIAL

On arrival

20. UNDERTAKER

E. L. Egle

ADDRESS

Blackfoot, Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 1-1
County of Burgham 1922 Primary Registration District No. 1-4
City of Belfair Idaho St.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

George KellerFile No. 39534
Registered No. 157

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male Caucasian Divorced
(Write the word.)

6. DATE OF BIRTH

October 5, 1876
(Month) (Day) (Year)

7. AGE

46 Yrs. 26 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Stone Cutter

9. BIRTHPLACE

(State or Country)

Pennsylvania

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

According to Martha E. High-Brookshaven
(Informant) Idaho Idaho
(Address) Idaho IdahoFiled 1922 Martha E. High-Brookshaven
Local Registrar

16. DATE OF DEATH

October 31, 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 20, 1921, to Oct. 31, 1922
that I last saw him alive on Oct. 31, 1922
and that death occurred on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:

Toxemia of Anasarca

(Duration) Yrs. 1 mos. ds.

Contributory Valvular disease of the heart
(Secondary) with dilatation

(Duration) 18 yrs. mos. ds.

(Signed) C. H. Hooper M. D.Oct. 31, 1922 (Address) Blackfoot, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 1 yrs. 27 days. In the State 18 yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence Boise, Idaho

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Boise Idaho 19

20. UNDERTAKER ADDRESS

Blackfoot Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bingham
City of BlackfootRegistration District No. 121
Primary Registration District No. 1007
St. South Burdick

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Unnamed RossState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 39535Registered No. 149

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDFemale White Single
(Write the word.)

6. DATE OF BIRTH

Oct 4 1922
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)None

9. BIRTHPLACE

(State or Country)

Blackfoot Idaho

10. NAME OF FATHER

Ebby Ross

11. BIRTHPLACE OF FATHER

(State or Country)

Calacado

12. MAIDEN NAME OF MOTHER

Lora Searles

13. BIRTHPLACE OF MOTHER

(State or Country)

Ind.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. J. Ross

(Address)

Blackfoot Ida.

15.

Filed

Oct 5 1922 Mr. E. J. Peterson

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 4th 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 4 1922 to 19that I last saw him alive on Oct 4th 1922and that death occurred on the date stated above, at 9:30 AM

The CAUSE OF DEATH* was as follows:

congenital defective heart

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) C. C. Hamplaine M. D.12/5/1922 (Address) Blackfoot Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Funeral home 5 1922

20. UNDERTAKER

ADDRESS

E. J. Frank Blackfoot

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Bingham*City of *Blackfoot*

If death occurs away from usual residence, give facts called for under special information.

Registration District No. *121*Primary Registration District No. *2196*(No. *101st Residence Asylum St.*)File No. *39536*Registered No. *150*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Julia Ferguson Brown

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

Caucasian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

widowed
(Write the word.)

6. DATE OF BIRTH

March

(Month)

17

(Day)

1849

(Year)

7. AGE

73

Yrs.

6

Mos.

22

ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Housewife

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

James F. Ferguson

11. BIRTHPLACE OF FATHER

(State or Country)

British Isles

12. MAIDEN NAME OF MOTHER

Lucy Cutting

13. BIRTHPLACE OF MOTHER

(State or Country)

Vermont, U.S.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Julia B. Gearstey, daughter

(Address)

Menasha, Idaho

15.

Filed

*Oct 10 1922**Wm. H. E. Paton*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct. 1

(Month)

9

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

*Oct. 1 1922 to Oct. 9 1922*that I last saw *her* alive on *Oct 9 1922*and that death occurred on the date stated above, at *11:20 PM.*

The CAUSE OF DEATH* was as follows:

Senile decay

(Duration)

Yrs.

3

mos.

ds.

Contributory
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

F. W. Wintz

M. D.

190 1922 (Address) *Blackfoot, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Orville Idaho

DATE OF BURIAL

19

20. UNDERTAKER

E. J. Rank

ADDRESS

Blackfoot

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39537**
Registered No. **137**

1. PLACE OF DEATH

County of Bingham
City of Blackfoot

Registration District No. 121
Primary Registration District No. 2194
(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary O. Jones

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Female

4. COLOR OR RACE

Caucasian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED
widowed
(Write the word.)

6. DATE OF BIRTH

Apr 1 1840
(Month) (Day) (Year)

7. AGE

82 Yrs. 6 Mos. 9 ds.
IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Wales

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) according to Asylum Records
Ray: Martha E. High - Blackfoot
(Address) Idaho Insane Asylum, Bldg.

15.

Filed Oct 11 1922 Mrs. Marcus E. Palmer
Local Registrar

16. DATE OF DEATH

Oct. 10. 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 22 1920 to Oct. 10 1922
that I last saw her alive on Oct. 10 1922
and that death occurred on the date stated above, at 11:45 A.M.
The CAUSE OF DEATH* was as follows:

Exhaustion of Senility

(Duration) Yrs. 2 mos. _____ ds.
Contributory Senile Dementia
(Secondary)

(Duration) Yrs. 2 mos. 18 ds.
(Signed) E. V. Hooper M. D.
10-11-1922 (Address) Blackfoot, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 2 yrs. 6 mos. _____ days. In the State 31 yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? Unknown

Former or usual residence Malad, Idaho

19. PLACE OF BURIAL OR REMOVAL

Malad, Ida.

20. UNDERTAKER

Earl Johnson

ADDRESS

Malad

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 121County of BinghamPrimary Registration District No. 2194City of Blackfoot

(No. _____ St.)

File No. 39538Registered No. 79

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

James L. Hull

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widowed

(Write the word.)

6. DATE OF BIRTH

Jun 13 1858
(Month) (Day) (Year)

7. AGE

64 Yrs. 4 Mos. 7 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farm.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Kansas

10. NAME OF FATHER

Richard Hull

11. BIRTHPLACE OF FATHER

(State or Country)

Cent. Know.

12. MAIDEN NAME OF MOTHER

Rodgers

13. BIRTHPLACE OF MOTHER

(State or Country)

Cent. Know.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Florence H. Hoffman

(Address)

Blackfoot, Idh.

15.

Oct 21 1922Mr. Walter E. Palmer

Local Registrar

16. DATE OF DEATH

Oct 22 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 20 1922 to 19
that I last saw him alive on Oct 20 1922
and that death occurred on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH was as follows

acute dilatation of heart

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

J. J. Hamblin M. D.(Address) Blackfoot, Idh.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

G. J. Park Blackfoot

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bingham
 City of Blackfoot

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 131Primary Registration District No. 2194

(No. _____ St.)

2. FULL NAME

Stazel A Howard

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 39539Registered No. 154

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single (Use the word.)

6. DATE OF BIRTH

Jan. 9 1920
 (Month) (Day) (Year)

7. AGE

2 Yrs. 9 Mos. 12 ds.

IF LESS than 1 day
 how many..... hrs.
 or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Groveland, Idaho.

10. NAME OF FATHER

Le Roy E Howard

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Hannah Summersall

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Ray E Howard
Rte 4 Blackfoot

15.

Filed

Oct. 22 1922 Mr. H. E. Fabric
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

165

16. DATE OF DEATH

Oct 21 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 19 1922 to October 21 1922
 that I last saw her alive on October 20 1922
 and that death occurred on the date stated above, at 9 A.M.
 The CAUSE OF DEATH* was as follows:

Acute Colitis(Duration) 1 Yrs. 12 mos. 12 ds.

Contributory (Secondary)

(Duration) 1 yrs. 12 mos. 12 ds.

(Signed)

W. W. Beck M. D.(Address) Blackfoot, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

GrovelandOct 22 1922

20. UNDERTAKER

ADDRESS

E. L. EgleBlackfoot

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39540**Registered No. **735**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

Registration District No. **121**County of **Bear River**Primary Registration District No. **2194**City of **Blackfoot**(No. **3110**)

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Alonso F. Baker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male white**married**

6. DATE OF BIRTH

Jan. 24

(Month)

(Day)

1875
(Year)

7. AGE

48 Yrs. **9** Mos. **24** ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Trin Smith

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

W. T. Baker

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Amelia C. Stephens

13. BIRTHPLACE OF MOTHER

(State or Country)

Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Daughter J. V. Miller

(Informant)

(Address)

107 N. Grant St.**Oct. 23 1922****Mr. Walter E. Padden**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

79

16. DATE OF DEATH

Oct 22

(Month)

(Day)

1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 13, 1922, to Oct. 22, 1922that I last saw him alive on **Oct. 22, 1922**and that death occurred on the date stated above, at **6:35 P.M.**

The CAUSE OF DEATH* was as follows:

Heart Failure of Granston(Duration) Yrs. mos. ds. **1 ds.**Contributory (Secondary) **Inanition of Maniac Depressive**(Duration) Yrs. mos. ds. **6 mos.**(Signed) **W. J. Hooper** M.D.**Oct. 23 1922** (Address) **Blackfoot, Ida**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. **4** Mos. **9** days. In the State **3** Yrs. Mos. days

Where was disease contracted if not at place of death?

Former or usual residence **Portello, Idaho**

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Pogden, Utah**19**

20. UNDERTAKER

ADDRESS

E. J. Peck Blackfoot

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of BinghamCity of Panguitch

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 121Primary Registration District No. 2194

(No. _____ St.)

2. FULL NAME

James CapeState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 39541Registered No. 56

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDMaleWhiteSingle
(Write the word.)

6. DATE OF BIRTH

Oct 27 1922
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day
how many 20 hrs.
or _____ min.?

Yrs. _____ Mos. _____ ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

None

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Ray Cape

11. BIRTHPLACE OF FATHER

(State or Country)

Mo

12. MAIDEN NAME OF MOTHER

Pearl Sealy

13. BIRTHPLACE OF MOTHER

(State or Country)

Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ray Cape
Panguitch

(Address)

15.

Filed

Oct 27 1922
Mrs. Helen E. Pate
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 28 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 27 1922 to Oct 28 1922
that I last saw him alive on Oct 28 1922
and that death occurred on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH was as follows:

Fracture due to injury

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

H. J. Simmons M. D.
1924 1922 (Address) Blackfoot Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Home of deceased Oct 30 1922

20. UNDERTAKER

ADDRESS

E. J. Cook Blackfoot

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39542**
Registered No. **138**

1. PLACE OF DEATH

County of **Bingham**
City of **Jerome**

Registration District No. **121**
Primary Registration District No. **2194**
(No. **South of Idaho Falls** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Clara Cordes

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX **Female** 4. COLOR OR RACE **American** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Single**
(write the word.)

6. DATE OF BIRTH

February first 1898
(Month) (Day) (Year)

7. AGE

24 Yrs. **3** Mos. **3** ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Invalid No

9. BIRTHPLACE

(State or Country)

Nebraska

10. NAME OF FATHER

Casper Cordes

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Katy Weisler

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Casper Cordes
Shelley Idaho

15. Filed

Oct. 30

Mr. J. C. P. P. P.

Local Registrar

16. DATE OF DEATH

Feb. 4 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Jan 11 1922** to **Feb 3 1922** that I last saw her alive on **Feb 3 1922** and that death occurred on the date stated above, at **9** M.

The CAUSE OF DEATH* was as follows:

Paralysis

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

Dr. Robert M. D.
2/4 1922 (Address) **Shelley Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rose Hill

Feb. 6 1922

20. UNDERTAKER

ADDRESS

Chaffin

Idaho Falls

39543

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

FORM V. S. No. 5-25 M. 1-19.

RECEIVED CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bingham Registration District No. 116
City of Shelburne Primary Registration District No. 2195 St. IdahoFile No. 4Registered No. 26If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

(Mrs) Philinda RoylanceIf death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDFemale White Widowed
(Write the word.)

6. DATE OF BIRTH

April - 1874
(Month) (Day) (Year)

7. AGE

78 Yrs. 5 Mos. - ds. IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
(or employer).

Housewife

9. BIRTHPLACE

(State or Country)

Illinois

10. NAME OF
FATHER

Moses Cutler

11. BIRTHPLACE
OF FATHER

(State or Country)

12. MAIDEN NAME
OF MOTHER

Philinda

13. BIRTHPLACE
OF MOTHER

(State or Country)

To R Roylance

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Shelburne Idaho

15.

Filed

Sept 27 1922 McConatunio

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 21 22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19

that I last saw him alive on 19

and that death occurred on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Gastro-Intestinal disease -
no physician in attendance -
no autopsy performed

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) McConatunio M. D.

Sept 21 1922 (Address) Shelburne Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Springville Utah

DATE OF BURIAL

Sept 23 1922

20. UNDERTAKER

A. W. Davis Ammonia Falls Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH
in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

39544

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
OCT 21 1922

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of

City of

Registration District No.

Primary Registration District No.

(No.)

St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Male

White

Single
(Write the word.)

6. DATE OF BIRTH

Month 5

(Day)

1922

(Year)

7. AGE

6 24

Yrs. Mos. ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Sept 30 1922 Mcmenamin

Local Registrar

16. DATE OF DEATH

Sept 29

(Month)

(Day)

1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 29 1922 to Sept 29 1922

that I last saw him alive on Sept 29 1922

and that death occurred on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

Infectious Diarrhoea

(Duration) Yrs. mos. 8 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Mcmenamin M. D.

Sept 30 1922 (Address) Aberdeen Id

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Thames Id

Sept 30 1922

20. UNDERTAKER

ADDRESS

Smith

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED

CERTIFICATE OF DEATH

33543

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bingham Registration District No. 116
 City of Aberdeen Primary Registration District No. 2155
 (No. 116 St.)

File No. 4
 Registered No. 77

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Herbert Otto Frank

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Male White Single
 (Write the word.)

6. DATE OF BIRTH

April 7 1901
 (Month) (Day) (Year)

7. AGE

21 Yrs. 5 Mos. 16 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer).

Farmer

9. BIRTHPLACE

(State or Country)

South Dakota10. NAME OF
FATHEREmanuel M Frank11. BIRTHPLACE
OF FATHER

(State or Country)

South Dakota12. MAIDEN NAME
OF MOTHERSalamine Radke13. BIRTHPLACE
OF MOTHER

(State or Country)

Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Emanuel M Frank

(Address)

Aberdeen Id

15.

Filed

Sept 23 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 23 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Sept 11 1922 to Sept 23 1922

that I last saw him alive on Sept 23 1922

and that death occurred on the date stated above, at 9:10 M.

The CAUSE OF DEATH* was as follows:

Septicemia

(Duration) Yrs. mos. 20 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. M. Kinnison M. D.

1922 (Address) Aberdeen, Id

*State the Disease Causing Death; or in deaths from Violent Causes, state
 (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
 if not at place of death?

Former or
 usual residence

19. PLACE OF BURIAL OR REMOVAL

Pleasant Valley

DATE OF BURIAL

Sept 24 1922

20. UNDERTAKER

R. N. Leithwhite

ADDRESS

Aberdeen, Id

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

39546

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Blaine
City of HelenaRegistration District No. 57
Primary Registration District No. 2022
(No. _____ St.)File No. _____
Registered No. 36

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Peter M. Gray

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH

(Month) _____ (Day) _____ (Year) _____

7. AGE

60 Yrs. about Mos. _____ ds. _____IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)Miner

9. BIRTHPLACE

(State or Country) ✓

10. NAME OF FATHER

✓

11. BIRTHPLACE OF FATHER

(State or Country) ✓

12. MAIDEN NAME OF MOTHER

✓

13. BIRTHPLACE OF MOTHER

(State or Country) ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Robt P. Thorne
(Address) Hailey15. Oct-20 19 22 R. H. Wright
Filed _____ Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct. 14 19 22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____ 19____, to _____ 19____

that I last saw him _____ alive on _____ 19____

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Houston E. Sayer M. D.10/15/19.22 (Address) Grey John (Coroner)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Salt Lake, Utah _____ 19____

20. UNDERTAKER

ADDRESS

C. D. Harris Hailey

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of BlaineCity of Hailey

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 57Primary Registration District No. 2022(No. 57 St.)State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 39547Registered No. 35

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Edward J. Flannery

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

Wht.5. SINGLE, MARRIED, WIDOWED OR DIVORCED
married
(Write the word.)

6. DATE OF BIRTH

Aug 21 1947
(Month) (Day) (Year)

7. AGE

75 Yrs. 1 Mos. 19 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Miner

9. BIRTHPLACE

(State or Country)

New York

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Edward Smick

(Address)

Pens, Nevada

15.

Filed

10-121922Robert H. Wright

Local Registrar

MEDICAL CERTIFICATE OF DEATH

Wright

16. DATE OF DEATH

Oct. 10 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

..... 19....., to 19.....

that I last saw him..... alive on..... 19.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Gun shot - Reef inflicted

..... (Duration) Yrs. mos. ds.

Contributory
(Secondary)

..... (Duration) yrs. mos. ds.

(Signed)

Robert H. Wright Coroner
10-10-1922 (Address) Hailey, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Hailey, Idaho

DATE OF BURIAL

Oct. 13, 1922

20. UNDERTAKER

W. H. Harris

ADDRESS

Hailey, Ida.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39548**
Registered No. **34**

1. PLACE OF DEATH

County of *Blaine*City of *Hailey*

If death occurs away from usual residence, give facts called for under special information.

Registration District No. *57*Primary Registration District No. *2022*(No. *57* St.)

2. FULL NAME

Ethel Alga Mc Gary

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

Aug. 26 19*22*
(Month) (Day) (Year)

7. AGE

1 Yrs. *12* Mos. *12* ds.

IF LESS than 1 day

how many *hrs.*
or *min.?*

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Cary Idaho

10. NAME OF FATHER

R. H. McGary

11. BIRTHPLACE OF FATHER

(State or Country)

Cary Idaho

12. MAIDEN NAME OF MOTHER

Mildred Hale

13. BIRTHPLACE OF MOTHER

(State or Country)

Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

R. H. McGary
Hailey Idaho

(Address)

15.

Filed *Oct - 15* 19*22* *Robert H. Wright*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

*Wright**Oct. 8* 19*22*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct - 8 19*22* to *Oct - 8* 19*22*that I last saw her alive on *Oct - 8* 19*22*and that death occurred on the date stated above, at *19 M.*

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *Robert H. Wright* M. D.*10-9-1922* (Address) *Hailey Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Hailey Ida

DATE OF BURIAL

Oct 9, 1922

20. UNDERTAKER

R. H. Harris

ADDRESS

Hailey

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

39549

1. PLACE OF DEATH

Registration District No. 57

County of Blaine

Primary Registration District No. 2075

City of Carey

(No. St.)

File No.

Registered No. 37

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Marwin J. Bennett

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Oct. 17 1918
(Month) (Day) (Year)

7. AGE

4 Yrs. 6 Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business or establishment in which employed (or employer)

Carey Idaho

9. BIRTHPLACE

(State or Country)

Carey Idaho

10. NAME OF FATHER

J. Lawrence Bennett

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Eva Johnson

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ammy Randall
Carey Idaho

(Address)

15.

Filed

11-1

19 22

Robert H. Wright

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct. 14 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct. 7 1922 to Oct. 14 1922

that I last saw him alive on Oct. 14 1922

and that death occurred on the date stated above, at 4:15 P.M.

The CAUSE OF DEATH was as follows:

Dysentery Infantum

(Duration) Yrs. mos. 7 ds.

Contributory
(Secondary)

Dysentery

(Duration) yrs. mos. 1 ds.

(Signed)

Auntie E. Snyder M.D.

10/15/22 (Address) Carey Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Carey, Ida

DATE OF BURIAL

10-16-1922

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Blaine
City of CaryRegistration District No. 57
Primary Registration District No. 7075
(No. _____ St.)File No. 39550
Registered No. 38

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Myra E Bennett

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH

Apr 17 1918
(Month) (Day) (Year)

7. AGE

1 Yrs. 7 Mos. _____ ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)Child
State

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

J. Lawrence Bennett

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Eva Johnson

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Amy Randall
Cary Idaho

15.

Filed

11-119 22Robert H. Wright

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 15 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Oct 2 1922 to Oct 15 1922that I last saw him alive on Oct 15 1922
and that death occurred on the date stated above, at 8:30 A.M.

The CAUSE OF DEATH* was as follows:

Cholera Infantum(Duration) _____ Yrs. _____ mos. 13 ds.
Contributory (Secondary) Acidosis(Duration) _____ yrs. _____ mos. 3 ds.
(Signed) Houston E. Shady M. D.
Cary Idaho
19 _____ (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cary, Ida10/16 1922

20. UNDERTAKER

ADDRESS

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH **Bellefonte** Registration District No. **57**
 County of **Blaine** Registration District No. **2022**
 City of **Bellefonte** (No. _____) St. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Betty Charlotte Nelson

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. **39551**
 Registered No. **31**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED
 (Write the word.)

6. DATE OF BIRTH **August 30 1922**
 (Month) (Day) (Year)

7. AGE **19** yrs. **19** mos. **19** ds.
 IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE **Bellefonte**
 (State or Country)

10. NAME OF FATHER **Alfred Nelson**

11. BIRTHPLACE OF FATHER **Idaho**
 (State or Country)

12. MAIDEN NAME OF MOTHER **Mary Bryden**

13. BIRTHPLACE OF MOTHER **Idaho**
 (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Alfred Nelson**
 (Address) **Bellefonte, Idaho**

15. Filed **Oct-10 1922** **R. H. Wright**
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

76

16. DATE OF DEATH **Sept. 18 1922**
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **9-16 1922** to **9-18 1922**
 that I last saw her alive on **9-18 1922**
 and that death occurred on the date stated above, at **7 P.M.**
 The CAUSE OF DEATH* was as follows:
Abscess ear

(Duration) Yrs. mos. **2** ds.

Contributory
 (Secondary)

(Duration) yrs. mos. ds.

(Signed) **E. H. Teed** M. D.

9-19 1922 (Address) **Hailey Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **Bellefonte** DATE OF BURIAL **Sept 20 1922**

20. UNDERTAKER **E. H. Teed** ADDRESS **Hailey**

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Register District No.

Municipal Registration District No.

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

10 - 10

19

22

R. H. Wright,

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

Yrs.

mos.

In the

days.

State

Yrs.

mos.

days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of BlaineCity of Mailey

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Anna Mizer

CERTIFICATE OF DEATH

Registration District No. 57Primary Registration District No. 2022State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 39553Registered No. 33

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married

(Write the word.)

6. DATE OF BIRTH

Sept. 16 1886
(Month) (Day) (Year)

7. AGE

66 Yrs.Mos. 3 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Housewife

9. BIRTHPLACE

(State or Country)

Kentucky

10. NAME OF FATHER

James Caldwell

11. BIRTHPLACE OF FATHER

(State or Country)

✓

12. MAIDEN NAME OF MOTHER

Anna Caldwell

13. BIRTHPLACE OF MOTHER

(State or Country)

✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Thos Mizer
Mailey Idaho

15.

Filed 10-10 192210-10R. H. Wright

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept. 27 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 10th 1922 to Sept 22nd 1922
that I last saw her alive on Sept 22nd 1922
and that death occurred on the date stated above, at 11:30 AM

The CAUSE OF DEATH* was as follows:

Gastroenteritis(Duration) Yrs. mos. 5 ds.Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

M. D.

(Address) Mailey Idaho

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Mailey

DATE OF BURIAL

9/27 1922

20. UNDERTAKER

R. Harris

ADDRESS

Mailey

FORM V. S. No. 5-25 M. 1-19.

Dr. Wendle

CERTIFICATE OF DEATH

39554

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bonner
City of HopeRegistration District No. 80Primary Registration District No. 2157File No. 34Registered No. 34

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Emma J. Crandal

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widowed
(Write the word.)

6. DATE OF BIRTH

October 1, 1850
(Month) (Day) (Year)

7. AGE

72 Yrs. 0 Mos. 19 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

None

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Wisconsin

10. NAME OF FATHER

George Carpener

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Harriet Dunn

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. Mabel Dunn(Address) Hope, Idaho.

15.

Filed Oct 28 1922J. M. Larson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct. 22, 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 19 1921 to Oct 22 1922
that I last saw her alive on Oct 21 1922
and that death occurred on the date stated above, at 1:30 A.M.

The CAUSE OF DEATH* was as follows:

INTERNAL Hemorrhage of unknown origin(Duration) Yrs. mos. 2 ds.

Contributory (Secondary)

Cholelithiasis

(Duration) Yrs. mos. ds.

(Signed)

Dr. Floyd B. Wendle10-26-22 (Address) Bridge St. Hope

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Hope, Idaho.

DATE OF BURIAL

10/24 1922

20. UNDERTAKER

Moon & Dale

ADDRESS

Sandpoint, Ida.By L. B. Moon

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

39555

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of **Bonner**City of **Priest River,**

If death occurs away from usual residence, give facts called for under special information.

Registration District No. **85**Primary Registration District No. **2185**File No. **3**Registered No. **13**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME **Walter H. Binkley**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

White**Married.**

(Write the word.)

6. DATE OF BIRTH

June 30 (Month) **1890** (Year)

7. AGE

31 Yrs. **3** Mos. **25** ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Garage Prop.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) **Ohio.**

10. NAME OF FATHER

H. W. BINKLEY.

11. BIRTHPLACE OF FATHER

(State or Country) **Ohio.**

12. MAIDEN NAME OF MOTHER

Mattie Weller.

13. BIRTHPLACE OF MOTHER

(State or Country) **Penn.**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Priest River, Ida.

15.

Filed **Nov 11** 19 **22**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 25 (Month) **1922** (Year)17. I HEREBY CERTIFY, That I attended deceased from **Oct 25** 19 **22** to **19**that I last saw him alive on **Oct 22 1922** and that death occurred on the date stated above, at **1130 AM**

The CAUSE OF DEATH* was as follows:

Rupture of blood vessel at base of heart.

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

M. D.

Oct 25 1922 (Address) **Priest River, Ida**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

39556

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of BonnerCity of Priest RiverRegistration District No. 85Primary Registration District No. 2185

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Halleck

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

M

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDSingle

(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

(Year)

7. AGE

42

Yrs. Mos. ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Lumberjack

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

Not known

11. BIRTHPLACE OF FATHER

(State or Country)

not known

12. MAIDEN NAME OF MOTHER

Not known

13. BIRTHPLACE OF MOTHER

(State or Country)

notknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Steve Walsh(Address) O.K. Coffe House . Trent AveSpokane Wash.

15.

Filed Nov 1 1922 19

Local Registrar

16. DATE OF DEATH

Oct

(Month)

27 1922

(Day)

19

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 27 1922 to Oct 27 1922
that I last saw him alive on Oct 27 1922
and that death occurred on the date stated above, at 1:10

The CAUSE OF DEATH* was as follows:

P.MAccidental injury to spine
fracture of scapula and ribs
on right side.Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) C. T. Gustaf M. D.Oct 27 1922 (Address) Priest River,

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Newport Wash.Nov 2 1922

20. UNDERTAKER

ADDRESS

Wm DavisNewport

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

39557

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of **Bonner**Registration District No. **85**City of **Priest River, Ida.**Primary Registration District No. **2185**

File No.

Registered No. **12**

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Ben Dew

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

White5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Married.
(Write the word.)

6. DATE OF BIRTH

Dec. 10 1853
(Month) (Day) (Year)

7. AGE

68 10Mos. **9** ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. **Farmer**

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Canada

10. NAME OF FATHER

Wm. Dew

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Ann. Downie

13. BIRTHPLACE OF MOTHER

(State or Country)

Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Anna Dew**(Address) **Priest River, Ida.**

15.

Filed **No. 1** 19 **24**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct. 19 1922
(Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 16 1922 to **Oct 19 1922**
that I last saw him alive on **Oct 16 1922**and that death occurred on the date stated above, at **12.15**The CAUSE OF DEATH* was as follows: **A. M****Cerebral Hemorrhage.**

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) **C. P. Gettys** M. D.**Oct 21 1922** (Address) **Priest River, Ida.**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Priest River, Ida.**Oct. 23 1922**

20. UNDERTAKER

ADDRESS

Wm Davis**Newport.**

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

39558

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bonner
City of Priest RiverRegistration District No. 85Primary Registration District No. 2185File No. 3Registered No. 71

If death occurs away from usual residence, give facts called for under special information.

FULL NAME

Frank W Webster

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

Aug 26 1885
(Month) (Day) (Year)

7. AGE

87

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Retired

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Bangor Ma

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

John Webster
State Maine

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Mary Allen
State Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Nov 11922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct. 8th 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct. 4 1922 to Oct. 8 1922that I last saw him alive on Oct. 7 1922and that death occurred on the date stated above, at 1:00 A.M.

The CAUSE OF DEATH* was as follows:

Acute Enteritis

(Duration) Yrs. mos. ds.

Contributory Lobar Pneumonia
(Secondary)

(Duration) yrs. mos. ds.

(Signed) A. D. Schlottbauer M. D.10/8 1922 (Address) Priest River Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Newport Oct 10 1922

20. UNDERTAKER

ADDRESS

W. J. D. Jones, Newport

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

39560

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bonner
City of NewportRegistration District No. 85Primary Registration District No. 2185(No. 111)

St.)

File No. 2Registered No. 69

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Seas Mac Neels

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Male

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

May 29

(Month)

(Day)

1885
(Year)

7. AGE

57 Yrs. 3 Mos. 27 ds.

IF LESS than 1 day

how many _____ hrs.

or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

Invalid

9. BIRTHPLACE

(State or Country)

Illinois

10. NAME OF FATHER

Not Known

11. BIRTHPLACE OF FATHER

(State or Country)

Not Known

12. MAIDEN NAME OF MOTHER

Not Known

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Lora Blanton

(Address)

Newport, Idaho

15.

Filed

Nov 11922E. F. Gentry

Local Registrar

16. DATE OF DEATH

Sept

(Month)

21st

(Day)

22
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19____, to 19____

that I last saw him _____ alive on 19____

and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Vascular Heart Disease10 Yrs. _____ mos. _____ ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

E. M. Moore, M. D.9/27/22

(Address)

Bonanza, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Chapman was Sep 23, 1922

20. UNDERTAKER

ADDRESS

Wm Davis Newport

Dr. Stackhouse

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bonner
City of SandpointRegistration District No. 78Primary Registration District No. 2155

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Gladys HildrethState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 39561

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDSingle
(Write the word.)

6. DATE OF BIRTH

May 26, 1915
(Month) (Day) (Year)

7. AGE

7 Yrs. 4 Mos. 20 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

School-Girl

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Edward Hildreth

11. BIRTHPLACE OF FATHER

(State or Country)

Michigan

12. MAIDEN NAME OF MOTHER

Lizzie Martin

13. BIRTHPLACE OF MOTHER

(State or Country)

Michigan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ed Hildreth

(Address)

Footstam Idaho

15.

Filed Nov 2 1922Vivian Allen
Deputy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct. 16, 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 26 - 1922, to Oct 16 - 1922that I last saw her alive on Oct 16 - 1922and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Embolism Ling. following Toxic Infection
General anesthetic, inspired Blood.(Duration) _____ Yrs. _____ mos. 9 hrs. ds.Contributory: Blood dyscrasia - purpura
(Secondary) associated with pus to the

(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed) E. P. Stackhouse M. D.10/16/22 (Address) Sandpoint

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Boyer, Idaho

DATE OF BURIAL

10/18, 1922

20. UNDERTAKER

ADDRESS

MOON & DALE Sandpoint, IdahoL. G. Moon

Dr Page

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Bonner*City of *Sandpoint*Registration District No. *78*Primary Registration District No. *2155*(No. *142*)

St.)

File No. *39562*

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Theodore Sherman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Unknown
(Write the word.)

6. DATE OF BIRTH

Unknown

(Month)

Day

1868
(Year)

7. AGE

34

Yrs.

Mos.

ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Woodsman

(b) General nature of industry, business or establishment in which employed (or employer).

Lumber mfg. Co.

9. BIRTHPLACE

(State or Country)

Wisconsin

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

O. F. Page & Mrs.

(Address)

Sandpoint Idaho.

15.

Filed

*Nov 2**1922**Viola Allen*
Deputy Local Registrar

MEDICAL CERTIFICATE OF DEATH

175 C

16. DATE OF DEATH

October
(Month)*2*
(Day)*1922*
(Year)17. I HEREBY CERTIFY, That I attended deceased from *Sept 26*, 1922, to *Oct 2nd*, 1922, that I last saw him alive on *Oct 2nd*, 1922, and that death occurred on the date stated above, at *6:30* M.

The CAUSE OF DEATH* was as follows:

Trammatism by being caught under falling logs(Duration) Yrs. mos. *6* ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

*O. F. Page**Oct 31*, 1922(Address) *Sandpoint Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Lakeview Cemetery**10/5*, 1922

20. UNDERTAKER

ADDRESS

Maon & Dale
*By L. B. Maon**Sandpoint Idaho*

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

Dr Wendle

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Conner
City of SandpointRegistration District No. 78
Primary Registration District No. 2155
(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Veronica McBrideFile No. **39563**

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Oct 3 1922
(Month) (Day) (Year)

7. AGE

3 yrs. 3 mos. 3 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

None

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho.

10. NAME OF FATHER

William McBride

11. BIRTHPLACE OF FATHER

(State or Country)

Wyo.

12. MAIDEN NAME OF MOTHER

Cora Oroske

13. BIRTHPLACE OF MOTHER

(State or Country)

Wis.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W & M McBride

(Address)

Sandpoint, Ida.

15.

Filed Nov 2 1922Viola Allen
Deputy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 5 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 3 1922 to Oct 5 1922that I last saw her alive on Oct 4th 1922and that death occurred on the date stated above, at 9:30 P.M.

The CAUSE OF DEATH* was as follows:

Premature Birth, 7 Month gestation

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W. H. H. H. M. D.Nov 2 19 22 (Address) Sandpoint, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lakewood Cemetery10/6 1922

20. UNDERTAKER

ADDRESS

Moore & Dale
Ray D. MooreSandpoint, Idaho

FORM V. S. No. 5-25 M. 1-19.

Dr. Anderson

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of BonnerCity of Shoup

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 78Primary Registration District No. 2155

(No. _____)

St. _____)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 39564

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Ari Kirkhoven

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widowed
(Write the word.)

6. DATE OF BIRTH

Nov 19 1838
(Month) (Day) (Year)

7. AGE

83 Yrs. 10 Mos. 26 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Holland

10. NAME OF FATHER

Henry Kirkhoven

11. BIRTHPLACE OF FATHER

(State or Country)

Holland

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Holland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

M. Kirkhoven

(Address)

Shoup, Idaho

15.

Filed Nov 2 1922Viola Allen
Deputy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct. 15 1924
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from 10-9 1922 to 10-9 1922 that I last saw him alive on 10-9 1922 and that death occurred on the date stated above, at 10-17 M.

The CAUSE OF DEATH* was as follows:

Hemiplegia.Arterio Sclerosis & Scurvy,

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

E. Anderson

M. D.

10/8/22 (Address) Shoup, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lakeview Cemetery10/18 1922

20. UNDERTAKER

ADDRESS

Wm. C. DaffShoup, IdahoBy L. Moon

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39566**

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Battle Registration District No. 59
City of Barlingham Primary Registration District No.
(No.) St.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

W. Neal

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Chief
(Write the word.)

6. DATE OF BIRTH

Dec 18 1910
(Month) (Day) (Year)

7. AGE

11 Yrs. 8 Mos. 23 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Student

9. BIRTHPLACE

(State or Country)

Kansas

10. NAME OF FATHER

Fred R. Neal

11. BIRTHPLACE OF FATHER

(State or Country)

Kansas

12. MAIDEN NAME OF MOTHER

Emma B. Kinskeep

13. BIRTHPLACE OF MOTHER

(State or Country)

Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Fred R. Neal

(Address)

Barlingham, Id.

15.

Filed

9-12 19221922E. J. Fox

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

9 - 11 - 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from 9-11-1922 to 9-11-1922that I last saw h. alive on 9-11-1922
and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Accidental
fracture of skull
(kicked by horse)(Duration) - Yrs. - mos. - ds.Contributory
(Secondary)(Duration) - yrs. - mos. - ds.(Signed) Carroll A. B. Jones, D.9/11/1922 (Address) Neachay, Id.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Barlingham9/12 1922

20. UNDERTAKER

ADDRESS

W. KingMoore

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Canyon Registration District No. 3
 City of ... Primary Registration District No. 2007 St. ...

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Bonnie Gahley

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 39567

Registered No. 23

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
 (Write the word.)

6. DATE OF BIRTH Apr 18 1920
 (Month) (Day) (Year)

7. AGE 2 Yrs. 4 Mos. 25 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE (State or Country) Canyon Co

10. NAME OF FATHER Carl Gahley

11. BIRTHPLACE OF FATHER (State or Country) Nebr.

12. MAIDEN NAME OF MOTHER Mary J Simpson

13. BIRTHPLACE OF MOTHER (State or Country) Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Frank Gahley
 (Address) ...

15. Filed 10-10 1922 Lulu Walchop
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 13 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 13 1922 to Sept 13 1922
 that I last saw her alive on Sept 13 1922
 and that death occurred on the date stated above, at 8 P.M.
 The CAUSE OF DEATH* was as follows:

Force kick of horse over heart.
 (Duration) Yes at once ds.

Contributory (Secondary) ...
 (Duration) ... yrs. ... mos. ... ds.

(Signed) D. M. Hutchell M. D.
9-14 1922 (Address) Parma Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Indian Cemetery DATE OF BURIAL Sept 15 1922

20. UNDERTAKER

Peckham Fur Co ADDRESS Parma

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

Recd Aug 25

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH UOI 21 1922

County of Canyon Registration District No. 3

City of Naftsi (No. 2087 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME August Jantz

File No. 39568

Registered No. 21

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH Aug 17 1922
(Month) (Day) (Year)

7. AGE 8 Yrs. 8 Mos. 8 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE
(State or Country) Canyon Co.

10. NAME OF FATHER August Jantz

11. BIRTHPLACE OF FATHER
(State or Country) Poland

12. MAIDEN NAME OF MOTHER Anna Nelker

13. BIRTHPLACE OF MOTHER
(State or Country) Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R Jantz
(Address) Naftsi

15. Filed 10-10 1922 Lulu Waldrop
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 25 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 17 1922 to Aug 23 1922
that I last saw him alive on Aug 23 1922
and that death occurred on the date stated above, at 20 Aug 25

The CAUSE OF DEATH* was as follows:
Ischaemic - Sclerosis Myocardium

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) S. B. Dwyer M. D.

19. (Address) Calderell St.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Presbyterian Church DATE OF BURIAL Aug 26 1922

20. UNDERTAKER Presbyterian Bur Co ADDRESS Barma

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Mathawan
City of Adrian

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ruthen McCreary

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

married

(Write the word.)

6. DATE OF BIRTH

Jan
(Month)10
(Day)1864
(Year)

7. AGE

58

Yrs.

7

Mos.

29

ds.

IF LESS than 1 day

how many.....hrs.

or.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Rancher

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ill

10. NAME OF FATHER

George McCreary

11. BIRTHPLACE OF FATHER

(State or Country)

Do not know

12. MAIDEN NAME OF MOTHER

Do not know

13. BIRTHPLACE OF MOTHER

(State or Country)

Do not know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Dollie F. McCreary

(Address)

Adrian, Mich.

15.

Filed 10-101922Paula Walchoff

Local Registrar

CERTIFICATE OF DEATH

Registration District No. 3Primary Registration District No. 2007

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 39569Registered No. 22

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 9
(Month) (Day)1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 15 1921 to Sept 8 1922that I last saw him alive on Sept 8 1922and that death occurred on the date stated above, at Sept 9 12-45

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(Duration) 3 Yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) W. M. Mitchell M. D.9-12-1922 (Address) Parma, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Roswell

DATE OF BURIAL

Sept 11 1922

20. UNDERTAKER

Bessie F. Co

ADDRESS

Parma

1. PLACE OF DEATH

County of Bannock Registration District No. 83
 City of Swan Lake Registration District No. 2160
 (State) _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Edgar Scroy Mc Kinzie

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 39570
 Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
 (Write the word.)

6. DATE OF BIRTH Sept 3 1914
 (Month) (Day) (Year)

7. AGE 8 Yrs. 1 Mos. 4 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

School Boy

9. BIRTHPLACE Swan Lake, Idaho
 (State or Country)

10. NAME OF FATHER Wm Mc Kinzie

11. BIRTHPLACE OF FATHER Smithfield, Utah
 (State or Country)

12. MAIDEN NAME OF MOTHER Annie Misson

13. BIRTHPLACE OF MOTHER Preston, Ida.
 (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm J. C. Kenzie
 (Address) Swan Lake, Idaho

15. Filed Oct. 9, 1922 R. J. Gortner
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct. 7, 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 7, 1922 to Oct. 7, 1922
 that I last saw him alive on Oct. 7, 1922
 and that death occurred on the date stated above, at 1:25 P.M.

The CAUSE OF DEATH* was as follows:

Anterior Poliomyelitis

(Duration) more Yrs. 3 mos. 3 ds.

Contributory (Secondary) more

(Duration) more yrs. 3 mos. 3 ds.

(Signed) R. J. Gortner, M. D.

10-9-1922 (Address) Swan Lake, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Swan Lake, Idaho DATE OF BURIAL 10-9-1922

20. UNDERTAKER None ADDRESS _____

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH **RECEIVED**
County of **Canyon** District No. **21**
City of **Nampa** Registration District No. **2006**
St.)

File No. **39571**

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Louisa Parker**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **married**

6. DATE OF BIRTH

1 (Month) **Sep** (Day) **15** (Year)

7. AGE

52 Yrs. **26** Mos. **26** ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

at Home

9. BIRTHPLACE

(State or Country)

Mo.

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Sept 11 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 10 (Month) **10** (Day) **1922** (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 14 1922 to **Sept 10 1922**
that I last saw her alive on **Sept 10 1922**
and that death occurred on the date stated above, at **4:40 P.M.**

The CAUSE OF DEATH was as follows:

Cholecystitis
Empyema of gall bladder

(Duration) Yrs. mos. **27** ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mendon Idaho **9-11-1922**

20. UNDERTAKER

ADDRESS

F. K. Robinson **Nampa Idaho**

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39572**

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH **RECEIVED**
County of **Canyon** Registration District No. **7**
City of **Marathon** Registration District No. **2006** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Hornet Lucile Lane**

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Single**
(Write the word.)6. DATE OF BIRTH. **Feb 8 1905**
(Month) (Day) (Year)7. AGE **17** Yrs. **7** Mos. **17** ds.
IF LESS than 1 day how many hrs. or min.?)8. OCCUPATION **None**(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer) **Idaho State Penitentiary**9. BIRTHPLACE **Marshalltown Ia.**
(State or Country)10. NAME OF FATHER **Ralph E Lane**11. BIRTHPLACE OF FATHER **Marshalltown Iowa**
(State or Country)12. MAIDEN NAME OF MOTHER **Grace Fullerton**13. BIRTHPLACE OF MOTHER **Newport Minnesota**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) **Ralph E Lane**(Address) **Meridian Idaho**15. Filed **Sept 25 1922****Pearle Dodds**
Local Registrar16. DATE OF DEATH **Sept 22 1922**
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from **Aug 24 1922** to **Sept 22 1922**, that I last saw him alive on **Sept 21 1922**, and that death occurred on the date stated above, at **5 A. M.**
The CAUSE OF DEATH* was as follows:**Status Epilepticus**

Contributory (Secondary)

(Duration) **Since child hood** Yrs. mos. ds.
(Signed) **Dr. R. E. Lane** M. D.**9/22-1922** (Address) **Marathon Idaho**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death **1** yrs. **11** mos. **28** days. In the State **10** yrs. mos. daysWhere was disease contracted if not at place of death? **Unknown**Former or usual residence **Marathon Idaho**19. PLACE OF BURIAL OR REMOVAL **Meridian** DATE OF BURIAL **Sept 23 1922**20. UNDERTAKER **W. B. Mendenhall** ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon
City of Rural

Registration District No. 7

Registration District No. 2006

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clell Eva Gealy

File No. 39573

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Fem

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

(Write the word.)

6. DATE OF BIRTH

Oct.
(Month)

9th
(Day)

1906
(Year)

7. AGE

15 Yrs. 11 Mos. 10 ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

In school

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Nebraska

10. NAME OF FATHER

F.G. Gealy

11. BIRTHPLACE OF FATHER

(State or Country)

Penn.

12. MAIDEN NAME OF MOTHER

Nellie E. Stauffer

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Fred G. Gealy

(Address) Nampa Idaho.

15.

Filed Oct. 10 1922 Pearle Dodds

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept
(Month)

18th 1922
(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 15 1922 to Sept 18 1922

that I last saw her alive on Sept 18 1922

and that death occurred on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Acute Anterior Poliomyelitis
Immediate cause was
Paralysis of respiration

(Duration) _____ Yrs. _____ mos. 4 ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Geo. R. Proctor M. D.

9/19 1922 (Address) Nampa, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Nampa Idaho

DATE OF BURIAL

9/20/22

20. UNDERTAKER

Fred K. Robinson

ADDRESS

Nampa, Ida

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 7
County of Canyon Primary Registration District No. 1806
City of Nampa (No. 1000 Key Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Chas Alice FarshiedFile No. 39574
Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widow
(Write the word.)

6. DATE OF BIRTH

Dec 20 1895
(Month) (Day) (Year)

7. AGE

65 Yrs. 9 Mos. 18 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country) Ill

10. NAME OF FATHER

Jas. Harfield

11. BIRTHPLACE OF FATHER

(State or Country) _____

12. MAIDEN NAME OF MOTHER

Mary Jones

13. BIRTHPLACE OF MOTHER

(State or Country) Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs H. H. Rodgers
(Address) 308-21 Ave

15.

Filed Oct 10 1922 Nampa Chas Alice Farshied
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 7 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 6 1922 to Oct 7 1922
that I last saw her alive on Oct 7 1922
and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral haemorrhage(Duration) ✓ Yrs. ✓ mos. 2 ds.Contributory (Secondary) Chronic Nephritis(Duration) Unknown mos. ds.(Signed) Geo W Chilton M. D.10/8 1922 (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Ontario Ore. 10-9 1922

20. UNDERTAKER

ADDRESS

W. H. Brown Nampa Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

39575

1. PLACE OF DEATH
 County of Canyon Registration District No. 7
 City of Naamans Primary Registration District No. 1006

File No. 39575
 Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph B Fitzgerald

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
 (Write the word.)

6. DATE OF BIRTH

Oct 24 1882
 (Month) (Day) (Year)

7. AGE

40 Yrs. - Mos. - ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer)

laborer

9. BIRTHPLACE

(State or Country)

Kentucky

10. NAME OF FATHER

John Fitzgerald

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr J B Fitzgerald
 (Address) Naamans, Id.

15. Filed Oct 10 1922 Pearle Dodds
 Local Registrar

16. DATE OF DEATH

Oct 8 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 20 1922 to Oct 8 1922
 that I last saw him alive on Oct 8 1922
 and that death occurred on the date stated above, at 4:30 MA

The CAUSE OF DEATH* was as follows:

Acute dilatation heart
(had attack chill & fever malaria 7-20-22)
 (Duration) Yrs. X mos. 1 ds.
 Contributory Chronic malaria, Chronic heart
 (Secondary) " suppurative den
Dysgonia (Duration) Chill 6 yrs. 1 mos. 1 ds.
 (Signed) Horace P Belknap M. D.
199 1922 (Address) Naamans Id.

*State the Disease Causing Death; or in death from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death... yrs... mos... days. In the State... yrs... mos... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Biggs Idaho 19

20. UNDERTAKER

ADDRESS

W R Currier Naamans Id.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 4
County of Canyon Primary Registration District No. 1006
City of Nampa Murphy Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Loyd OwensFile No. 39576
Registered No. 109.6

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male white Single
(Write the word.)

6. DATE OF BIRTH

Oct 30 1884
(Month) (Day) (Year)

7. AGE

17 Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)In school

9. BIRTHPLACE

(State or Country)

Nash

10. NAME OF FATHER

Morris Owens

11. BIRTHPLACE OF FATHER

(State or Country)

Wales

12. MAIDEN NAME OF MOTHER

Maggie E. Roberts

13. BIRTHPLACE OF MOTHER

(State or Country)

Wis

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Morris Owens

(Address)

Turn Falls & Co #3

15.

Filed

Oct 10 1922Pearle Dodds

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

September 26 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept. 22 1922, to Sept. 26 1922,
that I last saw him alive on Sept. 26 1922,
and that death occurred on the date stated above, at 3 A.M.

The CAUSE OF DEATH* was as follows:

acute intestinal obstruction(Duration) 6 Yrs. 0 mos. 4 ds.Contributory Bad digestive absorption
(Secondary)(Duration) 3 yrs. 6 mos. 0 ds.(Signed) Geo. D. Kellogg9-26-1922 (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Turn Falls & Co 19

20. UNDERTAKER

ADDRESS

Fred K. Robinson Nampa

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39577**

1. PLACE OF DEATH. **California** Registration District No. **7**
County of **San Diego** Primary Registration District No. **1006**
City of **Napa** (No. **1006** St.)

Registered No. **39577**
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Abbie E Stees**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **married**
(Write the word.)

6. DATE OF BIRTH **Mar 17 1857**
(Month) (Day) (Year)

7. AGE **65 yrs. 6 mos. 8 ds.**
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work **Housewife**
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE **Mass.**
(State or Country)

10. NAME OF FATHER **Ichabod Samson**

11. BIRTHPLACE OF FATHER **Mass.**
(State or Country)

12. MAIDEN NAME OF MOTHER **Mary Thompson**

13. BIRTHPLACE OF MOTHER **Mass.**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **J. E. Stees**
(Address) **Filer Ida**

15. Filed **Oct 10 1922** **Pearle Dodds**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **Sep 25 1922**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Sep 20 1922** to **Sep 25 1922**
that I last saw **her** alive on **Sep 25 1922**
and that death occurred on the date stated above, at **10 A.M.**

The CAUSE OF DEATH* was as follows:
Chronic Valvular Heart-Disease

(Duration) **4** yrs. mos. ds.

Contributory (Secondary)

(Duration) **4** yrs. mos. ds.

(Signed) **H. P. Roas** M. D.

Sep 19 1922 (Address) **Napa, Ida**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL **Filer Ida** DATE OF BURIAL **191...**

20. UNDERTAKER **Dred H. Robinson** ADDRESS **Napa Ida**

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of CanyonRegistration District No. 7City of NampaPrimary Registration District No. 1886City of Nampa (Ind.) St.)File No. 39579

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Beryl Hattie Robb

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widowed
(When the word.)

6. DATE OF BIRTH

Mar 7 1904
(Month) (Day) (Year)

7. AGE

18 Yrs. 7 Mos. 6 ds.
IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Housewife

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

O. C. McClure

11. BIRTHPLACE OF FATHER

(State or Country)

Mo.

12. MAIDEN NAME OF MOTHER

Minnie Partrick

13. BIRTHPLACE OF MOTHER

(State or Country)

Calif

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

O. C. McClure

15.

Filed Nov 6 1922Nampa IdaPearl D. Dicks
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 13 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Sept 29 1922 to Oct 13 1922
that I last saw her alive on Oct 13 1922
and that death occurred on the date stated above, at 11 AM.

The CAUSE OF DEATH* was as follows:

Perforation of bowel(Duration) Yrs. mos. ds.
Contributory (Secondary) Typhoid Fever(Duration) yrs. mos. ds.
(Signed) Drs Chilton & Belknap M. D.10-13-1922 (Address) Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Kohlerbury Cem 10-15 1922

20. UNDERTAKER

ADDRESS

Fred W. Robinson Nampa

FORM V. S. No. 5-A—25 M. 1-19.

322
CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of SamsonCity of Nampa

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7Primary Registration District No. 2006(No. Glenn)(St. Smith)State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39580**

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Glenn Smith

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDMale White single
(Write the word.)

6. DATE OF BIRTH

Apr 5 1922
(Month) (Day) (Year)

7. AGE

1 Yrs. 6 Mos. 14 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)none

9. BIRTHPLACE

(State or Country)

Ida

10. NAME OF FATHER

Calvin W Smith

11. BIRTHPLACE OF FATHER

(State or Country)

Mo.

12. MAIDEN NAME OF MOTHER

Oran A. Johnson

13. BIRTHPLACE OF MOTHER

(State or Country)

Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Calvin Smith

(Address)

Nampa R # 2

15.

Filed Nov 6 1922Frank J. Jorden

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 18 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 18 1922, to Oct 18 1922
that I last saw him alive on Oct 18 1922
and that death occurred on the date stated above, at 9 P M.

The CAUSE OF DEATH* was as follows:

Membranous croup(Duration) Yrs. mos. 3 ds.Contributory
(Secondary)Typhoid(Duration) yrs. mos. 2 ds.

(Signed)

Horace P. Belknap M. D.Oct 1922(Address) Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Kohlman Cem 11-20-1922

20. UNDERTAKER

ADDRESS

F. K. Robinson

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon
City of Hampden

Registration District No. 7
Primary Registration District No. 2056
(No. 7 St.)

File No. 39582
Registered No. 636

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Wm. Berry

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-OWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH Aug 23 1899
(Month) (Day) (Year)

7. AGE 63 Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Rancher
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Iowa

10. NAME OF FATHER Thos Berry

11. BIRTHPLACE OF FATHER
(State or Country) Ohio

12. MAIDEN NAME OF MOTHER Diana Moyer

13. BIRTHPLACE OF MOTHER
(State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mag. Wm. Berry
(Address) Rt 3 Hampden Mo

15. Filed Nov 6 1922 Peck Bode
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 23 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 2 1922 to Aug 17 1922
that I last saw him alive on Aug 17 1922
and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:
attended by Dr. Tallman
Aug 20 to 21
death - Hemiplegia
(Duration) Yrs. 3 mos. ds.

Contributory (Secondary) Dr. H. Tallman
(Signature) Yrs. mos. ds.
Geo. R. Crocker M. D.
(Address) Hampden

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Roughley Cem DATE OF BURIAL 10-21-1922

20. UNDERTAKER Frederic R. Turner ADDRESS Hampden

Printer

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED

NOV 8 1922

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of

Oanyon

City of

Nampa

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No.

7

Primary Registration District No.

1006

(No.)

St.)

Registered No.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 39584

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Fem

White

Married
(Write the word.)

6. DATE OF BIRTH

Aug. 4 1888
(Month) (Day) (Year)

7. AGE

83

Yrs.

Mos.

ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

Averard

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Kathrine

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J.E. Parks

(Address)

520 - 19 Ave. S.

15.

Filed

Nov. 6 1922

Pearle Dodd

Local Registrar

MEDICAL CERTIFICATE OF DEATH

135

16. DATE OF DEATH

Oct. 17 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 1 1922 to Oct 17 1922

that I last saw her alive on Oct 17 1922

and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Hemorrhage and Shock following confinement

(Duration)

Yrs.

3 hours
mos. ds.Contributory
(Secondary)

(Duration)

Yrs.

mos. ds.

(Signed)

Geo. R. Proctor M. D.

19

(Address)

Nampa, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death..... yrs..... mos..... days.

In the

State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rohrerbaum Cem

10 - 21 1922

20. UNDERTAKER

ADDRESS

F. H. Robinson

Nampa

FORM V. S. No. 5-A—25 M. 1-19.

1. PLACE OF DEATH

County of Bunyon

City of _____

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

RECEIVED CERTIFICATE OF DEATH

NOV 8 1922
Registration District No. _____

Primary Registration District No. _____

(No. _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

39585

File No. _____

Registered No. _____

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Male white (Write the word.)

6. DATE OF BIRTH

Feb 3 1913
(Month) (Day) (Year)

7. AGE

9 Yrs. Mos. ds. IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

In school

9. BIRTHPLACE

(State or Country) Oregon10. NAME OF
FATHER

J. S. Makin

11. BIRTHPLACE
OF FATHER(State or Country) Idaho12. MAIDEN NAME
OF MOTHER

Hattie Akley

13. BIRTHPLACE
OF MOTHER(State or Country) Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address) J. S. Makin

15.

Filed Nov 6 1922 Pearl Dada

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept. 3rd 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept. 26th 1922, to Oct. 3rd 1922that I last saw him alive on Oct. 3rd 1922

and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Subphrenic abscess.

(Duration) 0 Yrs. 0 mos. 2 ds.

Contributory (Secondary) Appendicitis.

(Duration) 8 yrs. 0 mos. 9 ds.

(Signed) W. A. R. Kuyper, M. D.

19 (Address) Nampa Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Nampa Cem. 10-5-1922

20. UNDERTAKER

H. K. Robinson Nampa

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

DEATH CERTIFICATE
County of Idaho NOV 8 1922
City of Nampa (STIC) Primaries Registration District No. 2001 St.) Registered No. 19
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME Ella Walker
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS
3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
6. DATE OF BIRTH Aug 9 1863
7. AGE 59 Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?
8. OCCUPATION Housewife
9. BIRTHPLACE Ill
10. NAME OF W. S. Hartford
11. BIRTHPLACE OF FATHER Ohio
12. MAIDEN NAME OF MOTHER Rebecca Thomas
13. BIRTHPLACE OF MOTHER Ohio
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Matt E. Howe
(Address) Nampa Ida
15. Filed Nov 6 1922 Pearle Dodd Local Registrar

MEDICAL CERTIFICATE OF DEATH
16. DATE OF DEATH Oct 11 1922
17. I HEREBY CERTIFY, That I attended deceased from Sept 26 1922 to Oct 10 1922
that I last saw her alive on Oct 10 1922
and that death occurred on the date stated above, at 9 A.M.
The CAUSE OF DEATH* was as follows:
Chronic Valvular Heart disease
(Duration) 3 Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) H. P. Ross M. D.
Oct 11 1922 (Address) Nampa, Ida
*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.
18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days.
Where was disease contracted if not at place of death?
Former or usual residence
19. PLACE OF BURIAL OR REMOVAL Kobukawa Bur DATE OF BURIAL 12/12/1922
20. UNDERTAKER F. K. Robinson ADDRESS Nampa Ida

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 7

County of Canyon

Primary Registration District No. 1006

City ofampa

(No. St.)

File No. 39587

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Oliver H. Cott

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male white widowed
(Write the word.)

6. DATE OF BIRTH

Sept 21 1842
(Month) (Day) (Year)

7. AGE

80 Yrs. 23 Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Wagon maker
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Penn

10. NAME OF FATHER

Jason M. Cott

11. BIRTHPLACE OF FATHER

(State or Country) Mass.

12. MAIDEN NAME OF MOTHER

Price

13. BIRTHPLACE OF MOTHER

(State or Country) Mass.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. M. Cott

(Address)ampa

15.

Filed Nov. 6 1922 Pearl D. Dadds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

October 14 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept. 2 1922, to Oct 14 1922

that I last saw him alive on Oct 14 1922

and that death occurred on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Valvular Insufficiency
Mitral Valve Leakage
(Duration) 1 Yrs. mos. ds.Contributory General Debility
(Secondary)

(Duration) 2 yrs. mos. ds.

(Signed) J. E. Standard M. D.

10-14-1922 (Address)ampa

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Dallas Co. 10 14 19

20. UNDERTAKER ADDRESS

Fred K. Robinsonampa

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 1086
(No. 118-jumper St.)

File No. 39588
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Maud V. Hout

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married

6. DATE OF BIRTH

Nov 10 1875
(Month) (Day) (Year)

7. AGE

46 Yrs. 11 Mos. 20 ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Housewife
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Id

10. NAME OF FATHER

James Cook

11. BIRTHPLACE OF FATHER

(State or Country) Id

12. MAIDEN NAME OF MOTHER

Pacal Wright

13. BIRTHPLACE OF MOTHER

(State or Country) Id

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) B. Hout
(Address) Nampa Ida

15.

Filed Nov 6 1922 Pearl D. Duda
Local Registrar

MEDICAL CERTIFICATE OF DEATH 28

16. DATE OF DEATH

Nov 1 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 23 1922 to 11-1- 1922
that I last saw h. alive on 11-1- 1922
and that death occurred on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 Yrs. 1 mos. 1 ds.
Contributory (Secondary) Bronchitis

(Duration) 3 yrs. 1 mos. 1 ds.
(Signed) D. C. Standard M. D.

19 (Address) NAMPA, IDAHO

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Buhl Ida

DATE OF BURIAL

11-2-1922

20. UNDERTAKER

FK Robinson

ADDRESS

Nampa Ida

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 7

County *Cumby*

Primary Registration District No. 2566

City of *Murfreesboro*(No. *57125* St.)

Registered No. 39590

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Santa Ruth Olamnia

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female White

(Write the word.)

6. DATE OF BIRTH

Oct 18 1922
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day
how many hrs.
or min.?Yrs. *5* Mos. *5* ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed *Nov. 6* 19*22**Pearle Dadds*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

10-22-1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

10-18-1922 to *10-22-1922*that I last saw her alive on *10-20-1922*and that death occurred on the date stated above, at *6 P. M.*

The CAUSE OF DEATH* was as follows:

acute enteric colitis(Duration) *0* Yrs. *0* mos. *4* ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *Geo. D. K. K. K. K. K.* M. D.19 (Address) *Nampa, Idaho.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Catholic Cem**10-24-22*

20. UNDERTAKER

ADDRESS

*Fred T. P. P. P.**Nampa*

1. PLACE OF DEATH

County of Canyon
 City of Caldwell

If death occurs away from
 usual residence, give facts
 called for under special in-
 formation.

RECEIVED

OCT 21 1922

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 3Registration District No. 1005-

St.)

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 39591Registered No. 94

If death occurred in a hos-
 pital, institution or camp,
 give its NAME instead of
 street and number.

2. FULL NAME Thomas Loy Lee

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Single

(Write the word.)

6. DATE OF BIRTH

Mch 5 1917

(Month)

(Day)

(Year)

7. AGE

5

Yrs.

6

Mos.

9

da.

IF LESS than 1 day

how many hrs.or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer).

9. BIRTHPLACE

(State or Country) Montana10. NAME OF
FATHERLoy H. Lee11. BIRTHPLACE
OF FATHER(State or Country) Utah12. MAIDEN NAME
OF MOTHERSusie F. Long13. BIRTHPLACE
OF MOTHER(State or Country) Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Susie F. Lee(Address) Caldwell Idaho

15.

Filed Sept. 15 - 1922

John B. Meyer
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept. 14-22

(Month)

(Day)

19

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

September 14, 1922 to September 14, 1922that I last saw him alive on September 14, 1922and that death occurred on the date stated above, at 12 noon M.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia(Duration) Yrs. two mos. ds.Contributory
(Secondary)(Duration) yrs. mos. ds.(Signed) C. R. Whittenberger D. O.Sept. 15, 1922 (Address) Caldwell, Idaho*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)At place
of death yrs. mos. days. In the
State yrs. mos. daysWhere was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Canyon Hill

DATE OF BURIAL

9-17-1922

20. UNDERTAKER

Paul L. Case

ADDRESS

Caldwell Ida

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39593**
Registered No. **102**

1. PLACE OF DEATH

County of QuincyCity of Maupass

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 3Primary Registration District No. 2005

St.)

2. FULL NAME

VITAL STATISTICS

Myrna Stevenson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

female white

(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

(Year)

7. AGE

3

Yrs. Mos. ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

At home

9. BIRTHPLACE

(State or Country)

Washington

10. NAME OF FATHER

W. E. Stevenson

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Julia Chase

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Geo. Chase

(Address)

Histon, Ida.

15.

Filed

Oct-8-1922John B. Meyer

Local Registrar

16. DATE OF DEATH

Oct 7

(Month)

(Day)

1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

October 6, 1922 to October 7, 1922that I last saw her alive on October 7, 1922and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Diphtheria

(Duration)

Yrs.

mos.

two ds.Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

C. P. Whittenberger, D.O.Oct 7, 1922 (Address) Caldwell, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Canyon HillOct 8, 1922

20. UNDERTAKER

ADDRESS

C. V. Beckham Caldwell

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39594**
Registered No. **101**

1. PLACE OF DEATH

County of Canyon
City of Wilder

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Hazel E. Stevenson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH

July 21 1921
(Month) (Day) (Year)

7. AGE

1 Yrs. 2 Mos. 12 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)At home

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

B. H. Stevenson

11. BIRTHPLACE OF FATHER

(State or Country)

Illinois

12. MAIDEN NAME OF MOTHER

Lizzie D. Brown

13. BIRTHPLACE OF MOTHER

(State or Country)

Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

B. H. Stevenson

(Address)

Wilder, Idaho

15.

Filed

Oct. 3 1922John V. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 3 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 1 1922 to Oct 3 1922that I last saw her alive on Oct 1 1922and that death occurred on the date stated above, at 4:20 M.

The CAUSE OF DEATH* was as follows:

Acute nephritis

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Oct 3 1922 (Address) Wilder, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wilder Cemetery10-3-1922

20. UNDERTAKER

ADDRESS

C. V. BeckhamCaldwell

1. PLACE OF DEATH

Canyon

County of

City of

Baldwell, R.T.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Nancy L. Nichols

RECEIVED CERTIFICATE OF DEATH

OCT 11 1922

BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

39595

Registered No.

100

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widow
(Write the word.)

6. DATE OF BIRTH

Sept

(Month)

13

(Day)

1922

(Year)

7. AGE

74

Yrs.

Mos.

19

ds.

IF LESS than 1 day
how many hrs.
or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

William Edsall

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Mamie Johnson

13. BIRTHPLACE OF MOTHER

(State or Country)

Id.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Jasper Nichols

(Address)

Baldwell

15.

Filed

Oct 3 - 1922

John H. Hughes -
Local Registrar

MEDICAL CERTIFICATE OF DEATH

77

16. DATE OF DEATH

Oct

2

(Month)

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 21, 1921, to Oct 1st 1922

that I last saw him alive on Oct 1st 1922

and that death occurred on the date stated above, at P. M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration) 1 Yrs. 2 mos. ds.

Contributory Age - Rheumatism,
(Secondary)

(Duration) 1 yrs. 2 mos. ds.

(Signed) T. D. Grossen, M. D.

10/2/22 (Address) Caldwell, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Banyon Hill

Oct 3 1922

20. UNDERTAKER

ADDRESS

Paul L. Case

Baldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

Stewart 79 one

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 39596
Registered No. 99

1. PLACE OF DEATH
County of Boise Registration District No. 3
City of Boise Registration District No. 2005 St.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Estella B. Kinney

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married

6. DATE OF BIRTH Oct 15 1881
(Month) (Day) (Year)

7. AGE 40 Yrs. 11 Mos. 16 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION House wife
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE Kansas
(State or Country)

10. NAME OF FATHER John R. Scott

11. BIRTHPLACE OF FATHER Indiana
(State or Country)

12. MAIDEN NAME OF MOTHER Louisa Harp

13. BIRTHPLACE OF MOTHER Iowa
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Albert Kinney
(Address) Homedale Ida.

15. Filed Oct. 3 1922 John V. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 1 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 27 1922 to Oct 1 1922
that I last saw him alive on Oct 1 1922
and that death occurred on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:
Structural Abnormality and Aneurysm
Operated
(Duration) Yrs. 8 mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) James Stewart M. D.
101 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Canyon Hill Cem. DATE OF BURIAL 10-3 1922

20. UNDERTAKER E. V. Deekham ADDRESS Caldwell

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39597**
Registered No. **98**

1. PLACE OF DEATH

Registration District No. **3**
County of **Canyon** Registration District No. **2005**
City of **Caldwell** (No. **VITAL** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

STATISTICS

Augusta Stivers

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Married**

6. DATE OF BIRTH

Jan. 1
(Month) (Day) (Year)

7. AGE

52 Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

House Wife

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Frank W. Stivers
Wilder Ida #1

15.

Filed

Oct. 1 - 1922

John V. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 29 19 **22**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 22 19 **19** to **Sept 29** 19 **22**
that I last saw her alive on **Sept 28** 19 **22**
and that death occurred on the date stated above, at **8:30 P.** M.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver

(Duration) Yrs. **6** mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. B. Beach M. D.

Sept 19 22 (Address) **Wilder Ida**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wilder Cemetery **10-1** 19 **22**

20. UNDERTAKER

ADDRESS

E. V. Beckham **Caldwell**

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39598**
Registered No. **97**

1. PLACE OF DEATH

County of Canyon Registration District No. 3
City of Greenleaf Primary Registration District No. 2005 St. STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Thos. C. Perisho

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married

6. DATE OF BIRTH

July 4 1861
(Month) (Day) (Year)

7. AGE

61 Yrs. 2 Mos. 21 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Iowa

10. NAME OF FATHER

John Perisho

11. BIRTHPLACE OF FATHER

(State or Country) North Carolina

12. MAIDEN NAME OF MOTHER

Fannie Marsh

13. BIRTHPLACE OF MOTHER

(State or Country) Don't know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. T. C. Perisho

(Address) Greenleaf, Ida

15.

Filed Sept. 28 - 1922 John L. Meyer

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 25 22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 20 1922 to Sept 25 1922
that I last saw him alive on Sept 20 1922
and that death occurred on the date stated above, at 9:45 P.M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) Yrs. mos. 3 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

9/26/22 (Address) Caldwell

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Greenleaf Cem 9-28-1922

20. UNDERTAKER

C. V. Peckham Caldwell

ADDRESS

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of CanyonCity of Caldwell

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Betty Lou FreemanRegistration District No. 3Primary Registration District No. 1004

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 39599Registered No. 96

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

(Write the word.)

6. DATE OF BIRTH

July
(Month)4 - 1917
(Day) (Year)

7. AGE

5

Yrs.

2

Mos.

15

ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

L.G. Freeman

11. BIRTHPLACE OF FATHER

(State or Country)

Iowa

12. MAIDEN NAME OF MOTHER

Beuna Orr

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Caldwell Idaho

15.

Filed

Sept 20 - 1922John P. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 19 1922

(Month)

(Day)

19

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 18 1922 to Sept. 19 1922
that I last saw her alive on Sept 19 1922

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Septic peritonitis, following obstruction from hemorrhoids.

(Duration)

Yrs.

mos.

2

ds.

Contributor
(Secondary)

(Duration)

Yrs.

mos.

1

ds.

(Signed)

C. M. Foley

M. D.

9-20-22(Address) Caldwell Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Canyon Hill

DATE OF BURIAL

9-20 1922

20. UNDERTAKER

Paul L. Case

ADDRESS

Caldwell Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39600**
Registered No. **95**

1. PLACE OF DEATH

Registration District No. **3**
County of **Canyon** Primary Registration District No. **2005**
City of **Caldwell** (No. **1**) St.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Henry William Kammejer
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **male** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **(write the word.)**

6. DATE OF BIRTH

Oct 15 1922
(Month) (Day) (Year)

7. AGE

11 Yrs. **3** Mos. **3** ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

at home

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

W. M. Kammejer

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Lillie Shelham

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wm Kammejer
Caldwell, Ida

(Address)

15.

Filled

Sept. 15 1922 **John H. Meyers**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 18 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 13 1922 to **Sept 15 1922**
that I last saw **him** alive on **Sept 15 1922**
and that death occurred on the date stated above, at **4:45 P.**
The CAUSE OF DEATH* was as follows:

Acute Enteric Colitis

(Duration) Yrs. mos. **6** ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) **Dr. G. R. Dudley** M. D.

19 (Address) **Caldwell-Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Star Cemetery **9-19-1922**

20. UNDERTAKER

ADDRESS

C. V. Beckham **Caldwell**

NORTH V. S. DEPARTMENT OF HEALTH

PLACE OF DEATH

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Statistics

3960

County of *Franklin*Registration District No. *2139*

File No.

City of *Franklin*(No. *Dr. Mackley Hospital* St.)Registered No. *14*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Perle Jensen

3. RACE AND STATISTICAL PARTICULARS

COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Married
(Write the word.)*White*

DATE OF BIRTH

August 4
(Month) (Day) (Year)*1842*

AGE

79 Yrs. *2* Mos. *11* ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)*Retired*

9. BIRTHPLACE

(State or Country)

Denmark

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

Denmark

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. P. Jensen
Montpelier

(Address)

15.

Filed *Oct 16* 19 *22**Eccis Hawley*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 15
(Month) (Day)17. I HEREBY CERTIFY, That I attended deceased from *June 15* 19 *22*, to *Oct 16* 19 *22*that I last saw him alive on *Oct 16* 19 *22*
and that death occurred on the date stated above, at *30* M.

The CAUSE OF DEATH* was as follows:

Chronic Cydosis(Duration) *5* Yrs. mos.Contributory (Secondary) *Indurated Prostate Gland*

(Duration) yrs. mos.

(Signed) *Eccis Hawley* M. D.

19 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. In the days. State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Montpelier Idaho**Oct 18*

20. UNDERTAKER

ADDRESS

*Schumacher & Hall**Portland*

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED

NOV 3 1922

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39602**
Registered No. **45**

1. PLACE OF DEATH

County of Canyon
City of Soda Springs

Registration District No. 82Primary Registration District No. 2159

(No. _____ St.)

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

John Williams

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDMW

(Write the word.)

6. DATE OF BIRTH

Nov 15th 1854
(Month) (Day) (Year)

7. AGE

67 Yrs. 10 Mos. 14 ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer).Farmer

9. BIRTHPLACE

(State or Country)

South Wales10. NAME OF
FATHERUnknown11. BIRTHPLACE
OF FATHER

(State or Country)

Unknown12. MAIDEN NAME
OF MOTHERUnknown13. BIRTHPLACE
OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John Williams

(Address)

Soda Springs Idaho

15.

Filed Oct 3rd 1922

Edwin Kelley
Local Registrar

MEDICAL CERTIFICATE OF DEATH

40

16. DATE OF DEATH

Oct 1 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sep 27 1922 to Oct 1 1922

that I last saw him alive on Oct 1 1922

and that death occurred on the date stated above, at 20 M.

The CAUSE OF DEATH* was/as follows:

Causes of Stomach

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

19 _____ (Address) _____

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho

19 _____

20. UNDERTAKER

ADDRESS

Johnson & HallCannella

CERTIFICATE OF DEATH

Patterson
State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 39603
Registered No. 616

1. PLACE OF DEATH **RECEIVED**
Registration District No. 117
County of **Latah** Registration District No. 2196
City of **Burley** (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Les Allen Palmer**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX **M** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Single**

6. DATE OF BIRTH

July 2 1922
(Month) (Day) (Year)

7. AGE

0 Yrs. **7** Mos. **3** ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Otis Palmer

11. BIRTHPLACE OF FATHER

(State or Country)

Mo

12. MAIDEN NAME OF MOTHER

Minnie Blazer

13. BIRTHPLACE OF MOTHER

(State or Country)

Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Otis Palmer

(Address)

Burley

15.

Filed

Oct. 3

1922

H. J. C. Patterson

Local Registrar

16. DATE OF DEATH

Sept 5 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Aug. 1 1922**, to **Sept 8.5 1922**, that I last saw him alive on **Sept. 4 1922**, and that death occurred on the date stated above, at **10.9 A. M.**

The CAUSE OF DEATH* was as follows:

abscess of Brain

(Duration) Yrs. mos. **36** ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. C. Patterson M. D.

(Address)

Burley, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Heapath Hill

Sept 6 1922

20. UNDERTAKER

ADDRESS

J. W. Pratt

Burley

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Cassia Registration District No. 117
 City of Burley Registration District No. 2196
 If death occurs away from usual residence, give facts called for under special information. (No. 1) St.)

File No. 622
 Registered No. 622
 If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Marionne Heyman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
 (Write the word.)

6. DATE OF BIRTH. Sept 5 1922
 (Month) (Day) (Year)

7. AGE IF LESS than 1 day how many hrs. or min.?
 Yrs. Mos. 4 ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Burley Ida.

10. NAME OF FATHER

George A. Heyman

11. BIRTHPLACE OF FATHER

(State or Country) Utah

12. MAIDEN NAME OF MOTHER

Emma Johnson

13. BIRTHPLACE OF MOTHER

(State or Country) Orid Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) George A. Heyman
 (Address) Burley Ida.

15. Filed Oct. 7th 1922 Prof. C. Patterson
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 9 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 5 1922 to Sept. 9 1922
 that I last saw her alive on Sept. 9 1922
 and that death occurred on the date stated above, at 5 a. M.

The CAUSE OF DEATH* was as follows:
Congenital Malformation

(Duration) Yrs. mos. ds.
 Contributory (Secondary)

(Duration) Yrs. mos. ds.
 (Signed) J. C. Patterson M. D.
9-9-22 (Address) Burley, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days, State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Orid Ida. DATE OF BURIAL Sept. 10 1922

20. UNDERTAKER L. B. Gallagher ADDRESS Burley Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BLENDING

1. PLACE OF DEATH

County of Cassia
City of Burley

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ella Hoagland

CERTIFICATE OF DEATH

Registration District No. 117Primary Registration District No. 2196

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 39605Registered No. 617

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Sept. 15 1922
(Month) (Day) (Year)

7. AGE

Yrs. 9 Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

None

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Burley Ida.

10. NAME OF FATHER

Joseph D. Hoagland

11. BIRTHPLACE OF FATHER

(State or Country) Salt Lake City Utah

12. MAIDEN NAME OF MOTHER

Sarah Evelyn Petting

13. BIRTHPLACE OF MOTHER

(State or Country) Willard Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. D. Hoagland
(Address) Burley Ida. For C.A.R.

15.

Filed Oct. 2 1922 Dr. J. C. Patterson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept. 24 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept. 15, 1922, to Sept. 24, 1922.
that I last saw her alive on Sept. 23, 1922.
and that death occurred on the date stated above, at 3:00 P.M.

The CAUSE OF DEATH* was as follows:

Septicemia Gravis (Sepsis)(Duration) Yrs. 9 mos. ds.Contributory Recto-rectal Abscess in mother
(Secondary) at birth of child.

(Duration) yrs. mos. ds.

(Signed) C. H. Rich M. D.9-24-1922 (Address) Burley Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Burley Idaho.

DATE OF BURIAL

Sept. 25, 1922

20. UNDERTAKER

None

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V, S. No. 5-12 M, 6-15-17.

RECEIVED
OCT 21 1922
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

39606

Patterson
State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No.
Registered No. *614*
If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

1. PLACE OF DEATH

County of *Coosia*
City of *Burley*
If death occurs away from
usual residence, give facts
called for under special
information.

Registration District No.
Registration District No.
(No. St.)

2. FULL NAME *Emma Josephine Kymas*

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED. *Married* (Write the word.)

6. DATE OF BIRTH. *Feb. 7*
(Month) (Day) (Year)

7. AGE *37* Yrs. Mos. ds.
IF LESS than 1 day
how many hrs. or
.... min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work *Housewife*
(b) General nature of in-
dustry, business, or estab-
lishment in which em-
ployed (or employer)

9. BIRTHPLACE

(State or Country) *Ovid Ida*

10. NAME OF
FATHER

Nels Johnson

11. BIRTHPLACE
OF FATHER

(State or Country) *Idaho*

12. MAIDEN NAME
OF MOTHER

Annie Berg

13. BIRTHPLACE
OF MOTHER

(State or Country) *Norway*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Geo. A. Kymas*
(Address) *R. F. #2, Burley, Ida.*

15. Filed *9-6-22* 191... *P. J. C. Patterson*
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *Sept. 5* 19*22*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Sept. 2 19*22* to *Sept. 5* 19*22*
that I last saw him alive on *Sept. 5* 19*22*
and that death occurred on the date stated above, at *8:50 P. M.*

The CAUSE OF DEATH* was as follows:

Infection of Gall bladder.
(Duration) *Unknown* yrs. ds.
Contributory *Pregnancy*
(Secondary)
(Duration) *8 1/2* yrs. mos. ds.
(Signed) *J. C. Patterson* M. D.
..... 19... (Address)

*State the Disease Causing Death; or in deaths from Violent
Causes, state (1) Means of Injury; and (2) whether Accidental,
Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place In the
of death yrs. mos. days, State yrs. mos. days
Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Liberty, Idaho

DATE OF BURIAL

Sept. 7 1922

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

1. PLACE OF DEATH

Registration District No. 117
 County of Cassia Primary Registration District No. 2196
 City of Burley (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Rolph Merrill Steel

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 39607Registered No. 625

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED Single (Write the word.)

6. DATE OF BIRTH

June 28 1
 (Month) (Day) (Year)

7. AGE

13 Yrs. 2 Mos. 5 ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Little Basin Idaho.

10. NAME OF FATHER

James S. Steel

11. BIRTHPLACE OF FATHER

(State or Country) Utah

12. MAIDEN NAME OF MOTHER

Annie M. Spray

13. BIRTHPLACE OF MOTHER

(State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James S. Steel

(Address) R.D. 1, Carey Ida.

15.

Filled Oct. 7 1922 R. J. C. Patterson

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 2 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug. 30 — 1922 to Sept 2nd — 1922.
 that I last saw him alive on Sept. 2nd 1922
 and that death occurred on the date stated above, at 10 P.M.
 The CAUSE OF DEATH* was as follows:

General Peritonitis

(Duration) Yrs. mos. ds.

Contributory
 (Secondary)

Appendicitis

(Duration) Yrs. mos. ds.

(Signed)

H. H. Cooper

M. D.

19

(Address)

Burley Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Little Basin Ida.

DATE OF BURIAL

Sept 5, 1922

20. UNDERTAKER

L. B. Talcott

ADDRESS

Burley Ida.

39608

Casper.

FORM V. S. No. 5-A-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH **RECEIVED**
 County of Cassia Registration District No. 117
 City of Burley Primary Registration District No. 2196
 (St.)

File No. 624
 Registered No. 624

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Kamiah Louise Jenkins

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED Married
 (Write the word.)

6. DATE OF BIRTH

April 27 1922
 (Month) (Day) (Year)

7. AGE

47 Yrs. 5 Mos. # ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Gauntville Utah

10. NAME OF FATHER

Thos. Williams

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

June Fawcett

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas. Jenkins

(Address) Burley Ida. R.F.D.

15. Filed Oct. 7 1922 H. J. Pullman
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept. 27 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 24 1922 to Sept. 27 1922
 that I last saw him alive on Sept. 27 1922
 and that death occurred on the date stated above, at 11 P.M.
 The CAUSE OF DEATH* was as follows:

General Peritonitis

(Duration) Yrs. 3 mos. 3 ds.
 Contributory (Secondary) Peritoneal Tubal Abscess

(Duration) Yrs. 28 mos. 28 ds.
 (Signed) C. J. Casper M. D.

19. (Address) Burley Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. 3 mos. 3 days. In the State Yrs. 3 mos. 3 days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Burley Idaho

DATE OF BURIAL

Sept. 30 1922

20. UNDERTAKER

L. B. Greengard

ADDRESS

Burley Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

39609

Smith.

FORM V. S. No. 5-12 M. 6-15-17.

RECEIVED
CERTIFICATE OF DEATH

Registration District No. 117

Bureau of Vital Statistics
Registration District No. 2196

(No. 117 St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 623

Registered No. 623
If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

1. PLACE OF DEATH

County of Cassia

City of Burley

If death occurs away from
usual residence, give facts
called for under special
information.

2. FULL NAME Glen Andrew Summow

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

Single (Write the word.)

6. DATE OF BIRTH.

July 10 1921
(Month) (Day) (Year)

7. AGE

1 Yrs. 3 Mos. ds.

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of in-
dustry, business, or estab-
lishment in which em-
ployed (or employer)

9. BIRTHPLACE

(State or Country)

Burley Ida.

10. NAME OF
FATHER

Fred Summow

11. BIRTHPLACE
OF FATHER

(State or Country)

Illinois

12. MAIDEN NAME
OF MOTHER

May E. Wickor

13. BIRTHPLACE
OF MOTHER

(State or Country)

Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Fred Summow

(Address) R. F. D. # 4, Burley, Ida.

15.

Filed Oct. 7 1922 Orla Patterson
Local Registrar.

MEDICAL CERTIFICATE OF DEATH 104

16. DATE OF DEATH

Aug. 30 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY That I attended deceased from

Aug. 28 1922 to Aug. 30 1922

that I last saw him alive on Aug. 30 1922

and that death occurred on the date stated above, at 9:45 P. M.

The CAUSE OF DEATH* was as follows:

Acute Ileo colitis

(Duration) Yrs. mos. 5 ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

8/30 1922 (Address) Burley Idaho

*State the Disease Causing Death; or in deaths from Violent
Causes, state (1) Means of Injury; and (2) whether Accidental,
Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)At place In the
of death yrs. mos. days, State yrs. mos. daysWhere was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Burley Ida.

DATE OF BURIAL

Sept. 1st 1922

20. UNDERTAKER

L. B. Gallagher

ADDRESS

Burley

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S
should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement
of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

39610

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No.
Registered No. 621...
If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.1. PLACE OF DEATH RECEIVED
County of Cassia OCT 21 1922 Registration District No. 117
City of Burley Registration District No. 2196 (St.)
If death occurs away from
usual residence, give facts
called for under special
information.2. FULL NAME Levon Bays

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED. Single (Write the word.)6. DATE OF BIRTH. Dec 13 1
(Month) (Day) (Year)7. AGE 2 Yrs. 8 Mos. 27 ds.
IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work at home
(b) General nature of in-
dustry, business, or estab-
lishment in which em-
ployed (or employer)

9. BIRTHPLACE

(State or Country) Burley Ida.10. NAME OF
FATHERSennie P. Bays11. BIRTHPLACE
OF FATHER(State or Country) Carter Co. Ky.12. MAIDEN NAME
OF MOTHERCressie M. Tabor13. BIRTHPLACE
OF MOTHER(State or Country) Carter Co. Ky.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) S. P. Bays(Address) Burley Ida.15. Oct 7 1922 Dr. J. C. Patterson

Filed Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 9 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
191. to 191.that I last saw h. alive on 191.
and that death occurred on the date stated above, at 11:20 A.M.

The CAUSE OF DEATH* was as follows:

Symptomatic
(Duration) Yrs. mos. ds.Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) L. B. Talley Cooner M.D.
9/9/1922 (Address) Burley Ida.*State the Disease Causing Death; or in deaths from Violent
Causes, state (1) Means of Injury; and (2) whether Accidental,
Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)At place In the
of death yrs. mos. days, State yrs. mos. daysWhere was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Burley Ida.

DATE OF BURIAL

9/12/1922

20. UNDERTAKER

L. B. Talley

ADDRESS

Burley Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS
should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement
of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

39611

State of Idaho
BOARD OF HEALTH

Bureau of Vital Statistics

File No.

Registered No. 620
If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

1. PLACE OF DEATH

County of Cassia Registration District No. 117
City of Burley Primary Registration District No. 2196
If death occurs away from
usual residence, give facts
called for under special
information. 427 N. Yale Ave. St.)2. FULL NAME Mary Virginia Martui

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.Female White Single (Write the word.)

6. DATE OF BIRTH.

Nov. 2 1
(Month) (Day) (Year)

7. AGE

4 Yrs. 10 Mos. 22 ds.IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work At Home
(b) General nature of in-
dustry, business, or estab-
lishment in which em-
ployed (or employer)

9. BIRTHPLACE

(State or Country) Burley Ida.10. NAME OF
FATHERAlfred H. Martui11. BIRTHPLACE
OF FATHER(State or Country) Jewell Co., Kansas.12. MAIDEN NAME
OF MOTHERMary Boldt13. BIRTHPLACE
OF MOTHER(State or Country) Michigan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Abe Martui(Address) Burley Ida.15. Filed Oct. 7 1922 D. J. Patterson

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

40

16. DATE OF DEATH

Sept 24 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

..... 191..... to 191.....
that I last saw h..... alive on 191.....

and that death occurred on the date stated above, at P.M.

The CAUSE OF DEATH* was as follows:

Sarcema Liver
(Duration) Yrs. 2 mos. ds.Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) L. B. Galloway Cooper M.D...... 19..... (Address) Burley Ida.*State the Disease Causing Death; or in deaths from Violent
Causes, state (1) Means of Injury; and (2) whether Accidental,
Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)At place In the
of death yrs. mos. days, State yrs. mos. daysWhere was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Burley Ida.

DATE OF BURIAL

Sept. 25, 1922

20. UNDERTAKER

L. B. Galloway

ADDRESS

Burley Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS
should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement
of OCCUPATION is very important. See instructions on back of certificate.

39612

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No.
Registered No. 619
If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

CERTIFICATE OF DEATH

1. PLACE OF DEATH
County of Cassia District No. 117
City of Burley Primary Registration District No. 2196
(No. St.)

If death occurs away from
usual residence, give facts
called for under special
information.

2. FULL NAME

Mary Golden

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH

March 18
(Month) (Day) (Year)

7. AGE

53 Yrs. 6 Mos. 1 ds.

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of in-
dustry, business, or estab-
lishment in which em-
ployed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Kansas

10. NAME OF FATHER

John Glamer

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. N. Golden

(Address)

R. F. S. Hayburn Ida.

15.

Filed

Oct 1 1922R. J. C. Patterson
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

41

16. DATE OF DEATH

Sept 19 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
191 to 191

that I last saw h. alive on 191

and that death occurred on the date stated above, at 6:00 A.M.

The CAUSE OF DEATH* was as follows:

Cancer of Bowels

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) L. B. Gecology (Coroner)9/19/1922, (Address) Burley Ida.

*State the Disease Causing Death; or in deaths from Violent
Causes, state (1) Means of Injury; and (2) whether Accidental,
Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days, State yrs. mos. days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Hayburn Ida.

DATE OF BURIAL

Sept. 21 1922

20. UNDERTAKER

L. B. Gecology

ADDRESS

Burley Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S
should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement
of OCCUPATION is very important. See instructions on back of certificate.

OCT 21 1922

CERTIFICATE OF DEATH

39613

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics1. PLACE OF DEATH
County of Cassia **STAT.**
City of BurleyRegistration District No. 117
Primary Registration District No. 2196
(No. St.)File No.
Registered No. 618

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Charles Wm. Erickson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH

Dec. 9 1885
(Month) (Day) (Year)

7. AGE

36 Yrs. 9 Mos. 21 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Mechanic

9. BIRTHPLACE

(State or Country)

Sweden

10. NAME OF FATHER

William Erickson

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) M. R. Chas. W. Erickson
(Address) Burley Ida.

15.

Filed Oct 1 19 22 H. J. C. Patterson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept. 30 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Sept 20 - 1922 to Sept 30 - 1922
that I last saw him alive on Sept 30 - 1922
and that death occurred on the date stated above, at 11 P. M.
The CAUSE OF DEATH* was as follows:Typhoid(Duration) Yrs. mos. ds.
Contributory (Secondary) Pneumonia(Duration) Yrs. mos. ds.
(Signed) Joseph Fremstad M. D.10/6 19 22 (Address) Burley Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. daysWhere was disease contracted if not at place of death? Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Burley Ida.

DATE OF BURIAL

Oct 3 - 1922

20. UNDERTAKER

L. B. Tallogly

ADDRESS

Burley Ida.

CERTIFICATE OF DEATH

39615

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No.
Registered No. 613....
If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

1. PLACE OF DEATH

County of Cassia

Registration District No.

Primary Registration District No.

City of BurleyIf death occurs away from
usual residence, give facts
called for under special
information.

2. FULL NAME

Louisa May George

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.Married
(Write the word.)

6. DATE OF BIRTH.

Oct 10 1881
(Month) (Day) (Year)

7. AGE

40 Yrs. 10 Mos. 26 ds.IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of in-
dustry, business, or estab-
lishment in which em-
ployed (or employer)Housewife

9. BIRTHPLACE

(State or Country) Bountiful Utah.10. NAME OF
FATHERSamuel J. Page11. BIRTHPLACE
OF FATHER(State or Country) England12. MAIDEN NAME
OF MOTHERMary Ann Maddox13. BIRTHPLACE
OF MOTHER(State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ray George(Address) R. F. D. #1 Burley, Id.

15.

Filed

Sept. 5 1922 W. J. C. Patterson
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 4
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug. 1 1922 to Sept 4 1922that I last saw her alive on Sept 3 1922and that death occurred on the date stated above, at 5 9 A. M.

The CAUSE OF DEATH* was as follows:

Gout and Valv. Heart trouble(Duration) Five Yrs. mos. ds.Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

G. E. Craver

M. D.

Sept 5 1922 (Address) Burley, Idaho*State the Disease Causing Death; or in deaths from Violent
Causes, state (1) Means of Injury; and (2) whether Accidental,
Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)At place In the
of death yrs. mos. days, State yrs. mos. daysWhere was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Bountiful Utah.

DATE OF BURIAL

9/6/22 191...

20. UNDERTAKER

L. B. Galloway

ADDRESS

Burley Id.

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

OCT 21 1922

Registration District No.

Primary Registration District No.

(No.)

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19
that I last saw him alive on Sept 19 1922
and that death occurred on the date stated above, at 1 A. M.
The CAUSE OF DEATH* was as follows:Premature
No care for several hours
after birth
(Duration) Yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

N. B.—Every issue of information in plain terms, not that is necessary on back of certificate.

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 38617

1. PLACE OF DEATH OCT 26 1922
County of Clearwater BUREAU'S REGISTRATION DISTRICT No. 2168
City of Profins (No. St.)

Registered No. 47
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henry Clay Sage

PERSONAL AND STATISTICAL PARTICULARS

SEX Male 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widowed (Write the word.)

DATE OF BIRTH March 2nd 1882 (Month) (Day) (Year)

AGE 90 Yrs. 6 Mos. 18 ds. IF LESS than 1 day how many hrs. or min.?

OCCUPATION Trade, profession or regular kind of work Carpenter General nature of industry, business or establishment in which employed (or employer)

BIRTHPLACE (State or Country) Ohio

NAME OF FATHER Isaac Sage

BIRTHPLACE OF FATHER (State or Country) Unknown

MAIDEN NAME OF MOTHER Mary Cambell

BIRTHPLACE OF MOTHER (State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ralph Shriver (Address) Profins Idaho

15. Filed Oct 27 1922 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 20 1922 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 19 to 19 that I last saw h. alive on 19 and that death occurred on the date stated above, at 2 P.M. The CAUSE OF DEATH* was as follows:

Paralysis

(Duration) Yrs. mos. ds. Contributory (Secondary) Paralysis (Duration) yrs. mos. ds.

(Signed) J. M. Fawcett (Address) Profins 9/21/22

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Profins, Ida. DATE OF BURIAL Sept 23 1922

20. UNDERTAKER L. E. Bobo ADDRESS Profins Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-17

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

 County of Clearwater
 City of Grew
Registration District No. 90Primary Registration District No. 2168

(No. _____ St.)

 If death occurs away from
 usual residence, give facts
 called for under special
 information.

2. FULL NAME

Julia Pratt
 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
File No. 39618Registered No. 44
 If death occurred in a hos-
 pital, institution or camp,
 give its NAME instead of
 street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.Widow
(Write the word.)

6. DATE OF BIRTH.

Aug 3 1848
 (Month) (Day) (Year)

7. AGE

79 Yrs. _____ Mos. _____ ds.

 IF LESS than 1 day
 how many _____ hrs. or
 _____ min.?

8. OCCUPATION

 (a) Trade, profession or
 particular kind of work...
 (b) General nature of in-
 dustry, business, or estab-
 lishment in which employ-
 ed (or employer).....
Housewife

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

Peater Nickum

11. BIRTHPLACE OF FATHER

(State or Country)

L

12. MAIDEN NAME OF MOTHER

Bettie Harland

13. BIRTHPLACE OF MOTHER

(State or Country)

L

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

G. H. Farnar

(Address)

Grew

15.

Filed

Oct 1, 1922
J. M. Fairly
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 17 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

 191..... to 191.....
 that I last saw her alive on 191.....
 and that death occurred on the date stated above, at 5:30 M.

The CAUSE OF DEATH* was as follows:

Heart failure

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

9/17/1922 (Address) Dr. J. M. Fairly M. D.

 *State the DISEASE CAUSING DEATH; or in death from VIOLENT CAUSES, state (1)
 MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

 Where was disease contracted
 if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

GibbetSept 18 1922

20. UNDERTAKER

ADDRESS

W. A. ShawCrofton

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED
001

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
39619
File No.
Registered No. 45

1. PLACE OF DEATH
County of Clearwater,
City of Orofino, Idaho.
Registration District No. 40
Primary Registration District No. 2168
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME TONY AIGNER,

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White, 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single,
(Write the word.)

6. DATE OF BIRTH
July Twenty-sixth, 1892,
(Month) (Day) (Year)

7. AGE
30 Yrs. 1 Mos. 24 ds.
IF LESS than 1 day how many..... hrs. or..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work None - Cripple,
(b) General nature of industry, business or establishment in which employed (or employer) None - Cripple,

9. BIRTHPLACE
(State or Country) Clinton, Wisconsin,

10. NAME OF FATHER
Aigner,

11. BIRTHPLACE OF FATHER
(State or Country) Unknown,

12. MAIDEN NAME OF MOTHER
Unknown,

13. BIRTHPLACE OF MOTHER
(State or Country) Unknown,

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John W. Givens
(Address) Orofino, Idaho.

15. Cox, 19 32 John W. Givens
Filed Local Registrar

16. DATE OF DEATH
September Eighteenth, 1922,
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 29th 1922, to Sept. 18th 1922, that I last saw him alive on Sept. 18th 1922, and that death occurred on the date stated above at M. The CAUSE OF DEATH* was as follows: 8:29 P. M. Cerebral Hemorrhage,

24 hours.
(Duration) Yrs. mos. ds.
Contributory (Secondary) Insanity,
Unknown,
(Duration) yrs. mos. ds.
(Signed) John W. Givens M. D.
9/19th, 22, (Address) Orofino, Idaho,

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place 1 yrs. 9 mos. 21 In the About days. State 8 yrs. mos. days
Where was disease contracted if not at place of death? Edgemere, Bonner Co., Idaho
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL N. 1. Sanitarium Cemetery, DATE OF BURIAL 9/21 1922
Grave #1, Row #6, New Add.,
20. UNDERTAKER Ed Elmore, ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39620**
Registered No. **43**

1. PLACE OF DEATH
County of *Clatsop* Registration District No. *90*
City of *Trask* (No. *1322*) St. *2/68*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Delan Carey*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. *Single*
(Write the word.)

16. DATE OF DEATH
Sept (Month) *4* (Day) *1922* (Year)

6. DATE OF BIRTH
March (Month) *11* (Day) *1921* (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Sept 4* 1922, to *Sept 4* 1922, that I last saw him alive on *Sept 4* 1922, and that death occurred on the date stated above, at *11.2* M.

7. AGE
1 Yrs. *7* Mos. ds.
IF LESS than 1 day how many hrs. or min.?

The CAUSE OF DEATH was as follows:
*Acute Septic enteric
exhaustion*

8. OCCUPATION
(a) Trade, profession or particular kind of work... *none*
(b) General nature of industry, business, or establishment in which employed (or employer).....

(Duration) Yrs. *18* Mos. ds.

9. BIRTHPLACE
(State or Country) *Ida*

Contributory (Secondary)

10. NAME OF FATHER *Frank Carey Jr*

(Signed) *E. W. Hargraves* M. D.

11. BIRTHPLACE OF FATHER
(State or Country)

19 (Address) *Trask Ida*

12. MAIDEN NAME OF MOTHER *Lucy Hull*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

13. BIRTHPLACE OF MOTHER
(State or Country) *Ida*

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) *Frank Carey*

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

(Address) *Trask*

Where was disease contracted if not at place of death?.....

15. Filed *Oex* 1922 *January*

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Trask Ida* DATE OF BURIAL *Sept 6 1922*

20. UNDERTAKER *V. A. Shaw* ADDRESS *Trask*

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39621**
Registered No. **46**

1. PLACE OF DEATH

County of **Clearwater,** Registration District No. **90**
City of **Crofino,** Primary Registration District No. **5168**
(No. _____) (St. _____)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **JOHN ANDERSON,**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX **Male** 4. COLOR OR RACE **White,** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Divorced,**
(Write the word.)

6. DATE OF BIRTH

About 1862
(Month) (Day) (Year)

7. AGE

Abt. 60 IF LESS than 1 day
Yrs. Mos. ds. how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work **Miner and Stage Driver,**
(b) General nature of industry, business or establishment in which employed (or employer) **Mining and driving stage.**

9. BIRTHPLACE

(State or Country) **Boston, Massachusetts,**

10. NAME OF FATHER

Anderson,

11. BIRTHPLACE OF FATHER

(State or Country) **Unknown,**

12. MAIDEN NAME OF MOTHER

Unknown,

13. BIRTHPLACE OF MOTHER

(State or Country) **Unknown,**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **John J. Givens**
(Address) **Crofino, Idaho.**15. **Oct 12**
Filed **1922****John J. Givens**
Local Registrar

16. DATE OF DEATH

September 21st **22,**
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from **June 22nd, 1913** to **Sept. 21st 1922**
that I last saw him alive on **Sept. 20, 1922,**
and that death occurred on the date stated above, at **M.**
The CAUSE OF DEATH* was as follows: **9:08 P.M.**
Typhoid Fever.(Duration) **0** Yrs. **0** mos. **10** ds.
Contributory (Secondary) **Insanity.**(Duration) **Unknown,** mos. ds.
(Signed) **John J. Givens** M. D.
(Address) **Crofino, Idaho.**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death **9** yrs. **3** mos. **27** days. In the State **27** yrs. mos. daysWhere was disease contracted if not at place of death? **The Northern Idaho Sanitarium,**Former or usual residence **Elk City, Idaho.**

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Place 2 Row 6 - New and the Northern Idaho Sanitarium **9/23/1922**20. UNDERTAKER **P. M. Johnson,** ADDRESS **Crofino, Idaho.**

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

39622

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Clearwater*
City of *Proffins*Registration District No. *90*Primary Registration District No. *2168*

File No. _____

Registered No. *48*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Benjamin Harris Simmons
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

single

(Write the word.)

6. DATE OF BIRTH

9/18
(Month) (Day) (Year)

7. AGE

3 Yrs. *7* Mos. *8* ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

none

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

James Simmons

11. BIRTHPLACE OF FATHER

(State or Country)

Missouri

12. MAIDEN NAME OF MOTHER

Lace Clark

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho, Wash.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Benjamin Harris Simmons

(Address)

Idaho

15.

Filed

Oct 1 1922 J. M. Bailey
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept. 21 19*22*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept. 11 19*22* to *Sept. 21* 19*22*
that I last saw him alive on *Sept. 21* 19*22*and that death occurred on the date stated above, at *1 P.* M.

The CAUSE OF DEATH was as follows:

Stroke

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

E. M. Brownell

M. D.

19

(Address)

Proffins, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Proffins, Idaho

DATE OF BURIAL

Sept. 22 1922

20. UNDERTAKER

J. B. Bono

ADDRESS

Proffins, Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Clearwater,City of Orofino,

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 90Primary Registration District No. 2168(No.)(St.)File No. 39623Registered No. 49

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME FRANK SEIPEL,

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White,

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married,

(Write the word.)

6. DATE OF BIRTH

About1896

(Month)

(Day)

(Year)

7. AGE

Abt. 26Yrs. Mos. ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Fireman,

(b) General nature of industry, business or establishment in which employed (or employer)

Unknown,

9. BIRTHPLACE

(State or Country)

Butte, Montana,

10. NAME OF FATHER

Seipel,

11. BIRTHPLACE OF FATHER

(State or Country)

St. Louis, Missouri,

12. MAIDEN NAME OF MOTHER

Unknown,

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah,

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. H. Hattaway(Address) Orofino, Idaho,

15.

Filed Oct 1, 1922Local Registrar J. W. Fain

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

September 21st

(Month)

(Day)

22,
(Year)17. I HEREBY CERTIFY, That I attended deceased from Jan. 28th--- 1922, to Sept. 21st 1922, that I last saw him alive on Sept. 20th, 1922, and that death occurred on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis,Unknown,

(Duration)

Yrs. mos. ds.

Contributory (Secondary)

Insanity,

(Duration)

Yrs. mos. ds. (Signed) John W. HinesM. D. 7/23/1922(Address) Orofino, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 0 yrs. 7 mos. 25 days. In the State 0 yrs. 11 mos. 11 days

Where was disease contracted if not at place of death?

Former or usual residence

Wallace, Idaho, Butte, Montana.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

W. H. Hines Orofino

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

County of Clearwater
City of Orlando

Registration District No. 90
Primary Registration District No. 2168
(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Donatha Beckin

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 39624
Registered No. 52

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-OWED OR DIVORCED.

Female white

Single
(Write the word.)

6. DATE OF BIRTH.

June 3 1907
(Month) (Day) (Year)

7. AGE

15 Yrs. 6 Mos. 23 ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

None

9. BIRTHPLACE

(State or Country)

Ida

10. NAME OF FATHER

John Beckin

11. BIRTHPLACE OF FATHER

(State or Country)

Missouri

12. MAIDEN NAME OF MOTHER

Minie Schumaker

13. BIRTHPLACE OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

John Beckin

(Address)

Gilbert

15.

Filed

Oct 1 1922

J. M. Smith
Local Registrar

16. DATE OF DEATH

Sept 26 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1912 to Sept 26 1922, that I last saw him alive on Sept 26 1922 and that death occurred on the date stated above, at 11:30 A.M. The CAUSE OF DEATH* was as follows:

Typhoid fever

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

7-27-1922 (Address) J. M. Smith M. D.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Gilbert

Sept 29 1922

20. UNDERTAKER

ADDRESS

W. A. Shaw

Orlando

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39626**Registered No. **57**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Franklin
City of RiverdaleRegistration District No. 27
Primary Registration District No. 2119
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

FULL NAME William Goforth Nelson

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word)

6. DATE OF BIRTH

June 10 1831
(Month) (Day) (Year)

7. AGE

91 Yrs. 4 Mos. 20 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Farmer

9. BIRTHPLACE

(State or Country)

Ill. U.S.

10. NAME OF FATHER

Estimond Nelson

11. BIRTHPLACE OF FATHER

(State or Country)

U.S.

12. MAIDEN NAME OF MOTHER

Jane Taylor

13. BIRTHPLACE OF MOTHER

(State or Country)

U.S.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Taylor Nelson

(Address)

Preston, Ida

15.

Filed Nov. 2 19 22Mrs Ida Lippett
Local Registrar

16. DATE OF DEATH

10 30 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

10 - 20 1922 to 10 - 20 1922
that I last saw him alive on 10 - 28 1922
and that death occurred on the date stated above, at 10 M.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia(Duration) Yrs. mos. 3 ds.Contributory Cause Chronic Myocarditis
(Secondary)(Duration) 10 yrs. mos. ds.

(Signed)

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

RiverdaleNov. 1 1922

20. UNDERTAKER

ADDRESS

W.A. SkidmorePreston, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39627**
Registered No. **57**

1. PLACE OF DEATH

County of Franklin Registration District No. 27
City of Preston Primary Registration District No. 2119
(No. _____) (St.) _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Thomas Jensen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH

Oct. 12 1853
(Month) (Day) (Year)

7. AGE

68 Yrs. 11 Mos. 27 ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Denmark

10. NAME OF FATHER

Jens Nielson

11. BIRTHPLACE OF FATHER

(State or Country)

Denmark

12. MAIDEN NAME OF MOTHER

Else Kackelsen

13. BIRTHPLACE OF MOTHER

(State or Country)

Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ida Jensen

(Address)

Frank Creek Ida

15.

Filed Nov. 2 19 22

Mrs Ida Lippick
Local Registrar

16. DATE OF DEATH

October 8 19 22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 6, 1920 to Oct 8 1922

that I last saw h. 1922 alive on Oct 7 1922

and that death occurred on the date stated above, at 6 A M.

The CAUSE OF DEATH* was as follows;

Chronic Mitral Insufficiency
with general edema, with gangrene (mostly)
of left leg & genital & beginning gangrene of right leg.

(Duration) Yrs. _____ mos. _____ ds.

Contributory Rheumatism - one
(Secondary) attack years ago.

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Curtis Bland M. D.

10/9 1922 (Address) Preston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Frank Creek Ida

DATE OF BURIAL

Oct. 10 1922

20. UNDERTAKER

W. C. Skidmore

ADDRESS

Preston Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39628**
Registered No. **141**

1. PLACE OF DEATH

County of *Franklin*
City of *Preston*Registration District No. *27*
Primary Registration District No. *2119*
(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

La Verne Hansen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *F* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*
(Write the word.)

6. DATE OF BIRTH

Oct 28 1922
(Month) (Day) (Year)

7. AGE

0 Yrs. *0* Mos. *3* ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)*None*

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Peter Thompson Hansen

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Nellie Monson

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

P. T. Hansen

(Address)

Preston Idaho

15.

Filed

*Nov 2 1922**Mrs Ida Lippert*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 31 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *Oct 28 1922* to *Oct 31 1922* that I last saw her alive on *Oct 31 1922* and that death occurred on the date stated above, at *3:45 P.M.*

The CAUSE OF DEATH* was as follows:

*Hemorrhage - gastrointestinal
due to congenital Phosphophilia*

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

11/1 1922 (Address) *Preston, Idaho*
Curis Blank M. D.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Preston Idaho *Nov 1 1922*

20. UNDERTAKER

ADDRESS

W. O. Erickson *Preston Idaho*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39630**
Registered No. **62**

1. PLACE OF DEATH. Registration District No. **27**
County of **Franklin** Primary Registration District No. **2119**
City of **Battle Creek** (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Nancy Lauritzen**

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Single**
(Write the word.)

6. DATE OF BIRTH **Oct 21 1922**
(Month) (Day) (Year)

7. AGE **1** yrs. **4** mos. **3** ds. IF LESS than 1 day how many **6** hrs. or **6** min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work. **✓**
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE **Franklin Co Idaho**
(State or Country)

10. NAME OF FATHER **E. C. Lauritzen**

11. BIRTHPLACE OF FATHER **Logan Utah**
(State or Country)

12. MAIDEN NAME OF MOTHER **Jennie Winn**

13. BIRTHPLACE OF MOTHER **Battle Creek**
(State or Country) **Franklin Co Idaho**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) **J. E. Winn**
(Address) **Preston, Idaho.**

15. Filed **Nov 3** 191**22** **Mrs Ida Lippert**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **Oct 24 1922**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Oct 21** 19**22**, to **Oct 24** 19**22**, that I last saw her alive on **Oct 24** 19**22** and that death occurred on the date stated above, at **8 P. M.**
The CAUSE OF DEATH* was as follows:

From premature birth
(Duration) **1** yrs. **4** mos. **6** ds.

Contributory (Secondary) **✓**
(Duration) **1** yrs. **4** mos. **6** ds.
(Signed) **G. W. Stiles** M. D.
Oct 25 19**22** (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death **Life** In the State **Life**
Where was disease contracted, If not at place of death?
Former or usual residence **None**

19. PLACE OF BURIAL OR REMOVAL **Preston Cemetery** DATE OF BURIAL **Oct. 26, 1922**
20. UNDERTAKER **Wm. O. Erickson** ADDRESS **Preston, Idaho**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH. Registration District No. 27
County of Franklin Primary Registration District No. 2119
City of Franklin (No. St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 39631
Registered No. 40

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

George F Fordham

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH April 21 1825
(Month) (Day) (Year)

7. AGE 97 yrs. 5 mos. 11 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION Farmer - G. A. R
(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer) Veteran -

9. BIRTHPLACE New York City
(State or Country)

10. NAME OF FATHER Elijah Fordham

11. BIRTHPLACE OF FATHER New York City
(State or Country)

12. MAIDEN NAME OF MOTHER Jane Ann Fisher

13. BIRTHPLACE OF MOTHER New York City
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) S. E. Hargham by J. H. Hargham
(Address) Franklin Idaho

15. Filed Nov. 2 1922 Mrs. Ida Lippel
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct - 2 - 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 20 1922, to Oct - 2 - 1922, that I last saw him alive on Sept - 30 1922, and that death occurred on the date stated above, at 3:40 A. M.

The CAUSE OF DEATH* was as follows:

General debility so far as known

(Duration) yrs. mos. ds.

Contributory (Secondary) Infirmities of Age

(Duration) yrs. mos. ds.

(Signed) G. W. States M. D.

Oct 4 1922 (Address) Preston, Id.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death. yrs. mos. ds. State. yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Franklin Cemetery Oct 5 1922

20. UNDERTAKER ADDRESS

J. H. Rink Franklin

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

103

Registration District No.

County **FREMONT**

Primary Registration District No.

6

File No.

39632

City of **ASHTON**

(No.

St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

RHEA. TINY BOHL

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

FEMALE

4. COLOR OR RACE

WHITE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write **SINGLE**)

6. DATE OF BIRTH

OCTOBER. 25th 1922

(Month)

(Day)

(Year)

7. AGE

Yrs.

Mos.

4

ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

ASHTON IDAHO

10. NAME OF FATHER

JAMES E. BOHL

11. BIRTHPLACE OF FATHER

(State or Country)

KNASAS.

12. MAIDEN NAME OF MOTHER

CARRIE POWELL

13. BIRTHPLACE OF MOTHER

(State or Country)

NEB.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **JAMES E. BOHL**(Address) **ASHTON IDAHO.**

15.

Filed

10-31-22

19

Local Registrar

- MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

October.

(Month)

29th

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

10-25

1922

10-28

1922

that I last saw ~~her~~ alive on **10-28-1922**and that death occurred on the date stated above, at **9:15 P.M.**

The CAUSE OF DEATH* was as follows:

Prima facie

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)**10-28**

(Duration)

yrs.

mos.

ds.

(Signed)

C. C. Cunningham M. D.**10-31-1922**

(Address)

Ashton, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death.....yrs.....mos.....days.

In the

State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

ASHTON IDAHO**10/31/22**

20. UNDERTAKER

Lewis Kiser

ADDRESS

Ashton Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39633**

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of *Gem*City of *Emmett*

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. St.)

2. FULL NAME

Edgar Wallace Terry

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

single
(Write the word.)

6. DATE OF BIRTH

June 27 1897
(Month) (Day) (Year)

7. AGE

*25 Yrs. 3 Mos. 8 ds.*IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Laborer

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Kansas

10. NAME OF FATHER

J. L. Terry

11. BIRTHPLACE OF FATHER

(State or Country)

Indiana

12. MAIDEN NAME OF MOTHER

Julia Mayhew

13. BIRTHPLACE OF MOTHER

(State or Country)

Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

R. B. Terry

(Address)

Emmett, Idaho

15.

Filed

10/7 1922

Local Registrar

H. E. Reynolds

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct. 5 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

*Oct 3 1922 to Oct 4 1922*that I last saw him alive on *Oct 4 1922*and that death occurred on the date stated above, at *1 P.M.*

The CAUSE OF DEATH* was as follows:

*Pulmonary pneumonia
lobar type*(Duration) Yrs. mos. *6* ds.Contributory (Secondary) *mitral heart lesion*(Duration) *Seven* yrs. mos. ds.(Signed) *H. E. Reynolds* M. D.*10/7 1922* (Address) *Emmett*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Meriden, Kansas

DATE OF BURIAL

19.....

20. UNDERTAKER

C. B. Buckner

ADDRESS

Emmett Idaho

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Idaho*City of *Emmett*

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No. *6*

(No.)

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39634**

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME *George M. Haner*

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

*male white**single*
(Write the word.)

6. DATE OF BIRTH

Aug 25 1865
(Month) (Day) (Year)

7. AGE

57 Yrs. — *13* Mos. *13* ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)*Laborer*

9. BIRTHPLACE

(State or Country)

Oregon

10. NAME OF FATHER

Epriam Haner

11. BIRTHPLACE OF FATHER

(State or Country)

New York

12. MAIDEN NAME OF MOTHER

Mary Suttle

13. BIRTHPLACE OF MOTHER

(State or Country)

Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Isa E. Haner*(Address) *Homedale Idaho*

15.

Filed *10/7* 19*22**J. H. Reynolds*
Local RegistrarMEDICAL CERTIFICATE OF DEATH *79*

16. DATE OF DEATH

Sept 18 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

.....19..... to19.....

that I last saw him alive on19.....

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Sudden death no doctor in attendance,

.....(Duration) Yrs. mos. ds.

Contributory
(Secondary)

.....(Duration) yrs. mos. ds.

(Signed) M. D.

.....19..... (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Emmett Idaho

DATE OF BURIAL

9/19 1922

20. UNDERTAKER

W. Ducknum

ADDRESS

Emmett Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39635**

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of *Idaho*City of *Emmett*

Registration District No.

Primary Registration District No.

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Daniel P. Fillmore

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

widower
(Write the word.)

6. DATE OF BIRTH

Oct 24 1846
(Month) (Day) (Year)

7. AGE

*75 Yrs. 11 Mos. 12 ds.*IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Farmer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Wisconsin

10. NAME OF FATHER

Daniel Fillmore

11. BIRTHPLACE OF FATHER

(State or Country)

New York

12. MAIDEN NAME OF MOTHER

Thankful Ann Grant

13. BIRTHPLACE OF MOTHER

(State or Country)

New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Roy Fillmore

(Address)

Emmett Idaho

15.

Filed *10/7*19 *22**J. L. Reynolds*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 6 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

*Oct 2 1922 to Oct 5 1922*that I last saw him alive on *Oct 5 1922*

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Thrombosis mesenteric Arteries?

(Duration) Yrs. mos. ds.

Contributory (Secondary)

Arterio sclerosis nephritis (Duration) *Seven* yrs. mos. ds.

(Signed)

R. J. Cummings M. D.(Address) *Emmett*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

19.....

20. UNDERTAKER

ADDRESS

C. D. Bucknum
Emmett Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39637**

1. PLACE OF DEATH

Registration District No. **6**
County of **Ben** Primary Registration District No. **100**
City of **Emmett** (No. **100** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Emma Newman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **female white** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **married**
(Write the word.)

6. DATE OF BIRTH

Apr 1 1871
(Month) (Day) (Year)

7. AGE

51 Yrs. 5 Mos. 29 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)**Housewife**

9. BIRTHPLACE

(State or Country)

Colorado

10. NAME OF FATHER

William Groves

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Amanda Neal

13. BIRTHPLACE OF MOTHER

(State or Country)

Arkansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wm. Groves
Emmett Ida

(Address)

15.

Filed **10/27** 19 **22**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 30 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from **Sept. 5 1922** to **Sept 30 1922**
that I last saw her alive on **Sept 19 1922**
and that death occurred on the date stated above, at **2 P.M.**

The CAUSE OF DEATH* was as follows:

Heart blockContributory
(Secondary)(Duration) **unknown** yrs. mos. ds.
Chronic albuminuria
(Signed) **A. S. Byrd** M. D.**9/7 1922** (Address) **Emmett Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

New Plymouth, Ida

DATE OF BURIAL

Oct 2 1922

20. UNDERTAKER

Ed Bucknum

ADDRESS

Emmett Ida

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39638**

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of *Gem*
City of *Emmett*

Registration District No.

Primary Registration District No. *6*

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Bonnie Hyde

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Infant

(Write the word.)

6. DATE OF BIRTH

Apr 24 1922
(Month) (Day) (Year)

7. AGE

6 Yrs. *6* Mos. *6* ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)*Infant*

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Carl Hyde

11. BIRTHPLACE OF FATHER

(State or Country)

North Carolina

12. MAIDEN NAME OF MOTHER

Sarah Storey

13. BIRTHPLACE OF MOTHER

(State or Country)

Colorado

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Carl Hyde*

(Address)

15.

Filed *10/27* 19*22**J. H. Reynolds*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 24 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 23 1922 to *Oct 24 1922*that I last saw her alive on *Oct 23 1922*and that death occurred on the date stated above, at *7:40* M.

The CAUSE OF DEATH* was as follows:

meningitis(Duration) Yrs. mos. *2* ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *L. H. Reynolds* M. D.*10/25/1922* (Address) *Emmett*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Emmett Ida

DATE OF BURIAL

10/26 1922

20. UNDERTAKER

O. Bucknum

ADDRESS

Emmett Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39639**
Registered No.

1. PLACE OF DEATH

County of *Ben*City of *Emmett*

Registration District No.

Primary Registration District No. *6*

(No.)

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Walter O Moore

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

widower
(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

(Year)

7. AGE

About 63 yrs

Yrs. Mos. ds.

IF LESS than 1 day

how many..... hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Labourer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

not known

11. BIRTHPLACE OF FATHER

(State or Country)

"

12. MAIDEN NAME OF MOTHER

"

13. BIRTHPLACE OF MOTHER

(State or Country)

"

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

O. D. Bucknum

(Address)

Emmett Ida

15.

Filed *10/30* 19*22**J. H. Reynolds*
Local Registrar

16. DATE OF DEATH

Oct. 25 19*22*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 24 19*22* to *Oct 24* 19*22*that I last saw him alive on *Oct 24* 19*22*and that death occurred on the date stated above, at *1* M.

The CAUSE OF DEATH* was as follows:

Cardiac insufficiency

(Duration) Yrs. mos. ds.

Contributory (Secondary)

Nephritis

(Duration) yrs. mos. ds.

(Signed)

R. H. Cunningham M. D.*27* 19*22* (Address) *Emmett Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Emmett Ida *Oct 29* 19*22*

20. UNDERTAKER

O. D. Bucknum

ADDRESS

Emmett Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **33640**
Registered No.

1. PLACE OF DEATH

County of *Idaho*City of *Emmett*

Registration District No.

Primary Registration District No. *6*

No.

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Hearer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

single

(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

(Year)

7. AGE

about 93 yrs

Yrs.

Mos.

ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Laborer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

not known

10. NAME OF FATHER

"

"

11. BIRTHPLACE OF FATHER

(State or Country)

"

"

12. MAIDEN NAME OF MOTHER

"

"

13. BIRTHPLACE OF MOTHER

(State or Country)

"

"

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

C. D. Bucknum

(Address)

Emmett Idaho

15.

Filed

*10/30*19*22**J. L. Reynolds*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

*Oct**8**1922*

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

9/21 19*22* to *Oct 7* 19*22*that I last saw him alive on *Oct 7* 19*22*and that death occurred on the date stated above, at *7 A.* M.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

R. N. Quinman

M. D.

10/7 1922

(Address) *Emmett Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Emmett Idaho

DATE OF BURIAL

Oct 9 19*22*

20. UNDERTAKER

C. D. Bucknum

ADDRESS

Emmett Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39641**

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of **Gooding**City of **Gooding**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED

Registration District No. _____

Primary Registration District No. _____

BUREAU OF VITAL STATISTICS

Chas E Miller

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married

6. DATE OF BIRTH

July 16th 1867

7. AGE

53 Yrs. **2** Mos. **6** ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

Real Estate Agent

9. BIRTHPLACE

(State or Country)

Indiana

10. NAME OF FATHER

Abe Miller

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Celia R. Grant

13. BIRTHPLACE OF MOTHER

(State or Country)

Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

W. J. Cary M.D.
Gooding Ida

15.

Filed **9-25-**19 **22****W. J. Cary M.D.**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept. 22 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from **June 1922** to **Sept 22 1922**that I last saw him alive on **Sept 22 1922**and that death occurred on the date stated above, at **4:00 PM**

The CAUSE OF DEATH* was as follows:

Chronic Bright's Disease(Duration) **2** Yrs. _____ mos. _____ ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

1/23 1922

(Address)

J. H. Crowell M. D.
Gooding Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Gooding Ida

DATE OF BURIAL

Sept 24 1922

20. UNDERTAKER

A. E. Thompson

ADDRESS

Gooding

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39642**

1. PLACE OF DEATH. **Gooding**
County of **Gooding**
City of **Gooding**
Registration District No. **24**
Primary Registration District No. **24**
St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Willmetta Darling

Registered No. _____

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Single**
(Write the word.)

6. DATE OF BIRTH

January 29 1922
(Month) (Day) (Year)

7. AGE

7 yrs. 22 mos. 22 ds. IF LESS than 1 day how many hrs. or min.

8. OCCUPATION

(a) Trade, profession, or particular kind of work **Infant**
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) **Idaho**

10. NAME OF FATHER

Ernest Darling

11. BIRTHPLACE OF FATHER

(State or Country) **Kansas**

12. MAIDEN NAME OF MOTHER

Blanche Swanson

13. BIRTHPLACE OF MOTHER

(State or Country) **Idaho**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Ernest Darling (Father)**

(Address) **Gooding Idaho**

15.

Filed **9-21-1922** **J. J. Cary, M.D.**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

September 21 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

9-4-1922 to **9-21-1922**
that I last saw him alive on **9-21-1922**

and that death occurred on the date stated above, at **4 A. M.**

The CAUSE OF DEATH* was as follows:

Enterocolitis

(Duration) yrs. mos. **20** ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) **J. W. Cary** M. D.
9/21 1922 (Address) **Gooding Idaho**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.
Where was Disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL

Gooding

DATE OF BURIAL

9-22 1922

20. UNDERTAKER

At Thompson

ADDRESS

Gooding, Ida

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED

CERTIFICATE OF DEATH.

1. PLACE OF DEATH **Idaho** OCT 21 1922
 County of **Idaho** Registration District No. **49**
 City of **Winona** Registration District No. **24**
 (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Laura Esttila Spreyer**

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. **33643**
 Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Married**
 (Write the word.)

6. DATE OF BIRTH. **Jan. 31 1874**
 (Month) (Day) (Year)

7. AGE **48** Yrs. **6** Mos. **18** ds.
 IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business, or establishment in which employed (or employer).

Housekeeper

9. BIRTHPLACE

(State or Country)

Oregon

10. NAME OF FATHER

Issie Darnville

11. BIRTHPLACE OF FATHER

(State or Country)

Ind.

12. MAIDEN NAME OF MOTHER

Mary Hill

13. BIRTHPLACE OF MOTHER

(State or Country)

Ind.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) **Chster E. Sprague**
 (Address) **Winona Idaho**

15. Filed **10/19** 19**22** **C. J. Johnson**
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug. 18 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Aug. 8th 191st** to **above** 191st, that I last saw him alive on **above** 191st, and that death occurred on the date stated above, at **10:30** M.

The CAUSE OF DEATH was as follows:

Acute Cataractal pneumonia

(Duration) Yrs. mos. **28** ds.

Contributory
 (Secondary)

(Duration) Yrs. mos. ds.

(Signed)

19. (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDE.

18. LENGTH OF RESIDENCE (For Hospitals, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Winona Cemetery

DATE OF BURIAL

10/20 1922

20. UNDERTAKER

C. J. Johnson

ADDRESS

Rainier

CERTIFICATE OF DEATH

39644

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 19
Registered No.

1. PLACE OF DEATH

County

City of

If death occurs away from usual residence, give facts called for under special information.

RECEIVED

OCT 21 1922

BUREAU OF VITAL

STATISTICS

2. FULL NAME

Harbert J. Riener

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

July 4 1921
(Month) (Day) (Year)

7. AGE

2 Yrs. 1 Mos. 28 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho.

10. NAME OF FATHER

Frank J. Riener

11. BIRTHPLACE OF FATHER

(State or Country)

Kansas

12. MAIDEN NAME OF MOTHER

Mary A. Stabbers

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Edward Daseylock
Cottonwood, Id.

(Address)

15.

Filed

Sept 30 1922

W. F. Orr

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 2 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Aug 31 1922 to Sept 2 1922
that I last saw him alive on Sept 2 1922
and that death occurred on the date stated above, at 4:30 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral convulsions due to
Acute Enteritis

(Duration) Yrs. mos. 3 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Wesley Orr M. D.

9/2 1922

(Address) Cottonwood

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Green Creek Id.

9-3 1922

20. UNDERTAKER

ADDRESS

A. H. Orr Cottonwood Id.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Kootenai*
City of *Prunella*Registration District No. *30*Primary Registration District No. *1067*(No. *1570 Third* St.)File No. *39646*Registered No. *1122*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Elliot R. McLaughlin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

Sept 21 1896
(Month) (Day) (Year)

7. AGE

26 Yrs. *0* Mos. *15* ds.IF LESS than 1 day
how many.....hrs.
or.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Draftsman

(b) General nature of industry, business or establishment in which employed (or employer)

Aviation Branch Service

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

William S. McLaughlin

11. BIRTHPLACE OF FATHER

(State or Country)

Penn

12. MAIDEN NAME OF MOTHER

Cornelia Bradley

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mr. R. McLaughlin

(Address)

Myrtle Miss

15.

Filed

Nov 3 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 6 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug. 16 1922, to *Oct 6 1922*that I last saw him alive on *Oct 6 1922*and that death occurred on the date stated above, at *7:15 P.*

The CAUSE OF DEATH* was as follows:

Pulm. Tuberculosis(Duration) *3* Yrs.mos.ds.Contributory
(Secondary)

(Duration)yrs.mos.ds.

(Signed)

Oct 7 1922 (Address) *Prunella Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State *2* yrs *6* mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Myrtle Miss

DATE OF BURIAL

Oct 11 1922

20. UNDERTAKER

R B Mooney

ADDRESS

P. O. 22

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39647**
Registered No. **1123**

1. PLACE OF DEATH

County of **Kootenai**
City of **Coeur d'Alene**

Registration District No. **30**Primary Registration District No. **1051**

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mrs. Ellen A. Todd

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

widow
(Write the word.)

6. DATE OF BIRTH

April 4 1898
(Month) (Day) (Year)

7. AGE

84 Yrs. 3 Mos. 20 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

New York

10. NAME OF FATHER

Hopstill Crittenden

11. BIRTHPLACE OF FATHER

(State or Country)

N. York

12. MAIDEN NAME OF MOTHER

Cassandary Noble

13. BIRTHPLACE OF MOTHER

(State or Country)

N. York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Lee H. Brooks

(Address)

City

15. Filled

Nov. 3 1922**L. A. Trema**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 24 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 1 1922 to June 24 1922
that I last saw him alive on **June 24 1922**
and that death occurred on the date stated above, at **1140 P.**

The CAUSE OF DEATH* was as follows:

Arterio sclerosis(Duration) **10** Yrs. **0** mos. **0** ds.Contributory **Chronic Dilatation of Heart**(Duration) **3** yrs. **0** mos. **0** ds.(Signed) **J. L. Patterson M. D.****June 25 1922** (Address) **Spokane Wash**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Chippewa Falls

DATE OF BURIAL

19

20. UNDERTAKER

Turnbull, Undertaker Co.

ADDRESS

Spokane Wash

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 30
County of Kootenai Primary Registration District No. 1057
City of Pain d'Alene (No. 743 Military Drive St.)File No. 39648
Registered No. 1124

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Thomas A. Stalwick

PERSONAL AND STATISTICAL PARTICULARS.

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH

March 1 1922
(Month) (Day) (Year)

7. AGE

1 Yrs. 7 Mos. 0 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Alfred Stalwick

11. BIRTHPLACE OF FATHER

(State or Country) Norway

12. MAIDEN NAME OF MOTHER

Evelyn Simonson

13. BIRTHPLACE OF MOTHER

(State or Country) Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Alfred Stalwick
(Address) Corn d'Alene15. Filed Nov 3 1922 S. D. Drenna
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 1 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Sept 25 1922 to Oct 1 1922that I last saw him alive on Oct 1 1922
and that death occurred on the date stated above, at 12:15 P.

The CAUSE OF DEATH* was as follows:

Complicating
Meningitis following acute
intestinal catarrh(Duration) _____ Yrs. _____ mos. 7 ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Oct 19 22

(Address)

John D. Drenna
Corn d'Alene

M. D.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State 1 yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Four Mile Cemetery

DATE OF BURIAL

10/3 1922

20. UNDERTAKER

R. B. Morney Pain d'Alene

ADDRESS

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of

City of

If death occurs away from
usual residence, give facts
called for under special in-
formation.

Registration District No. 30

Primary Registration District No. 1037

(No. 308 Lindon St.)

2. FULL NAME

Hans Nielsen

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 39649

Registered No. 1125

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH

10 - 31 1869
(Month) (Day) (Year)

7. AGE

32 Yrs. 11 Mos. 4 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer).

Salesman

9. BIRTHPLACE

(State or Country)

Wis

10. NAME OF
FATHER

Hans Nielsen

11. BIRTHPLACE
OF FATHER

(State or Country)

Denmark

12. MAIDEN NAME
OF MOTHER13. BIRTHPLACE
OF MOTHER

(State or Country)

Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs H R Nielsen

(Address)

Corn & Alene

15.

Filed

Nov 3 19 22 D D Dreman

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 5 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 6 1922 to Sept 6 1922

that I last saw him alive on Sept 6 1922

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

The Heart Disease of

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) D D Dreman - M. D.

10/8 1922 (Address) Corn & Alene

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Forest Cemetery 10-8 1922

20. UNDERTAKER

ADDRESS

C Cassidy Corn & Alene

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39650**
Registered No. **1126**

1. PLACE OF DEATH

County of **Hotlen**
City of **Cornuda**Registration District No. **30**
Primary Registration District No. **1057**
(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Clyde A. Burton Jr.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

10 6 1922
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day
how many **6** hrs.
or **?** min.?

Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

Clyde A. Burton

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Alta Curry

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Wm. I. M. Burton**
(Address) **Cornuda**

15.

Filed **Nov 3 1922** **S. D. Hanna**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 6 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 19____ to _____ 19____

that I last saw him alive on **Oct 6 1922**
and that death occurred on the date stated above, at **12 M.**

The CAUSE OF DEATH* was as follows:

Premature birth - about 6 1/4 months

(Duration) Yrs. mos. ds.

Contributory **No known cause**
(Secondary)

(Duration) yrs. mos. ds.

(Signed) **M. H. Haedeman M. D.****10/6 1922** (Address) **Cornuda Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Forest Cemetery

DATE OF BURIAL

10/8 1922

20. UNDERTAKER

C. Cassidy Cornuda

ADDRESS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Kootenai

City of _____

Registration District No. 30Primary Registration District No. 1051

(No. _____)

(St. _____)

File No. _____

Registered No. 1130

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anna Jacobson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widowed

(Write the word.)

6. DATE OF BIRTH

(Month) _____

(Day) _____

(Year) _____

7. AGE

88 Yrs. _____ Mos. _____ ds.IF LESS than 1 day
how many _____ hrs. or
_____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... At Home
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country) _____

Norway

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country) _____

Norway

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country) _____

Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M. G. Molland(Address) Spokane Bridge Wash

15.

Filed Nov 3 1922Edy Drennan
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct
(Month)14
(Day)1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Died before a Physician
that I last saw him alive on arrived 1922

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Heart Disease

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)Received injury about 4
years ago
(signed) J. H. McCauley D.
Oct 19 22 (Address) Post Falls, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Pleasant View CemeteryOct 16 1922

20. UNDERTAKER

ADDRESS

Hazen & JaegerSpokane W. sh

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
39654

1. PLACE OF DEATH

County of *Kootenai*
City of *Coeur d'Alene*

Registration District No. *30*

Primary Registration District No. *1051*

(No. *8th + Pennsylvania St.*)

File No. *39654*

Registered No. *1131*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Clarence Gore Lahr

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

single
(Write the word.)

6. DATE OF BIRTH

March 6 1913
(Month) (Day) (Year)

7. AGE

9 Yrs. *7* Mos. *9* ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

scholar

9. BIRTHPLACE

(State or Country)

Mont.

10. NAME OF FATHER

O. Gore

11. BIRTHPLACE OF FATHER

(State or Country)

Iowa

12. MAIDEN NAME OF MOTHER

Rebecca Brewer

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Frank J. Lahr

15.

Filed *Nov 3* 19*22* *W. H. Brennan*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct. 15 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Oct 14 1922*, to *Oct 15 1922*

that I last saw him alive on *Oct. 15 1922*

and that death occurred on the date stated above, *11 A.M.*

The CAUSE OF DEATH* was as follows:

Accident
(Crushing injury under automobile)

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

(Address)

J. C. Lahr M. D.
Coeur d'Alene Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Forest Cem. Coeur d'Alene *10-18 1922*

20. UNDERTAKER

ADDRESS

C. Carstedt *Coeur d'Alene*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 30

County of

Primary Registration District No. 1057

City of

(No. 578, Indiana St.)

File No. 39655

Registered No. 1032

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Charlie Burk

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH July 15, 1881
(Month) (Day) (Year)

7. AGE 41 Yrs. 3 Mos. 11 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION Cook
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE Mich.
(State or Country)

10. NAME OF FATHER Burk

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Susie Burk
(Address) 518 Ind. Ave.

15. Filed Nov. 3, 1922 L. D. Brennan
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 26, 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 21, 1922, to Oct. 26, 1922, that I last saw him alive on Oct. 26, 1922, and that death occurred on the date stated above, at 7 P.M.
The CAUSE OF DEATH* was as follows:

Traumatic Peritonitis
1 wk. operation

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D. Brennan M. D.

19 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Forest-Cem, Co. Valenc DATE OF BURIAL 10-28-1922

20. UNDERTAKER C. Carsey ADDRESS Co. Valenc

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
39656
File No. _____
Registered No. 1133

1. PLACE OF DEATH

County of Kootenai
City of Power & Colma

Registration District No. 30Primary Registration District No. 1027
(No. Power & Colma Twp.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Paige S. Nelson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Feb 7 1904
(Month) (Day) (Year)

7. AGE

18 Yrs. 7 Mos. 19 ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

School Teacher

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Oscar Nelson

11. BIRTHPLACE OF FATHER

(State or Country) Sweden

12. MAIDEN NAME OF MOTHER

Grace E. Nelson

13. BIRTHPLACE OF MOTHER

(State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Oscar Nelson

(Address) _____

15.

Filed Nov 3 1922 D. D. Brennan

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 26 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct. 23 1922 to Oct 25 1922that I last saw him alive on Oct 25 1922and that death occurred on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

Diabetic Coma(Duration) Yrs. _____ mos. 1 ds.Contributory (Secondary) Quincy(Duration) yrs. _____ mos. 4 ds.(Signed) D. D. Brennan M. D.Oct 26 1922 (Address) Power & Colma Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State 18 yrs. 7 mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence Power & Colma

19. PLACE OF BURIAL OR REMOVAL

Forest Cemetery

DATE OF BURIAL

Oct 27 1922

20. UNDERTAKER

P. B. Mooney Power & Colma

ADDRESS

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of TetonCity of Gibbs

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 30Primary Registration District No. 10.51(No. Gibbs St.)File No. 39657Registered No. 1134

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Martha A Reed

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

aug 27 1849
(Month) (Day) (Year)

7. AGE

73 Yrs. 2 Mos. 1 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Housewife

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Mo

10. NAME OF FATHER

Johnathon Bright

11. BIRTHPLACE OF FATHER

(State or Country)

Ind

12. MAIDEN NAME OF MOTHER

Moore

13. BIRTHPLACE OF MOTHER

(State or Country)

U.S.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. J. Reed(Address) Gibbs, Ida.

15.

Filed 11/22 W. H. L. Lunnar

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 28 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19that I last saw him alive on Oct 27 1929and that death occurred on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:

dropped suddenly dead
Choking, supposed
calculus back disease

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) W. H. Lunnar M. D.19 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Forest Cemetery

DATE OF BURIAL

Oct 28 1929

20. UNDERTAKER

W. H. Lunnar

ADDRESS

Forest Cemetery

CERTIFICATE OF DEATH.

39658

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 126
County of Kootenai Primary Registration District No. 2204
City of Rose Lake (No. _____) St. _____File No. 9
Registered No. 9

If death occurs away from usual residence, give facts called for under special information.

DECEASED NAME John Adam Collyer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)6. DATE OF BIRTH. Nov. 4 1874
(Month) (Day) (Year)7. AGE 47 11 2
Yrs. Mos. ds. IF LESS than 1 day how many.....hrs. or.....min.?)8. OCCUPATION Farmer
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....9. BIRTHPLACE Columbus, Kansas
(State or Country)10. NAME OF FATHER Benjamin F. Collyer11. BIRTHPLACE OF FATHER _____
(State or Country)12. MAIDEN NAME OF MOTHER Sophia Berger13. BIRTHPLACE OF MOTHER _____
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Elmira L. Collyer
(Address) Rose Lake, Idaho15. Filed 11-1-22 1922 M. J. Manning
Local RegistrarMEDICAL CERTIFICATE OF DEATH 2816. DATE OF DEATH October 6 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Oct 1 1922 to Oct 6 1922
that I last saw him alive on Oct 6 1922
and that death occurred on the date stated above, at 2:30 PM M.The CAUSE OF DEATH* was as follows:
tuberculosis pulmonis(Duration) 5 Yrs. mos. ds.

Contributory (Secondary) _____

(Signed) L. J. Stauffer M. D.
Oct 7 1922 (Address) Rose Lake, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Rose Lake, Idaho DATE OF BURIAL Oct 8 192220. UNDERTAKER none ADDRESS _____

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

39659

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Kootenai Registration District No. 26
City of Harrison Primary Registration District No. 2204
(No. 3) St.)File No. 3
Registered No. 10

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Raymond Benjamin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH.

May 24 1907
(Month) (Day) (Year)

7. AGE

15 Yrs. 5 Mos. ds.IF LESS than 1 day
how many hrs. or
.... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).....School Boy

9. BIRTHPLACE

(State or Country)

N. W.

10. NAME OF FATHER

Lucian Benjamin

11. BIRTHPLACE OF FATHER

(State or Country)

Wis

12. MAIDEN NAME OF MOTHER

Ida Kellbach

13. BIRTHPLACE OF MOTHER

(State or Country)

Wis

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Ida Kellbach

(Address)

Harrison Ida

15.

Filed

11-1

19

22 Benjamin

Local Registrar

MEDICAL CERTIFICATE OF DEATH

170

16. DATE OF DEATH

Oct 24 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191..... to 191.....
that I last saw him alive on 191.....
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Accidental
Shot by own gun while
hunting

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

1025-1922 (Address) Harrison Ida M. D.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Harrison11-26 1922

20. UNDERTAKER

ADDRESS

B. Carney
by M. Ketchum

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Kootenai*City of *Moscow*Registration District No. *61*Primary Registration District No. *1011*

St.)

File No. *39660*Registered No. *30*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary Weigand

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widowed
(Write the word.)

6. DATE OF BIRTH

Nov 1 1858
(Month) (Day) (Year)

7. AGE

63 Yrs. *11* Mos. *18* ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)*At home with children*
Housew.

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

Ferris

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Germany

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Louis Weigand*(Address) *Moscow Idaho*

15.

Filed *10/19* 19 *22*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 18 22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 12 1922 to *Oct 18 1922*that I last saw him alive on *Oct 18 1922*and that death occurred on the date stated above, at *3 P.M.*

The CAUSE OF DEATH* was as follows:

Carcinoma of leg.

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Chas. L. Gritman M. D.*10/19 22* (Address) *Moscow Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Moscow

DATE OF BURIAL

10/21 1922

20. UNDERTAKER

Glenn Gries

ADDRESS

Moscow

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Katah*
City of *Moscow*Registration District No. *61*
Primary Registration District No. *1011*
(No. St.)File No. *39661*Registered No. *33*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Susan Mathis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Widowed*

6. DATE OF BIRTH

Nov 12th 1842
(Month) (Day) (Year)

7. AGE

*79 Yrs 11 Mos 13 ds.*IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)*House wife at home with children*

9. BIRTHPLACE

(State or Country)

Arkansas

10. NAME OF FATHER

Gilbert Luper

11. BIRTHPLACE OF FATHER

(State or Country)

Arkansas

12. MAIDEN NAME OF MOTHER

Susan Ingman

13. BIRTHPLACE OF MOTHER

(State or Country)

Arkansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs Roy Holman

(Address)

Moscow Idaho

15. Filed

*10/28 1922**1922**M. C. Mathis*

Local Registrar

16. DATE OF DEATH

Oct 27th 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct. 24th 1922 to Oct. 27 1922
that I last saw him alive on *Oct. 24 1922*
and that death occurred on the date stated above, at *5:30 AM*

The CAUSE OF DEATH* was as follows:

Mild Carditis

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Chas. L. Gibbons M. D.(Address) *Moscow, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Moscow**10/24 1922*

20. UNDERTAKER

ADDRESS

*Blue Grace**Moscow*

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH *Idaho* Registration District No. *601*
County of *Moose* Primary Registration District No. *1011*
City of *Moose* (No. *11* St.)

File No. *39662*Registered No. *29*

If death occurs away from usual residence, give facts called for under special information.

FULL NAME

Albertina Gustafson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *M* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*
(Write the word.)

6. DATE OF BIRTH *Sept 29 1866*
(Month) (Day) (Year)

7. AGE *56* Yrs. *15* Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Housewifz,

9. BIRTHPLACE

(State or Country)

Sweden

10. NAME OF FATHER

John Furgerson

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME OF MOTHER

Christina Johnson

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Herman Gustafson

(Address)

Moose

15.

Filed *10/16* 19 *22**M. H. Parthens*

Local Registrar

16. DATE OF DEATH

Oct 14 22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Sept 14 1922* to *Oct 14 1922* that I last saw her alive on *Oct 14 1922* and that death occurred on the date stated above, at *7 P.* M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(Duration) *3* Yrs. mos. ds.

Contributory (Secondary)

Cardiac failure

(Duration) yrs. mos. ds.

(Signed)

E. Magae M. D.

(Address)

Moose

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Moose**10/17 1922*

20. UNDERTAKER

ADDRESS

Ellen Guie Moose

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of

City of

Registration District No.

Primary Registration District No.

(No.

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 39663

Registered No. 321

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

19

Local Registrar

16. DATE OF DEATH

(Month)

(Day)

19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19....., to

19.....

that I last saw him..... alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

Supposed to be Phalaris
Morbus "No Inquest held"
No doctor calledContributory
(Secondary)

(Signed)

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

Registration District No.

Primary Registration District No.

(No.)

St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

19

Local Registrar

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Signed)

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No.

Primary Registration District No.

(No.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

19.22

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

19....., to 19.....

that I last saw h..... alive on 19.....

and that death occurred on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

10/11 19.22 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 39666

Registered No. 31

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Idaho
City of MoscowRegistration District No. 61
Primary Registration District No. 2141
(No. County Home St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Enoch Perry Stone

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Widowed
(Write the word.)6. DATE OF BIRTH May 3rd 1859
(Month) (Day) (Year)7. AGE 65 5 19 IF LESS than 1 day
Yrs. Mos. ds. how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Farmer

9. BIRTHPLACE

(State or Country)

Kansas

10. NAME OF FATHER

George W. Stone

11. BIRTHPLACE OF FATHER

(State or Country)

Illinois

12. MAIDEN NAME OF MOTHER

Rebecca Dean

13. BIRTHPLACE OF MOTHER

(State or Country)

Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

William Russell

(Address)

Moscow

15.

Filed

10/23 22 M. H. Baughers
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 22nd 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Oct 19th 1922 to Oct 22nd 1922
that I last saw him alive on Oct 22nd 1922
and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH was as follows:

Coronal Arteriosclerosis

(Duration) Yrs. mos. ds.

Contributory
(Secondary)Arteriosclerosis

(Duration) Yrs. mos. ds.

(Signed)

J. W. Stevenson M. D.Address Moscow, Id.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Gloucester, Va.10/24/1922

20. UNDERTAKER

ADDRESS

Steu. GiesMoscow

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39667**
Registered No. **25**

1. PLACE OF DEATH

County of **Latah**
City of **Moscow**

Registration District No. **61**Primary Registration District No. **1011**

(No. _____) (St. _____)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Isiah Lockard

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

m

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

married
(Write the word.)

6. DATE OF BIRTH

Sept 9 1838
(Month) (Day) (Year)

7. AGE

84 Yrs. **1** Mos. **ds.**

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Retired farmer

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

Luben Lockard

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Charlotte Thomas

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Oliver Lockard
Moscow

(Address)

15.

Filed **10/7/22** **M. Baruther**
19 **22**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 7 22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **July 1st 1922** to **Sept 28 1922**
that I last saw h.l.m. alive on **28th Sept 1922**
and that death occurred on the date stated above, at **1⁰⁵ A.M.**

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma(Duration) **4** Yrs. **nos.** **ds.**Contributory (Secondary) **General Asthenia**(Duration) **2** Yrs. **mos.** **ds.**(Signed) **C. Nagle** M. D.

Oct 7 1922 (Address) **Moscow**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? **Latah Co**Former or usual residence **Latah Co**

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Moscow **10/8 1922**

20. UNDERTAKER **Howe & Co** ADDRESS **Moscow**

MARGIN RESERVING FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39668**

1. PLACE OF DEATH

County of

City of

Registration District No. **61**Primary Registration District No. **1011**

(No. _____)

St. _____

Registered No. **27**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary Howell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

19

22

Local Registrar

16. DATE OF DEATH

October 10
(Month) (Day)19 **22**
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept. 30 19 **21** to **Oct. 10** 19 **22**that I last saw him alive on **Oct. 10** 19 **22**and that death occurred on the date stated above, at **11:00 A.M.**

The CAUSE OF DEATH* was as follows:

**Tuberculosis
(not Pulmonary)**

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) **Chas. L. Gutman** M. D.**10/4** 19 **22** (Address) **Moscow, Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Breeze Idaho**10/12** 19 **22**

20. UNDERTAKER

ADDRESS

John McGee Moscow

FORM V. S. No. 5-25 M/1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No.

St.

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15. Filed

19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept. 25 1922 to Oct. 12 1922

that I last saw him alive on Oct. 12 1922

and that death occurred on the date stated above, at 6:20 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis +
Cardiac Insufficiency

(Duration) 15 Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

1922 (Address) Moscow, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Moscow 10/14 1922

20. UNDERTAKER

ADDRESS

Elen Gice Moscow

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 39670

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No.

St.)

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15. Filed

16. DATE OF DEATH

17. I HEREBY CERTIFY That I attended deceased from

that I last saw h.e.v. alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH was as follows:

Fractured ribs & Septic pneumonia
(3 aft)
Septic Parotitis

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed)

10/8 19.22 (Address) Moscow

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39671**
Registered No. _____

1. PLACE OF DEATH
County of **Latah** Registration District No. **64**
City of **Troy** Primary Registration District No. **2144**
(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ray Clarke Kettleson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Single**
(Write the word.)

6. DATE OF BIRTH **Jan. 30 1922**
(Month) (Day) (Year)

7. AGE **8 26**
Yrs. Mos. ds. IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. **none**
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE **Troy Ida**
(State or Country)

10. NAME OF FATHER **Carl Kettleson**

11. BIRTHPLACE OF FATHER **Minn**
(State or Country)

12. MAIDEN NAME OF MOTHER **Mary Ella Sumner**

13. BIRTHPLACE OF MOTHER **Iowa**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) **Carl Kettleson**
(Address) **Troy Ida**

15. Filed **Oct 31 1922** **Lucy M. Pickard**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **Oct 26 1922**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Oct 9 1922** to **Oct 14 1922**
that I last saw him alive on **Oct 14 1922**
and that death occurred on the date stated above, at _____ M.
The CAUSE OF DEATH* was as follows:

Euler's - colitis

(Duration) _____ Yrs. _____ mos. **21** ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) **R. Nelson** M. D.

1027 1922 (Address) **Troy, Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **Beulah Cem.** DATE OF BURIAL **Oct 27 1922**

20. UNDERTAKER ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39672**

1. PLACE OF DEATH **Salatou**
County of **Troy** (No. _____, St.)
Registration District No. **6**
Primary Registration District No. **2144**

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME **Maugus Johanson**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Single**
(Write the word.)

6. DATE OF BIRTH **exact date not known**
(Month) (Day) (Year)

7. AGE **6.3** Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Sweden

10. NAME OF FATHER

Nels Johanson

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME OF MOTHER

Mary Erickson

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **John Johanson**
(Address) **Troy Idaho**

15. Filed **Oct 31** 19 **21** **Lucy M. Pickard**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

October 29 19 **22**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **✓** 19 **✓** to **✓** 19 **✓**

that I last saw him alive on **✓** 19 **✓**
and that death occurred on the date stated above, at **11:30** A.M.

The CAUSE OF DEATH* was as follows:

Died suddenly while at Church - did not move from seat. Probably Apoplexy
(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) **R. Pickard** M. D.(Address) **Troy Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Dry Creek Bur. DATE OF BURIAL **Oct 31, 19 22**

20. UNDERTAKER

John J. Pickard ADDRESS **Troy Ida**

FORM V. S. No. 5-26 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH **RECEIVED**
 County of **Boate** Registration District No. **61**
 City of **Moscow** Registration District No. **1011** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

BUREAU OF VITAL STATISTICS

Robt. Henry Cay

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. **39673**
 Registered No. **23**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **M** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED **married**
 (Write the word.)

6. DATE OF BIRTH **Sept 9 1862**
 (Month) (Day) (Year)

7. AGE **60** Yrs. **20** Mos. **20** ds.
 IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

Retired

Farmer

9. BIRTHPLACE

(State or Country)

Bangor Wis.

10. NAME OF FATHER

Robert Cay

11. BIRTHPLACE OF FATHER

(State or Country)

Bangor Wis.

12. MAIDEN NAME OF MOTHER

Alma Richardson

13. BIRTHPLACE OF MOTHER

(State or Country)

Bangor Wis.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

L. E. Cay
Moscow

15.

Filed **9/30** 19**22** **R. H. Baughers**
 Local Registrar

SYN-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **Sept 19. 1922**
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Aug 30 1922** to **Sept 25 1922**

that I last saw him alive on **Sept 25 1922**

and that death occurred on the date stated above, at **5:30 A.M.**

The CAUSE OF DEATH* was as follows:

Tuberc Dorsalis with progressive paralysis

(Duration) **2+** Yrs. **20** Mos. **20** ds.
 Contributory (Secondary) **Bladder & kidney disease**

(Duration) **1** yrs. **1** Mos. **1** ds.
 (Signed) **B. Nagel** M. D.

9/30/1922 (Address) **Moscow**

*State the Disease Causing Death; or Deaths from Violent Causes, state (1) Means of Injury; and (2) whether accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death **3** yrs. **19** Mos. **19** days. In the State **19** yrs. **19** Mos. **19** days

Where was disease contracted if not at place of death? **Do not know**

Former or usual residence **Moscow**

19. PLACE OF BURIAL OR REMOVAL **Moscow Cemetery** DATE OF BURIAL **Oct 19 22**

20. UNDERTAKER **Glen Grace** ADDRESS **Moscow**

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH *RECEIVED*
 County of *Latah* Registration District No. *61*
 City of *Moscow* Primary Registration District No. *2141*
 (State) *ID.* St.)

File No. *39674*Registered No. *20*

If death occurs away from
 usual residence, give facts
 called for under special in-
 formation.

2. FULL NAME

Hans Halverson

If death occurred in a hos-
 pital, institution or camp,
 give its NAME instead of
 street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M.* 4. COLOR OR RACE *W.* 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED *Married*
 (Write the word.)

6. DATE OF BIRTH *Mar 9 1847*
 (Month) (Day) (Year)

7. AGE *75-6* IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION *Farming*
 (a) Trade, profession or
 particular kind of work
 (b) General nature of in-
 dustry, business or estab-
 lishment in which employ-
 ed (or employer)

9. BIRTHPLACE *Norway*
 (State or Country)

10. NAME OF FATHER *Halvor Halgeson*

11. BIRTHPLACE OF FATHER *Norway*
 (State or Country)

12. MAIDEN NAME OF MOTHER *not known.*

13. BIRTHPLACE OF MOTHER *" "*
 (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) *Mrs Clara Bartholomey*
 (Address) *Moscow Idaho*

15. Filed *9/10* 19*22* *W. H. Bartholomey*
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *Sept 8 1922*
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Sept 1 1922 to *Sept 8 1922*
 that I last saw him alive on *Sept 1 1922*
 and that death occurred on the date stated above, at *3 P.* M.
 The CAUSE OF DEATH* was as follows:
acute nephritis

(Duration) Yrs. mos. *14* ds.
 Contributory (Secondary) *cold*
 (Duration) yrs. mos. ds.
 (Signed) *J. H. Clarke* M. D.
9/10 19. (Address) *Moscow*

*State the Disease Causing Death; or in deaths from Violent Causes, state
 (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
 Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
 if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Moscow Ida.* DATE OF BURIAL *Sept 11 1922*

20. UNDERTAKER *W. H. Bartholomey* ADDRESS *Moscow Ida.*

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH **RECEIVED**
 County of **Latah** Registration District No. **61**
 City of **Moose Creek** Registration District No. **2141**
 (State)

File No. **39675**Registered No. **19**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Christ Durtchi

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **M** 4. COLOR OR RACE **W** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Single**
 (Write the word.)

6. DATE OF BIRTH **July 10 1850**
 (Month) (Day) (Year)

7. AGE **72** Yrs. **1** Mos. **29** ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION **Farmer**
 (a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE **Switzerland**
 (State or Country)

10. NAME OF FATHER **Not known here**

11. BIRTHPLACE OF FATHER " " " (State or Country)

12. MAIDEN NAME OF MOTHER " " " (State or Country)

13. BIRTHPLACE OF MOTHER " " " (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) **Frank Burch**
 (Address) **Moose Creek Ida**

15. Filed **9/10** 19**22** **W H Barish**
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **Sept 8 1922**
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 19 to 19 that I last saw h. alive on 19 and that death occurred on the date stated above, at M. The CAUSE OF DEATH* was as follows:

Apoplexy
 (Duration) Yrs. mos. ds.

Contributory (Secondary) **Glaucoma**
 (Duration) Yrs. mos. ds.
 (Signed) **Allen Gice** M. D.
9/10 1922 (Address) **Moose Creek Ida**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **Moose Creek** DATE OF BURIAL **9/10 1922**
 20. UNDERTAKER **Allen Gice** ADDRESS **Moose Creek**

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 61

County of

Primary Registration District No. 2141

City of

(No.)

St.)

File No. 39676

Registered No. 21

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

M

W

Married
(Write the word.)

6. DATE OF BIRTH

April 30 1844
(Month) (Day) (Year)

7. AGE

78 4 14
Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Minister of Gospel

9. BIRTHPLACE

(State or Country)

North Carolina

10. NAME OF FATHER

Clemey Buchanan

11. BIRTHPLACE OF FATHER

(State or Country)

North Carolina

12. MAIDEN NAME OF MOTHER

Mary Sparks

13. BIRTHPLACE OF MOTHER

(State or Country)

North Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wilson Buchanan

(Address)

Julietta, Ida

15.

Filed

9/16 1922 M. H. Matthews
Local Registrar

16. DATE OF DEATH

Sept 14 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19

that I last saw h. alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

probably fatty degeneration of the heart, no request
field (Duration) Yrs. mos. ds.Contributory
(Secondary)

Duration Yrs. mos. ds.

(Signed)

Glen Grace Coroner

9/16/22 (Address) Moscow, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Moscow 9/17 1922

UNDERTAKER

ADDRESS

Glen Grace Moscow

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 39677

Registered No. 18

1. PLACE OF DEATH

County of Idaho

City of Juliaetta

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Thomas Edward Schumacher

If death occurred in a hos-
pital, institution or camp,
give name instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

M

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Married

6. DATE OF BIRTH

March 7 1857

7. AGE

65 5 24

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer).Salesman
General Store

9. BIRTHPLACE

(State or Country)

10. NAME OF
FATHER11. BIRTHPLACE
OF FATHER

(State or Country)

12. MAIDEN NAME
OF MOTHER13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15. Filed

Sept 3 1922

Local Registrar

16. DATE OF DEATH

Sept 2 22

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19

that I last saw him alive on 19

and that death occurred on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:

Heart Trouble
no inquest held

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Glen Rice coroner

9/3 1922 (Address) Moscow Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Moscow Idaho, 9/5 1922

20. UNDERTAKER

ADDRESS

Glen Rice Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH

County of *Idaho*

City of *Moscow*

If death occurs away from usual residence, give facts called for under special information.

RECEIVED

CERTIFICATE OF DEATH

Registration District No. *61*

Primary Registration District No. *1011*

(No. *1011*)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. *39678*

Registered No. *22*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

James Russell Strong

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widowed

(Write the word.)

6. DATE OF BIRTH

Sept 24 1849

7. AGE

72 Yrs. *11* Mos. *26* ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

City Clerk.
Bookkeeper

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

Orren Strong

11. BIRTHPLACE OF FATHER

(State or Country)

New York

12. MAIDEN NAME OF MOTHER

Amanda Gibbs

13. BIRTHPLACE OF MOTHER

(State or Country)

Vermont

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mrs. Solis McEwen*

(Address) *Moscow*

15.

Filed *9/21 1922*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 20 1922

17. I HEREBY CERTIFY, That I attended deceased from

Sept 14 1922 to *Sept 26 1922*
that I last saw him alive on *Sept 20 1922*
and that death occurred on the date stated above, at *7:25 P.M.*

The CAUSE OF DEATH* was as follows:

Calculus (Bladder)

(Duration) Yrs. *6* mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. H. Clarke

M. D.

9/21 1922 (Address) *Moscow*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Moscow

DATE OF BURIAL

9/22 1922

20. UNDERTAKER

Edwin Price

ADDRESS

Moscow

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39679**

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

Registration District No. **68**
County of **Latah**
City of **Juliaetta** (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Leonard F. Simmons

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male White Widower
(Write the word.)

6. DATE OF BIRTH

January 17 1886
(Month) (Day) (Year)

7. AGE

95 Yrs. 8 Mos. 23 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).**Mechanic**

9. BIRTHPLACE

(State or Country)

New York

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Mrs. A. Perryman**(Address) **Juliaetta, Idaho**

15.

Filed **Sept 26 1922****R. F. Pepple**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

September 24 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept. 24 1922 to **19**
that I last saw him alive on **Sept. 24 1922**
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Asthenia due to a severe attack of Gastro-intestinal disturbance with acute diarrhea(Duration) _____ Yrs. _____ mos. **7** ds.

Contributory (Secondary)

(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed) **Andrew Otterson, M. D.****9/25/1922** (Address) **Hendrick, Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Juliaetta Cemetery 9.26 1922

20. UNDERTAKER

ADDRESS

Johnson Juliaetta

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH. *Walcher*

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39680**

1. PLACE OF DEATH
County of *Idaho* Registration District No. *68*
City of *Julietta* Primary Registration District No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Francis Walcher

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female *Austrian* *Widowed*
(Write the word.)

6. DATE OF BIRTH.

1862
(Month) (Day) (Year)

7. AGE

60 Yrs. Mos. ds.

IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) *Großmünz, Styria*

10. NAME OF FATHER

Matthew Walcher

11. BIRTHPLACE OF FATHER

(State or Country) *Austria*

12. MAIDEN NAME OF MOTHER

Catherine

13. BIRTHPLACE OF MOTHER

(State or Country) *Austria*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

G. F. Fink
Southwick, Idaho

15.

Filed

Sept 7 1922 *R. F. Rippe*

Local Registrar

MEDICAL CERTIFICATE OF DEATH *42*

16. DATE OF DEATH

Sept 1 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to 191
that I last saw him alive on 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus with metastases to other abdominal organs.
(Duration) *2* Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) *Andrew Ottensmeyer*

9/1 1922 (Address) *Kendrick, Idaho*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

Julietta, Idaho *9/22/22*
J. B. Houchens *Julietta, Idaho*

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No.

St.)

File No.

Registered No.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED
(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15. Filed

Local Registrar

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw her alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

39682

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No.

St.)

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15. Filled

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

Contributory (Secondary)

(Signed)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death In the State

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH.

1. PLACE OF DEATH.

County of Latah Registration District No. 65
 City of Potlatch Primary Registration District No. 2145
 (No.) (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Parker, Bernard. Flasher.

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. **39683**

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male. White. Single.
 (Write the word.)

6. DATE OF BIRTH.

Sept. 21 1922
 (Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
 how many 2 hrs. or
 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... None.
 (b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country) Idaho.

10. NAME OF FATHER

Lester. Flasher.

11. BIRTHPLACE OF FATHER

(State or Country) Wisconsin

12. MAIDEN NAME OF MOTHER

Frances. Parker.

13. BIRTHPLACE OF MOTHER

(State or Country) Minnesota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lester. G. Flasher.

(Address) Potlatch

15.

Filed Sept. 23 1922. J. J. Thompson.
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept. 21 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 21 1922, to Sept. 21 1922, that I last saw him alive on Sept. 21 1922, and that death occurred on the date stated above, at 9:15 AM.
 The CAUSE OF DEATH* was as follows:

Infantile
(Premature birth)

(Duration) Yrs. mos. ds.

Contributory Premature birth.
 (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. J. Thompson. M. D.

9/23/1922 (Address) Potlatch.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Potlatch Cemetery Sept. 23 1922

20. UNDERTAKER

ADDRESS

Parents. Potlatch.

RECEIVED
OCT 24 1922
WASH. STATE BOARD OF HEALTH

Deliver This Certificate to Your Local Registrar. Not to the State Board of Health.

Idaho State Board of Health
Washington State Board of Health

Record No. 39634

PLACE OF DEATH

County of Latah
City or Town of Princeton

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registered No.

Registration Dist. No. 65

(No.) St.; Ward)

[If death occurs away from USUAL RESIDENCE give facts called for under item 18.]

FULL NAME Martha Belle Thresher [If death occurred in a Hospital or Institution give its NAME instead of street and number.]

Personal and Statistical Particulars

3 Sex Female 4 Color or Race White 5 Single, Married, Widowed, or Divorced Married

6 Date of Birth Oct 11 1899
(Month) (Day) (Year)

7 Age 62 yrs. 11 mos. 19 ds. If LESS than 1 day, ___ hrs. or ___ min?

8 Occupation (a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business or establishment in which employed (or employer)

9 Birthplace (State or country) Iowa

PARENTS
10 Name of Father Joseph Bunny
11 Birthplace of Father (State or country) England
12 Maiden name of Mother Mary Brooks
13 Birthplace of Mother (State or country) Indiana

14 The above is true to the best of my knowledge
(Informant) Joseph Thresher
(Address) Princeton

15 Filed Sept. 23, 1922 J. W. Thompson M.D.
Registrar.

I HEREBY CERTIFY, That I have been unable to secure answers to Questions

Medical Certificate of Death

16 Date of Death Sept 22, 1922
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from August 1922 to Sept 22 1922 that I last saw her alive on noon Sept 1922 and that death occurred, on the date above, at Princeton. The CAUSE OF DEATH* was as follows:

Cancer of Uterus Inc. Estans
(Duration) 2 yrs. 4 mos. 4 ds.

Contributory (Secondary)

(Duration) ___ yrs. ___ mos. ___ ds.
(Signed) J. M. Poloway, M. D.
Sept 22 1922 (Address) Princeton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 Length of Residence (For Hospitals, Institutions, Transients, or Recent Residents)

At Place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 Place of Burial or Removal Pottlatch Ida Date of Burial Sept 24 1922

20 Undertaker J. M. Poloway Address

J. M. Poloway
(Insert numbers of unanswered questions)

(Signature of Undertaker)

MARGIN RESERVED FOR BINDING
V. S. No. 1.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Deliver This Certificate to Your Local Registrar. Not to the State Board of Health.

PLACE OF DEATH

~~Washington~~ **Idaho** State Board of Health

Record No.

County of Latah
City or Town of Pollatch

BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH

Registered No.

Registration Dist. No. 65

(No.)

St.; Ward)

[If death occurs away from USUAL RESIDENCE give facts called for under Item 18.]

FULL NAME

Sarah Jane Budd

[If death occurred in a Hospital or Institution give its NAME instead of street and number.]

Personal and Statistical Particulars

3 Sex Female 4 Color or Race White 5 Single, Married, Widowed, or Divorced Married
(Write the word)

6 Date of Birth July 5 1837
(Month) (Day) (Year)

7 Age 85 yrs. 2 mos. 22 ds. If LESS than 1 day, ____ hrs. or ____ min?

8 Occupation (a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business or establishment in which employed (or employer)

9 Birthplace (State or country) Indiana

PARENTS
10 Name of Father A. Dillley
11 Birthplace of Father (State or country) Ohio
12 Maiden name of Mother Batekill
13 Birthplace of Mother (State or country) Not known

14 The above is true to the best of my knowledge
(Informant) Mrs. Bert Crooks
(Address) Paloalto

15 Filed Sept. 28, 1922 D. J. M. Thompson
Registrar.

Medical Certificate of Death

16 Date of Death Sept 26 1922
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 20, 1920, to Sept. 17, 1922, that I last saw her alive on Sept. 12, 1922, and that death occurred, on the date above, at 10:30 P. m. The CAUSE OF DEATH* was as follows:
Bright's Disease

(Duration) 3 yrs. ____ mos. ____ ds.
Contributory (Secondary) Fracture of femur
(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) Walter Farnham, M. D.
Sept 28, 1922 (Address) Paloalto, Wash

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

Length of Residence (For Hospitals, Institutions, Transients, or Recent Residents)
At Place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 Place of Burial or Removal Paloalto Wash. Date of Burial Sept 28, 1922

20 Undertaker J. M. Irwin Address

I HEREBY CERTIFY, That I have been unable to secure answers to Questions. (Insert numbers of unanswered questions)

(Signature of Undertaker)

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED
OCT 21 1922
HEALTH
STATE

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39686**

1. PLACE OF DEATH
County of Latah
City of Palouse
Registration District No. 65
Primary Registration District No. 2145
St. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hans Adolf Hansen

Registered No. _____
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH Aug 28 1870
(Month) (Day) (Year)

7. AGE 51 Yrs. 11 Mos. 26 ds.
IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business or establishment in which employed (or employer) _____

9. BIRTHPLACE Norway
(State or Country)

10. NAME OF FATHER Sven Hansen

11. BIRTHPLACE OF FATHER Norway
(State or Country)

12. MAIDEN NAME OF MOTHER Catharin Hansen

13. BIRTHPLACE OF MOTHER Norway
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. H. L. Hansen
(Address) Viola Ash.

15. Filed Aug 28 1922 D. J. Thompson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 26 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 26 1922 to _____ 19____
that I last saw h_____ alive on _____ 19____
and that death occurred on the date stated above, at 7 A.M.
The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy
(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) E. K. Wolfe M. D.
Aug 26 1922 (Address) Palouse, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Palouse, Wash. DATE OF BURIAL Sept 1, 1922

20. UNDERTAKER A. M. Irwin ADDRESS Palouse, Wash.

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH

Registration District No. 62
 County of Butala Primary Registration District No. 2142
 City of STATISTICS (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Girl Bumpuss

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 39687
 Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Fe

4. COLOR OR RACE

Wh

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

(Write the word.)

6. DATE OF BIRTH

Sept 16 1922
 (Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
 how many 4 hrs.
 or min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Genesee Idaho

10. NAME OF FATHER

Claude Harold Bumpuss

11. BIRTHPLACE OF FATHER

(State or Country)

Washington

12. MAIDEN NAME OF MOTHER

Alice Irene Garside

13. BIRTHPLACE OF MOTHER

(State or Country)

Nevada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Claude H. Bumpuss

(Address) Boise Idaho

15.

Sept 15 1922

Local Registrar

16. DATE OF DEATH

Sept 16 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 10 1922, to Sept 16 1922
 that I last saw her alive on Sept 16 1922
 and that death occurred on the date stated above, at 4:30 AM.

The CAUSE OF DEATH* was as follows:

Cremature Birth

(Duration) Yrs. mos. ds.

Contributory
 (Secondary)

(Duration) yrs. mos. ds.

(Signed) C. J. Truitt M. D.

(Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Genesee Idaho Sept 16 1922

20. UNDERTAKER

ADDRESS

Falton

Boise

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Lenhi
City of Salmon

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Peter Jeppesen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male white

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

married
(Write the word.)

6. DATE OF BIRTH

Feb 13 1899
(Month) (Day) (Year)

7. AGE

63 Yrs. 7 Mos. 21 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Farming

9. BIRTHPLACE

(State or Country)

U S

10. NAME OF FATHER

Pernasseen Nelson Jeppesen

11. BIRTHPLACE OF FATHER

(State or Country)

Denmark

12. MAIDEN NAME OF MOTHER

unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs L R Jeppesen

(Address)

Salmon Ida.

15.

Filed

Oct. 4 1922Chas Bellamy

Local Registrar

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51088

RECEIVED
OCT 21 1922
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 41Primary Registration District No. 2116

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 39688

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 4 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

me with 19 on Sept 27 1922
that I last saw him alive on Sept 27 1922
and that death occurred on the date stated above, at 6:00 A.M.

The CAUSE OF DEATH* as follows:

Heart of Stomach, possibly
malnutrition(Duration) about 15 min Yrs. mos. ds.Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

19 22

(Address)

Chas Bellamy M. D.
Salmon, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Moore Ida.

DATE OF BURIAL

Oct 4 1922

20. UNDERTAKER

R.C. Doehler

ADDRESS

Salmon

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Lincoln Registration District No. 41
 City of Salmon Primary Registration District No. 2116
 St.

File No. 39689Registered No.

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Mary Black M. Quincy

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH

June 18 19
(Month) (Day) (Year)

7. AGE

73 Yrs. 3 Mos. 19 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer).

House wife

9. BIRTHPLACE

(State or Country)

Scotland

10. NAME OF FATHER

James Black.

11. BIRTHPLACE OF FATHER

(State or Country)

Scotland

12. MAIDEN NAME OF MOTHER

Jane Moffet

13. BIRTHPLACE OF MOTHER

(State or Country)

Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Peter M. Quincy

(Address)

Salmon Idaho

15.

Filed Oct 10 - 1922

Local Registrar

Cliff Bellamydy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

SEP 29 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 1 1922 to Sept 29 1922
that I last saw her alive on Sept 29 1922
and that death occurred on the date stated above, at 8:00 M.

The CAUSE OF DEATH* was as follows:

Fracture of thigh

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas F. Hammer M. D.Date 19 (Address) Salmon

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Salmon Cemetery Oct 1st 1922

20. UNDERTAKER

W. B. Jacobs ADDRESS Salmon Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39690**

Registered No.

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

1. PLACE OF DEATH

County of **Lewiston** Registration District No. **41**
City of **Salmon** Primary Registration District No. **2116**
(No. St.)If death occurs away from
usual residence, give facts
called for under special in-
formation.2. FULL NAME **Helen Morton**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED **Married**

6. DATE OF BIRTH

December 7 1841
(Month) (Day) (Year)

7. AGE

80 Yrs. **9** Mos. **25** ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)**House keeper**

9. BIRTHPLACE

(State or Country)

New York10. NAME OF
FATHER**John Alexander**11. BIRTHPLACE
OF FATHER

(State or Country)

Unknown12. MAIDEN NAME
OF MOTHER**Anilla Seward**13. BIRTHPLACE
OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mettie M. Norton

(Address)

Salmon - Idaho

15.

Filed

Oct. 10 - 1922 **Chas. Bellamy**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

October 22 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept. 28 1922, to **Oct. 2** 1922
that I last saw him alive on **Oct. 2** 1922
and that death occurred on the date stated above, at **3:15 P.M.**

The CAUSE OF DEATH* was as follows:

Bronchial Asthma(Duration) **3** Yrs. mos. ds.Contributory
(Secondary)**Bronchitis (acute)**(Duration) Yrs. mos. **14** ds.

(Signed)

10/3/22

(Address)

Idaho*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Salmon Cemetery**Oct 4** 1922

20. UNDERTAKER

ADDRESS

H.C. Joche**Salmon Ida.**

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39691**

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH **RECEIVED**
County of **Jeremi** Registration District No. **41**
City of **Johns** Primary Registration District No. **2116**
St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **John C. Incomb**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED**Male White Single** (With the word.)

6. DATE OF BIRTH

Oct 12 1957
(Month) (Day) (Year)

7. AGE

63 Yrs. 10 Mos. 13 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)**Laborer
Ranch**

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

John Incomb

11. BIRTHPLACE OF FATHER

(State or Country)

Devonshire, England

12. MAIDEN NAME OF MOTHER

Shirah Rathborn

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Naomi R. Ingerson(Address) **329 H 10, Superior, Minn.**

15.

Filed **Oct. 10 - 1922** **Chas Bellamy**
Local RegistrarMEDICAL CERTIFICATE OF DEATH **60**

16. DATE OF DEATH

August 25 19**22**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 20 1922 to Aug 26 1922
that I last saw him alive on **Aug 20 1922**and that death occurred on the date stated above, at **11 A.M.**

The CAUSE OF DEATH* was as follows:

apoplexy

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) **Chas F. Hammer** M. D.(Address) **Salmon**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Salmon Cemetery

DATE OF BURIAL

8-27-1922

20. UNDERTAKER

W.C. Toebler

ADDRESS

Salmon, Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39692**
Registered No.

1. PLACE OF DEATH

County of Lemhi Registration District No. 41
City of Salmon Registration District No. 2116 (NAT'L) St.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Minnie M. Shanon

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH August 19 1896
(Month) (Day) (Year)

7. AGE 26 Yrs. 22 Mos. 22 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Lemhi Co. Idaho

10. NAME OF FATHER

Philip Shanon

11. BIRTHPLACE OF FATHER

(State or Country) Ireland

12. MAIDEN NAME OF MOTHER

Minnie M. Kinney

13. BIRTHPLACE OF MOTHER

(State or Country) Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Minnie M. Hart
(Address) Salmon, Idaho

15. Filed Oct 10 - 1922 Chas Bellomy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

108

16. DATE OF DEATH

Sept 10 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1 1922 to Sept 10 1922 that I last saw him alive on Sept 10 1922 and that death occurred on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Tubercular appendicitis - (operated)

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas F. Hammer M. D.

Sept 10 1922 (Address) Salmon

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Salmon Cemetery DATE OF BURIAL 9-13-22

20. UNDERTAKER W.C. Doedic ADDRESS Salmon Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39693**

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Lemhi Registration District No. 41
City of Lemhi Primary Registration District No. 2116 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Phisha Pyeatt

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female White Married
(Write the word.)

6. DATE OF BIRTH

January 1 1848
(Month) (Day) (Year)

7. AGE

74 Yrs. 9 Mos. 17 ds. IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Farmer
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) De Quoin, Ill.

10. NAME OF FATHER

Washington Gill

11. BIRTHPLACE OF FATHER

(State or Country) Virginia

12. MAIDEN NAME OF MOTHER

Virginia Freshman

13. BIRTHPLACE OF MOTHER

(State or Country) Tennessee

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William B. Pyeatt
(Address) Lemhi, Ida15. Filed Oct - 10 - 1922 Chas Bellamy

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

September 17th 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 4 1922 to Sept 15th 1922
that I last saw her alive on Sept 15th 1922
and that death occurred on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:

Old age
(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) F. B. Wright M. D.Oct 7 1922 (Address) Salmon

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Yearian Cemetery Junction 9-19 1922

20. UNDERTAKER ADDRESS

H. C. Joehle Ida Johnson Ida

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39694**

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of **Leucy**
City of **Salmon, Ida.**

Registration District No.

Primary Registration District No.

(No.

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William Richards

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write in word.)

6. DATE OF BIRTH

Not known
(Month) (Day) (Year)

7. AGE

47 Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)**Quartz Miner**

9. BIRTHPLACE

(State or Country)

Not known

10. NAME OF FATHER

" "

11. BIRTHPLACE OF FATHER

(State or Country)

" "

12. MAIDEN NAME OF MOTHER

" "

13. BIRTHPLACE OF MOTHER

(State or Country)

" "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. Berrell Brough
(Address) **Salmon**

15.

Filed

Oct. 10 - 1922**Cliff Bellman**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 2nd 19**22**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 1 19**22** to **Oct 2** 19**22**
that I last saw him alive on **Oct 2** 19**22**
and that death occurred on the date stated above, at **10 A** M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) Yrs. mos. ds.

Contributory
(Secondary)**about 4 years** (Duration) yrs. mos. ds.(Signed) **Charles F. Hammer** M. D.**Oct 6** 19**22** (Address) **Salmon**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Salmon Cemetery **Oct 3** 19**22**

20. UNDERTAKER

ADDRESS

W. C. Joekle **Salmon, Ida.**

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39695**

1. PLACE OF DEATH

Registration District No. **41**
County of **Salmon** Primary Registration District No. **2116**
City of **Salmon** (No. **1**) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John O. Minde

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WID-OWED OR DIVORCED **Married (the wife)**6. DATE OF BIRTH **Jan 6** (Month) **1** (Day) **1868** (Year)7. AGE **57** Yrs. **1** Mos. **1** ds. IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)**Rancher**

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

O. O. Minde

11. BIRTHPLACE OF FATHER

(State or Country)

Norway

12. MAIDEN NAME OF MOTHER

Laura Lovtenson

13. BIRTHPLACE OF MOTHER

(State or Country)

Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. O. Minde

(Address)

112 7th St. Salmon, Idaho

15.

Filed

Sept 27 - 1922**Chas E. Bellamy**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 27 (Month) **27** (Day) **1922** (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 20 19 **22** to **Sept 27** 19 **22** that I last saw him alive on **Sept 27** 19 **22** and that death occurred on the date stated above, at **1 A.M.**

The CAUSE OF DEATH* was as follows:

DecompositionContributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) **Chas F. Hammer, M.D.****Sept 27 1922** (Address) **Salmon**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

W. E. Stickle**Salmon, Idaho**

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Lemhi Registration District No. 41
City of Salmon Primary Registration District No. 2116
City of Salmon (St.)File No. 39696

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

BUREAU OF VITAL STATISTICS

2. FULL NAME

Bessie Myrtle Kilborn

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-OWED OR DIVORCED

female white married
(Write the word.)

6. DATE OF BIRTH

July 8 1884
(Month) (Day) (Year)

7. AGE

35 Yrs. 2 Mos. 12 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)House Wife

9. BIRTHPLACE

(State or Country)

Illinois

10. NAME OF FATHER

Jacob Bliler

11. BIRTHPLACE OF FATHER

(State or Country)

Not Known

12. MAIDEN NAME OF MOTHER

Mary Hollier

13. BIRTHPLACE OF MOTHER

(State or Country)

Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

William Kilborn

(Address)

Salmon

15.

Filed

Sept. 22 1922Clis Bellamy
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

September 20th 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____ 19____, to _____ 19____

that I last saw h. _____ alive on _____ 19____

and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Accidentally
killed by auto truck, Crushed
on left side, by falling auto.
(Duration) _____ Yrs. _____ mos. _____ ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) William C. Joebler Coroner M.D.9-22-1922 (Address) Salmon, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Livingston Mont

_____ 19____

20. UNDERTAKER

ADDRESS

W. C. JoeblerSalmon, Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Lewiston*
City of *Morristown*Registration District No. *60*Primary Registration District No. *2/29*

(No. _____ St.)

File No. *39697*Registered No. *15*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Norman Miles Colbert
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED*male white Infant*
(Write the word)

6. DATE OF BIRTH

Dec. 2 1921
(Month) (Day) (Year)

7. AGE

*Yrs. 10 Mos. 3 ds.*IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)*Infant*

9. BIRTHPLACE

(State or Country)

Morristown Idaho

10. NAME OF FATHER

Norman F. Colbert

11. BIRTHPLACE OF FATHER

(State or Country)

Oregon

12. MAIDEN NAME OF MOTHER

Elsie E. Coleman

13. BIRTHPLACE OF MOTHER

(State or Country)

Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Norman F. Colbert

(Address)

Craigmont, Ida.

15.

Filed

10/17 1922 R. D. Dumb

Local Registrar

MEDICAL CERTIFICATE OF DEATH

104

16. DATE OF DEATH

Oct. 12 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *Baby dead when I moved*that I last saw him alive on *when born* 19____
and that death occurred on the date stated above, at *4:20 PM*.

The CAUSE OF DEATH* was as follows:

Gastro Intest Toxemia(Duration) Yrs. mos. *5* ds.Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

J. C. L. L. L. D.(Address) *Winchester St*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Westside Ida Oct 13 1922

20. UNDERTAKER

ADDRESS

Norman F. Colbert Craigmont, Ida

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Lewis*City of *Winchester*

If death occurs away from usual residence, give facts called for under special information.

Registration District No. *62*Primary Registration District No. *2129*(No. *Alfred Everett*)

St.)

File No. *39698*Registered No. *16*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED*male**white**Infant*
(Write the word.)

6. DATE OF BIRTH

*Oct**14**1922*

(Month)

(Day)

(Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

Infant

9. BIRTHPLACE

(State or Country)

Winchester Idaho

10. NAME OF FATHER

Francis Crane

11. BIRTHPLACE OF FATHER

(State or Country)

Mass.

12. MAIDEN NAME OF MOTHER

Jessie Adams

13. BIRTHPLACE OF MOTHER

(State or Country)

Wash

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Grand Crane

(Address)

Winchester Ida

15.

Filed

*10/17**1922**R E Dunch*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

*Oct**14**1922*

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

*Suffered 3 hours*that I last saw him alive on *after birth*and that death occurred on the date stated above, at *5 P.* M.

The CAUSE OF DEATH* was as follows:

Do not know

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)*Difficult birth*

(Duration)

yrs.

mos.

ds.

(Signed)

R E Dunch M. D.*Oct 17 1922* (Address) *Winchester Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Memorial Cemetery**10/15 1922*

20. UNDERTAKER

ADDRESS

*Hotel Thompson**Winchester Ida*

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD —
N. B.—Every item of information should be carefully supplied. AGE should be given in plain terms, so that it may be properly classified. Exact statement of OCCUPATION.

CERTIFICATE OF DEATH

STATE OF ALABAMA
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS

PLACE OF DEATH

Registration District No.

Registration District No.

City of Craigmont

(No.)

St.)

Registered No. 38599

Death occurs away from
usual residence, give facts
and place for under special in-
vestigation.

2. FULL NAME

Granville William Long

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDMale WhiteWidowed
(Write the word.)

DATE OF BIRTH

Sept 8
(Month) (Day) (Year)1940
(Year)82 Yrs. 1 Mos. 16 ds.

IF LESS than 1 day
how many hrs.
or min.?

OCCUPATION

(a) Trade, profession or
particular kind of work.(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)Farmer Retired

9. BIRTHPLACE

(State or Country)

Indiana10. NAME OF
FATHERSolomon Long11. BIRTHPLACE
OF FATHER

(State or Country)

Pennsylvania12. MAIDEN NAME
OF MOTHERKatherine13. BIRTHPLACE
OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

CB Garry

(Address)

Craigmont, Ala

15.

Filed

10/25

19

1922 R.E. Dumb

Local Registrar

MEDICAL CERTIFICATE OF DEATH 126

16. DATE OF DEATH

October 24
(Month) (Day) (Year)1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from
July 9 1922, to July 14 1922

that I last saw him alive on July 14 1922
and that death occurred on the date stated above, at 8:20 A.M.

The CAUSE OF DEATH* was as follows:

Hypertension Portale(Duration) Five yrs. mos. ds.Contributory
(Secondary)Malnutrition(Duration) 1 yrs. mos. ds.

(Signed)

R.E. Dumb M. D.10/25/22(Address) Craigmont, Ala.

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Union Cemetery

DATE OF BURIAL

10/25 1922

20. UNDERTAKER

St. Mary's

ADDRESS

Craigmont

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Madison
City of BoyleRegistration District No. 100
Primary Registration District No. 278
(No.) _____ St. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED
NOV 4 1922
BUREAU

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.Male
(Write the word.)

6. DATE OF BIRTH

Aug 5
(Month) (Day)1922
(Year)

7. AGE

Yrs. 7 Mos. 2 ds.IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)Male

9. BIRTHPLACE

(State or Country)

Reynolds Idaho

10. NAME OF FATHER

Charles Stuns

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Pauline Knickley

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Chas. Stuns

(Address)

Boyle Idaho

15.

Filed

10/31922J. R. Young

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct.
(Month)1
(Day)1922
(Year)17. I HEREBY CERTIFY, That I attended deceased from
Aug 5 1922 to Aug 15 1922...
that I last saw her alive on Aug 15 1922...
and that death occurred on the date stated above, at 5: a M.
The CAUSE OF DEATH* was as follows:Pertussis

(Duration)

Yrs.

mos.

5 ds.Contributory
(Secondary)pneumonia

(Duration)

Yrs.

mos.

3 ds.

(Signed)

10/3 1922. (Address)Louis Stuns
Reynolds Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....Yrs.....mos.....days In the State.....Yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

J. R. YoungReynolds

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

39701

File No.

Registered No. 19

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Madison
City of PlanoRegistration District No. 100
Primary Registration District No. 2178
St.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Beatrice Briney

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH

October 11 1922
(Month) (Day) (Year)

7. AGE

X Yrs. 4 Mos. 24 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)NoneChild

9. BIRTHPLACE

(State or Country)

Colorado
Plano, Ida.

10. NAME OF FATHER

John Briney

11. BIRTHPLACE OF FATHER

(State or Country)

Arkansas

12. MAIDEN NAME OF MOTHER

Edna Osborn

13. BIRTHPLACE OF MOTHER

(State or Country)

Oklohama

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15. Filed

10/51922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

October 4th 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Oct 3 1922, to Oct 3 1922, that I last saw h. er. alive on Oct 3 1922, and that death occurred on the date stated above, at 7:30 A.M.
The CAUSE OF DEATH* was as follows:
Marasmus(Duration) Yrs. 1 mos. 1 ds.
Contributory (Secondary) Malnutrition(Duration) yrs. 2 mos. 1 ds.(Signed) Larin F. Rich M.D.10/4 1922 (Address) Reeburg Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Plano, Ida.

DATE OF BURIAL

10/5 1922

20. UNDERTAKER

ADDRESS

David Young Reeburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

1. PLACE OF DEATH.

County of Madison
City of Reynolds

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100
Primary Registration District No. 2178
(No. _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 39702
Registered No. 18

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Roman Siepart

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH. May 31 - 1894
(Month) (Day) (Year)

7. AGE 68 Yrs. 4 Mos. _____ ds. IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...

Farm

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

Conrad Siepart

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Caroline Anthony

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs R. Siepart
(Address) R.F.D. #1

15. Filed 10/3 19122 Roman
Local Registrar

MEDICAL CERTIFICATE OF DEATH

64

16. DATE OF DEATH

Oct. 1 19122
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1 1922, to Oct 1 1922,

that I last saw him alive on _____ 191____ and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Dead when I arrived.

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed) Harley Nelson M. D.

10-1-1922 (Address) Reynolds Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....Yrs.....Mos.....Days In the State.....Yrs.....Mos.....Days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Reynolds 10/4 19122

20. UNDERTAKER

ADDRESS

Roman Reynolds

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of MadisonCity of Sugar

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100Primary Registration District No. 2178No. 60

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 39703Registered No. 60

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Ellen Bean

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Married
(Write the word.)

6. DATE OF BIRTH

May

(Month)

3rd

(Day)

1866

(Year)

7. AGE

56

Yrs.

5

Mos.

2

ds.

IF LESS than 1 day

how many _____ hrs.

or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Housewife

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Caleb W. Haws

11. BIRTHPLACE OF FATHER

(State or Country)

Illinois

12. MAIDEN NAME OF MOTHER

Eliza Ann Snow

13. BIRTHPLACE OF MOTHER

(State or Country)

Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) George A. Bean(Address) Sugar City, Ida.15. 10/6Filed 19221922J. W. Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct

(Month)

5

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 1922, to Oct 4 1922that I last saw her alive on Oct 4 1922and that death occurred on the date stated above, at 7:35 M.

The CAUSE OF DEATH* was as follows:

Chronic Bright disease

(Duration) Yrs. _____ mos. _____ ds.

Contributory (Secondary) Myocarditis(Duration) yrs. 6 mos. _____ ds.(Signed) A. B. Sutherland M. D.10-6-1922 (Address) Plexburg, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. _____ mos. _____ days. In the State yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Sugar City Ida

DATE OF BURIAL

10/8 1922

20. UNDERTAKER

David Young

ADDRESS

Plexburg

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39704**
Registered No. **66**

1. PLACE OF DEATH **Madison** Registration District No. **120**
County of **Madison** Primary Registration District No. **2178**
City of **Boyle** (No. **120** St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Rora Foell**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **F** 4. COLOR OR RACE **w** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
married
(Write the word.)

6. DATE OF BIRTH **March 15 1858**
(Month) (Day) (Year)

7. AGE **64 yrs 7 mos 13 ds.** IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work **Housewife**
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE **Germany**
(State or Country)

10. NAME OF FATHER **Pieding Weber**

11. BIRTHPLACE OF FATHER **Germany**
(State or Country)

12. MAIDEN NAME OF MOTHER **Rora Stugel**

13. BIRTHPLACE OF MOTHER **Germany**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Wm Foell**(Address) **City of Boyle**15. **10/28** 191**22**Filed **10/28** 191**22** **J. Ryan** Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **Oct 28 1922**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **191**, to **191**, that I last saw h. alive on **191**, and that death occurred on the date stated above, at **M.**

The CAUSE OF DEATH* was as follows:

Found dead in bed.**apoplexy**

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) **Wm Foell** M.D.**10/28 1922** (Address) **Boyle**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death: yrs. mos. days. In the State: yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL **Boyle** DATE OF BURIAL **10/31 1922**20. UNDERTAKER **J. Ryan** ADDRESS **Boyle**

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

1. PLACE OF DEATH. Registration District No. 100
County of Madison Primary Registration District No. 2178
City of Perley St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarah Aguiris

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 39705
Registered No. 65

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Oct 24 1922
(Month) (Day) (Year)

7. AGE 5 yrs. 5 mos. 5 ds.
IF LESS than 1 day how many hrs. or mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work Boiler
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE Thornton Idaho
(State or Country)

10. NAME OF FATHER Lawrence B. Aguiris

11. BIRTHPLACE OF FATHER Idaho
(State or Country)

12. MAIDEN NAME OF MOTHER Verna Burns

13. BIRTHPLACE OF MOTHER Idaho
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. My Biggs
(Address) Thornton

15. Filed 10/30 1922 W. Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 29 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191 to 191,
that I last saw h. alive on 191,
and that death occurred on the date stated above, at M.
The CAUSE OF DEATH* was as follows:

Sept 29
Thrombotic Death
No Physician Called
(Duration) 0 yrs. 0 mos. 0 ds.

Contributory (Secondary)
(Duration) 0 yrs. 0 mos. 0 ds.

(Signed) W. Young Reg. M. D.
10/29 1922 (Address) Perley

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 0 yrs. 0 mos. 0 days. In the State 0 yrs. 0 mos. 0 days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Archer DATE OF BURIAL 10/30 1922

20. UNDERTAKER W. Young ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

1. PLACE OF DEATH *Madison* Registration District No. *100*
County of *Butte* Primary Registration District No. *2178*
City of *Butte* (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Elisabeth Nelson

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
39706
File No. _____
Registered No. *64*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *F* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. *Married*
(Write the word.)

6. DATE OF BIRTH. *July 17 1855*
(Month) (Day) (Year)

7. AGE *67* Yrs. *3* Mos. *7* ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. *Housewife*
(b) General nature of industry, business, or establishment in which employed (or employer).

9. BIRTHPLACE *Dumack*
(State or Country)

10. NAME OF FATHER *Alonzo Erickson*

11. BIRTHPLACE OF FATHER *Dumack*
(State or Country)

12. MAIDEN NAME OF MOTHER *Johnson*

13. BIRTHPLACE OF MOTHER *Dumack*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Emily Thompson*
(Address) *112 E. 1st St. Butte*

15. Filed *10/30* 19*22* *J. Brown* Local Registrar

16. DATE OF DEATH *Oct. 24 1922*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 191____, to _____ 191____, that I last saw him alive on _____ 191____, and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:
old age - simply died
No Physician called
(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) *J. Brown* Reg. M. D.
10/24 1922 (Address) *Butte, Idaho*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL *Butte* DATE OF BURIAL *10/26 1922*

20. UNDERTAKER *J. Brown* ADDRESS *Butte*

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39707**
Registered No. **63**

1. PLACE OF DEATH *Madison*
County of *Boyle*
City of *Boyle*
Registration District No. *100*
Primary Registration District No. *2178*
(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Henry Leroy Boicer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *M* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. *Married*
(Write the word.)

6. DATE OF BIRTH. *May 8 1891*
(Month) (Day) (Year)

7. AGE *41* Yrs. *5* Mos. *13* ds.
IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

Farm

9. BIRTHPLACE
(State or Country)

Utah

10. NAME OF FATHER *William J Boicer*

11. BIRTHPLACE OF FATHER
(State or Country)

Utah

12. MAIDEN NAME OF MOTHER *Elmira Mowbr*

13. BIRTHPLACE OF MOTHER
(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *R. G. Boicer*
(Address) _____

15.

Filed *1922* 1912

Local Registrar

16. DATE OF DEATH
(Month) (Day) (Year) *1922*

17. I HEREBY CERTIFY, That I attended deceased from *Oct 20 1922* to *Oct 20 1922*, that I last saw h. i. m. alive on *Oct 20 1922* and that death occurred on the date stated above, at *9:30 A.M.*

The CAUSE OF DEATH* was as follows:

Fracture cervical vertebra

(Duration) Yrs. mos. ds. *1*
Contributory (Secondary) *fall from farm machine*

(Duration) Yrs. mos. ds. *10*
(Signed) *W. L. Sutherland* M. D.
1922 (Address) *Reburg, Ida.*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

1912

20. UNDERTAKER ADDRESS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39708**
Registered No. **62**

1. PLACE OF DEATH.

County of *Mydisjoined* Registration District No. *100*
City of *Pay City* Registration District No. *2178*
(St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lena Amanda Douglas

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married

(Write the word.)

6. DATE OF BIRTH.

Feb 2 - *1* (Month) (Day) (Year)

7. AGE

42 Yrs. *8* Mos. *17* ds.

If LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

Housewife

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Isac. M. Sweet

11. BIRTHPLACE OF FATHER

(State or Country)

Mass

12. MAIDEN NAME OF MOTHER

Susan. Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Charles Douglas

(Address)

Idaho

15.

Filed

10/20

1912

JR Young

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

10 - *18* - *1912*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

10-21-1912, to *10-18-1912*,
that I last saw him alive on *10-18-1912*

and that death occurred on the date stated above, at *2:05 P.M.*

The CAUSE OF DEATH* was as follows:

Uremia

(Duration) Yrs. mos. *15* ds.

Contributory (Secondary)

Nephritis

(Duration) Yrs. mos. ds.

% (Signed)

Louis F. Rich, M.D.

19.1912 (Address)

Reebing, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Idaho

DATE OF BURIAL

10/22 1912

20. UNDERTAKER

JR Young

ADDRESS

Reebing

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFAADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

75

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of

City of

Registration District No.

Primary Registration District No.

(No.)

St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

6. DATE OF BIRTH.

7. AGE

IF LESS than 1 day
how many.....hrs. or
.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15.

Filed

191

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

Sept. 13 1922, to Oct. 6 1922,

that I last saw him alive on Oct. 4, 1922,

and that death occurred on the date stated above, at 8:30 A.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE-OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

39710

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Cassia
City of Colley
Registration District No. 120
Primary Registration District No. 2197
(No. 1522) St.)

File No. 2444
Registered No. 24

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ray B Price

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-OWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH October 12 1886
(Month) (Day) (Year)

7. AGE 36 Yrs. 2 Mos. 9 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION Farmer
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE Idaho
(State or Country)

10. NAME OF FATHER John N. Price

11. BIRTHPLACE OF FATHER Utah
(State or Country)

12. MAIDEN NAME OF MOTHER Minnie North

13. BIRTHPLACE OF MOTHER Utah
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John N Price
(Address) Colley, Id

15. Filed Oct. 25 1922
At Colley
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October 2 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10/21 1922 to 10/21 1922
that I last saw him alive on 10/21 1922
and that death occurred on the date stated above, at Colley, Id

The CAUSE OF DEATH* was as follows:
accidental

(Duration) 1 yrs. 1 mos. 1 ds.
Contributory (Secondary) hemorrhage
(Duration) 1 yrs. 1 mos. 1 ds.
(Signed) F. H. Schutte M. D.
(Address) Colley, Id

*State the Disease Causing Death; or in deaths from Violent Causes, state 1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Colley, Id DATE OF BURIAL 10/23 1922

20. UNDERTAKER Chas. Clark ADDRESS Colley, Idaho

39711

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Casper Registration District No. 120
 City of Casper Primary Registration District No. 2199
 (No. _____) (St.) _____

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Henry M. Griffith

File No. XVII
Registered No. 21

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED single

(Write the word.)

6. DATE OF BIRTH

March 22 1876
(Month) (Day) (Year)

7. AGE

46 Yrs. 7 Mos. 2 ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

Laborer

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

J. F. Griffith

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Nancy DeSpain

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Don Griffith
Casper, Wyo.

15.

Filled Oct. 31 1922 N. D. Nelson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct. 24 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct. 21 1922 to Oct. 24 1922
that I last saw him alive on Oct. 24 1922
and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) _____ Yrs. _____ mos. 4 ds.

Contributory (Secondary)

(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed)

N. D. Nelson D.
Casper, Wyo. (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted
if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Casper, Wyo. Oct. 31 1922

20. UNDERTAKER

ADDRESS

Wm. Edwards Casper, Wyo.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. E.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH
in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

39712

CERTIFICATE OF DEATH

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Cassia
City of Idaho Falls

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 120
Primary Registration District No. 2197
(No. St.)

File No. XVIII
Registered No. 22

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Ezra Clair Wilson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED single
(Write in words.)

6. DATE OF BIRTH Febr. 9 1906
(Month) (Day) (Year)

7. AGE 16 Yrs. 6 Mos. 26 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

School Boy

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Daniel B. Wilson

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Edith Clark

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Daniel B. Wilson

(Address)

Oakley, Idaho

15. Filed Oct. 31 1922 R. H. O. Nielson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 5th 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1st 1922 to Sept 5th 1922
that I last saw him alive on Sept 5th 1922
and that death occurred on the date stated above, at 6 A.M.
The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Duration) 1 Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) R. H. O. Nielson M. D.
13/ 1922 (Address) Oakley, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Oakley, Id. Sept. 7 - 1922

20. UNDERTAKER

ADDRESS

R. H. O. Nielson Oakley, Id.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

39713

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of CassRegistration District No. 120City of PaysonPrimary Registration District No. 2199(No. 3)

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Myrtle TracyFile No. 120Registered No. 120

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)
married

6. DATE OF BIRTH

Aug 5 1899
(Month) (Day) (Year)

7. AGE

23 Yrs. 3 Mos. 14 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)Housewife

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Job. Rowells

11. BIRTHPLACE OF FATHER

(State or Country)

Wah

12. MAIDEN NAME OF MOTHER

Mellie Garry

13. BIRTHPLACE OF MOTHER

(State or Country)

Wah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Mellie Rowells
Payson, Idaho

(Address)

15.

Filed Oct 31 1922St. O. Nelson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept. 19 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Aug 1 1922 to Sept. 19 1922that I last saw h. or alive on Sept. 17 1922
and that death occurred on the date stated above, at 12:00 M.

The CAUSE OF DEATH* was as follows:

Nephritis and Cardiac lesion(Duration) Yrs. 6 mos. — ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) St. O. Nelson M. D.Oct 31 1922 (Address) Payson, Id.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Payson, Idaho Sept 21 1922

20. UNDERTAKER

ADDRESS

Chas. Harper Payson, Id.

1. PLACE OF DEATH

County of *Boise*City of *Lewiston*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Edward Evans

CERTIFICATE OF DEATH

RECEIVED
OCT 21 1922
BUREAU OF VITAL STATISTICSRegistration District No. *96*Primary Registration District No. *1009*

(St.)

File No. *39714*Registered No. *155*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED*Male white married*
(Write the word.)

6. DATE OF BIRTH

Apr 18 1870
(Month) (Day) (Year)

7. AGE

*52 Yrs 4 Mos 11 ds.*IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

Supt. Streets City Lewiston

9. BIRTHPLACE

(State or Country)

Minn.

10. NAME OF FATHER

Mr. Evans.

11. BIRTHPLACE OF FATHER

(State or Country)

Wales.

12. MAIDEN NAME OF MOTHER

Lucretia Sweet.

13. BIRTHPLACE OF MOTHER

(State or Country)

Minn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wm. H. Evans

(Address)

1629 1/2 2nd Ave.

15.

Filed *Oct. 3.* 19 *22* *F.T. Harris, M.D.*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

79

16. DATE OF DEATH

Aug 29 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

*Aug 27 1922 to Aug 29 1922*that I last saw him alive on *Aug 29 1922*and that death occurred on the date stated above, at *11 P.* M.

The CAUSE OF DEATH* was as follows:

Acute dilatation of Heart(Duration) yrs. mos. ds. *1 hour*Contributory (Secondary) *Acute alcoholism.*(Duration) yrs. mos. ds. *7*(Signed) *E. H. White* M. D.*8-31 1922* (Address) *Lewiston Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Lewiston Ida.

DATE OF BURIAL

Sept 19 1922

20. UNDERTAKER

ADDRESS

*Lewiston**Ida*

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH **RECEIVED**
 County of *My Precinct* Registration District No. **96**
 City of *Idaho Falls* Primary Registration District No. **1009**
 (No. **121** St.)

File No. **39715**
 Registered No. **156**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ethel Elizabeth Whipple

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WID-OWED OR DIVORCED *married*
 (Write the word.)

6. DATE OF BIRTH

Apr 3 1882
 (Month) (Day) (Year)

7. AGE

40 Yrs. *5* Mos. *2* ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

Henry Snyder

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Sarah E. Harper

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Ethel Whipple
Lewiston Idaho

15.

Filed *Oct. 3* 19 *22*

F. T. Harris, M.D.
 Local Registrar

16. DATE OF DEATH

Sept 5 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Dec 1st 1921* to *Sept 5th 1922*
 that I last saw her alive on *Sept 5th 1922*
 and that death occurred on the date stated above, at *11* M.
 The CAUSE OF DEATH* was as follows:

Melanotic Carcinoma(Duration) Yrs. *3* mos. ds.Contributory (Secondary) *Uterine Carcinoma*(Duration) yrs. *9* mos. *5* ds.(Signed) *O. C. Leveson* M. D.19 (Address) *Lewiston Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lewiston Idaho *9/7 1922*

20. UNDERTAKER

ADDRESS

Baroar Lund Co., Lewiston Idaho

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39716**
Registered No. **157**

1. PLACE OF DEATH **OCT 2 1922**
County of **Boise** Registration District No. **96**
City of **Lewiston** Primary Registration District No. **1009**
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mr. T. Ward

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **married**
(Write the word.)

6. DATE OF BIRTH **Apr 8 1857**
(Month) (Day) (Year)

7. AGE **65 Yrs. 5 Mos. 3 ds.** IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Mo

10. NAME OF FATHER

Theodore Ward

11. BIRTHPLACE OF FATHER

(State or Country)

Mo

12. MAIDEN NAME OF MOTHER

Mary Jacobs

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **J. J. Ward**

(Address)

15. Filed **Oct. 3. 1922** **F. T. Harris, M. D.**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 11 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 19 to 19 that I last saw him alive on **Sept 11 1922** and that death occurred on the date stated above, at **10 A.M.**, The CAUSE OF DEATH* was as follows:

Acute nephritis(Duration) Yrs. mos. **7** ds.Contributory (Secondary) **Bulbar Paralysis**

(Duration) Yrs. mos. ds.

(Signed) **L. J. Perkins** M. D.9/14 1922 (Address) **Lewiston Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Lewiston Idaho **Sept 14 1922**

20. UNDERTAKER ADDRESS

VASSAR UNDERTAKING **Lewiston Ida**

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Jersey Registration District No. 96
 City of Leviston Primary Registration District No. 1009
 State of Idaho

If death occurs away from
 usual residence, give facts
 called for under special in-
 formation.

2. FULL NAME

Mary J. Mungror

If death occurred in a hos-
 pital, institution or camp,
 give its NAME instead of
 street and number.

Registered No. 158

File No.

39717

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED Widow

(Write the word.)

6. DATE OF BIRTH

March 7 1840
 (Month) (Day) (Year)

7. AGE

82 Yrs. 6 Mos. 5 ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or
 particular kind of work
 (b) General nature of in-
 dustry, business or estab-
 lishment in which employ-
 ed (or employer)

at home

9. BIRTHPLACE

(State or Country)

Mo.

10. NAME OF FATHER

E. T. Jackson
Ky

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Margaret Bayless

13. BIRTHPLACE OF MOTHER

(State or Country)

Ky.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

M. J. Mungror

(Address)

Leviston, Idaho

15.

Filed Oct. 3. 1922

F. T. Harris, M.D.
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 12 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY That I attended deceased from
July 6th 1922 to Sept 12th 1922
 that I last saw h. at alive on Sept 12th 1922
 and that death occurred on the date stated above, at 3:15 P.M.
 The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

(Duration) Yrs. 7 mos. 1 ds.

Contributory (Secondary)

Arteriosclerosis

(Duration) 7 yrs. 1 mos. 1 ds.

(Signed)

O. C. Carsson M. D.
9/13 1922 (Address) Leviston Id

*State the Disease Causing Death; or in deaths from Violent Causes, state
 (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
 if not at place of death?

Former or
 usual residence

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Walla Walla Wash

20. UNDERTAKER

ADDRESS

Leviston Idaho

RECEIVED

OCT 2 1922 CERTIFICATE OF DEATH

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Nez Perce
City of _____

BUREAU

Registration District No. _____

96

Primary Registration District No. _____

~~1000~~ 1009

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

A. J. Gordon or BordenState of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 39718
Registered No. 159

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

unknown
(Write the word.)

6. DATE OF BIRTH

Unknown

(Month) (Day) (Year)

7. AGE

about 60

Yrs. Mos. ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Mechanic

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Maine

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ed Ester

(Address)

15.

Filed Oct. 3. 19 22F. T. Harris, M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

166

16. DATE OF DEATH

Sept 12 19 22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____ 19____, to Sept 12 19 22that I last saw him alive on Sept 12 19 22and that death occurred on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH* was as follows:

Burns from fire covering over 1/3 of skin area.

(Duration) Yrs. mos. ds.

Contributory (Secondary)

Toxaemia

(Duration) Yrs. mos. ds.

(Signed)

Edgar L. White M. D.9-15-22 (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sept 14 19 22

20. UNDERTAKER

ADDRESS

Lewiston Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

RECEIVED

Union District No.

96

County of

OCT 21

Primary Registration District No.

1009

City of

(No.

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Victor Christopherson

File No.

Registered No.

160

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WID-

OWED OR DIVORCED

unknown

(Write the word.)

6. DATE OF BIRTH

unknown

(Month)

(Day)

1

(Year)

7. AGE

60

Yrs.

Mos.

ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Unknown

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Came to Lewiston from Pasberg the

10. NAME OF FATHER

all else unknown.

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Whites Hospital Records

(Address)

Lewiston

15.

Filed

Oct. 3. 19 22

F. T. Harris, M. D.

Local Registrar

16. DATE OF DEATH

Sept 14

(Month)

(Day)

19 22 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19

to

Sept 14

19 22

that I last saw him alive on

Sept 14

19 22

and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Mesenteric Thrombosis
Post operative

(Duration)

Yrs.

mos.

3

ds.

Contributory (Secondary)

Gastric ulcer

(Duration)

2

yrs.

mos.

ds.

(Signed)

Edgar L. White, M. D.

9-15-22

(Address)

Lewiston, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

yrs.

In the

days

State

yrs.

mos.

days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sept 15 19 22

20. UNDERTAKER

ADDRESS

Lewiston, Ida.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of *Idaho*City of *Reynolds*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No. *96*Primary Registration District No. *1009*(No. *33*)

St.)

File No.

Registered No. *162*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

single
(Write the word.)

6. DATE OF BIRTH

dec 25
(Month) (Day)*1844*
(Year)

7. AGE

77 Yrs*8* Mos*22* ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

not known

9. BIRTHPLACE

(State or Country)

New Castle Penn.

10. NAME OF FATHER

Fredrick Robinson

11. BIRTHPLACE OF FATHER

(State or Country)

Scotland

12. MAIDEN NAME OF MOTHER

Nancy Dougherty

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Records of St. Joseph's Hospital

(Address)

Shawston Idaho

15.

Filed

*Oct. 3.**19 22**F. T. Harris, M. D.*

Local Registrar

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

39720

Registered No.

162

MEDICAL CERTIFICATE OF DEATH

76

16. DATE OF DEATH

Sept
(Month)*17*
(Day)*1922*
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 1 1922 to *Sept* 1922
that I last saw him alive on *Sept* 1922

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows

Reverberation of Gas

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. H. Alley, M. D.

19

(Address)

Reynolds

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place* of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Reynolds Idaho**9-18 1922*

20. UNDERTAKER

ADDRESS

Reynolds Idaho

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ne. PershingCity of LewistonRegistration District No. 96Primary Registration District No. 1009

(No. _____ St.)

File No. _____

Registered No. 163

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Edward H. Thyfault

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Man (American)

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

April 19th 1886
(Month) (Day) (Year)

7. AGE

36 Yrs. 4 Mos. 2 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

Farming

9. BIRTHPLACE

(State or Country)

Kansas, Booth Co.

10. NAME OF FATHER

M. H. Thyfault

11. BIRTHPLACE OF FATHER

(State or Country)

Canada, Quebec

12. MAIDEN NAME OF MOTHER

Anna Diamond

13. BIRTHPLACE OF MOTHER

(State or Country)

Mich. Hancock Co.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

M. H. Thyfault
Clairville Kansas

15.

Filed

Oct. 3. 1922F. T. Harris, M.D.

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept. 17 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Sept 16th 1922 to Sept 17th 1922that I last saw him alive on Sept 17th 1922and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Shock(Duration) _____ Yrs. _____ mos. 7 ds.Contributory
(Secondary)Injured from Auto Accident(Duration) _____ yrs. _____ mos. 7 ds.

(Signed)

O. C. Pearson M. D.19. (Address) Lewiston Id.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Planville Kansas

19

20. UNDERTAKER

ADDRESS

W. H. Harris, Lewiston, Idaho

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH *Reverston* Registration District No. *96*
 County of *Reverston* Primary Registration District No. *1009*
 City of *Reverston* (No. _____ St.)

File No. *39722*
 Registered No. *164*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Wm E. Johnson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*
 (Write the word.)

6. DATE OF BIRTH

Not Known
 (Month) (Day) (Year)

7. AGE

64 Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

Mechanic

9. BIRTHPLACE

(State or Country)

Sweden

10. NAME OF FATHER

Johnson

11. BIRTHPLACE OF FATHER

(State or Country)

Not Known

12. MAIDEN NAME OF MOTHER

Not Known

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Reed Hughes
Reverston Idaho

15.

Filed

*Oct. 3. 1922**F. T. Harris, M. D.*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 20 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 16 1922 to *Sept 20 1922*
 that I last saw him alive on *Sept 19 1922*
 and that death occurred on the date stated above, at *2 A. M.*

The CAUSE OF DEATH* was as follows:

apoplexy

(Duration) Yrs. mos. *4* ds.

Contributory
 (Secondary)

(Duration) Yrs. mos. ds.

(Signed)

John H. Alley M. D.

19

(Address) *Reverston Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Reverston, Idaho

DATE OF BURIAL

Oct 3 1922

20. UNDERTAKER

ADDRESS

Reverston Idaho

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

OCT 21 1922

CERTIFICATE OF DEATH

Purkins
State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39723**
Registered No. **165**

1. PLACE OF DEATH

County of *Myer*
City of *Lewiston*

Registration District No. **96**Primary Registration District No. **1009**

(No.)

St.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Watson Delbert Fanning**Fanning.*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male *White* *Married*
(Write the word.)

6. DATE OF BIRTH

Apr 22 1886
(Month) (Day) (Year)

7. AGE

36 Yrs. *1* Mos. *28* ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Mechanic

(b) General nature of industry, business or establishment in which employed (or employer).

Machinery

9. BIRTHPLACE

(State or Country)

Oregon

10. NAME OF FATHER

E. C. Fanning

11. BIRTHPLACE OF FATHER

(State or Country)

Oregon

12. MAIDEN NAME OF MOTHER

Mary Ann Gladhill

13. BIRTHPLACE OF MOTHER

(State or Country)

Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Sam Fanning

(Address)

15.

Filed *Oct. 3.* 1922*F. T. Harris, M.D.*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 20 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 18 1922, to *Sept 19* 1922

that I last saw him alive on *Sept 19* 1922

and that death occurred on the date stated above, at *3 A.* M.

The CAUSE OF DEATH was as follows:

Myocardial infarction(Duration) *1* Yrs. *2* mos. *2* ds.

Contributory (Secondary)

(Duration) *1* yrs. *1* mos. *1* ds.

(Signed)

L. J. Purkins

M. D.

9/21 1922 (Address) *L. J. Purkins*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Pomeroy, Ore. *9/22* 1922

20. UNDERTAKER

ADDRESS

Lewiston, Id.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH **RECEIVED**
County of *Boyer* Registration District No. *96*
City of *Lewiston* Primary Registration District No. *1009*
(No. (St.)

File No.
Registered No. *166*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Harry William Blake

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *single*
(Write the word.)

6. DATE OF BIRTH *Feb 10 1912*
(Month) (Day) (Year)

7. AGE *10* Yrs. *7* Mos. *15* ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

School Boy

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

H. B. Blake

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Mary Whiting

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

H. B. Blake

(Address)

Hebb 2 dty

15.

Filed *Oct. 3. 1922*

F. T. Harris, M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 25 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Sept 24, 1922* to *Sept 25 1922* that I last saw him alive on *Sept 24 1922* and that death occurred on the date stated above, at M. The CAUSE OF DEATH* was as follows:

Tuberculosis

(Duration) Yrs. mos. *14* ds.

Contributory (Secondary)

24th Street

(Duration) yrs. mos. *1* ds.

(Signed)

O. Carson

M. D.

19. (Address) *Lewiston, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Lewiston, Ida

DATE OF BURIAL

26 1922

20. UNDERTAKER

Vassar and Co

ADDRESS

Lewiston Ida

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39725**
Registered No. **167**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of New Pura
City of Idaho

Registration District No. 96Primary Registration District No. 1009

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

George York

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Sept 19 1911
(Month) (Day) (Year)

7. AGE

11 Yrs. _____ Mos. _____ ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

School Boy

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

T. B. York

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Georgia A. Sauer

13. BIRTHPLACE OF MOTHER

(State or Country)

Calo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Travis B. York

(Address)

Elk City, Ida.

15.

Filed

Oct. 3. 1922F. T. Harris, M.D.

Local Registrar

MEDICAL CERTIFICATE OF DEATH

170

16. DATE OF DEATH

Sept 26 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 25, 1922, to Sept 26, 1922
that I last saw him alive on Sept 26, 1922
and that death occurred on the date stated above, at 9:50 AM.
The CAUSE OF DEATH* was as follows:

Peritonitis
(Duration) _____ Yrs. _____ mos. _____ ds.
Contributory (Secondary) Pistol shot wounds through
undersides
(Duration) _____ Yrs. _____ mos. _____ ds.
(Signed) O. C. Carson M. D.
19 _____ (Address) Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho19

20. UNDERTAKER

ADDRESS

IdahoSept. 27 1922

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of New Peru
City of LewistonRegistration District No. 96Primary Registration District No. 1009(No. 1 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Albert William Jarvis

White
State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 39726
Registered No. 168

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Divorced
(Write the word.)

6. DATE OF BIRTH

Bellville, OntarioAugust
(Month)25
(Day)1870
(Year)

7. AGE

52 Yrs.1 Mos.4 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Saw Filer

(b) General nature of industry, business or establishment in which employed (or employer).

in Lumber mill

9. BIRTHPLACE

(State or Country)

Bellville, Ontario

10. NAME OF FATHER

William Jarvis

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Sarah Laycock

13. BIRTHPLACE OF MOTHER

(State or Country)

Canning, Ontario

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Emile V. McEwen

(Address)

3915 Burke Ave Seattle WA

15.

Filed

Oct. 3. 1922F. T. Harris, M.D.

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 29
(Month) (Day)1922
(Year)17. I HEREBY CERTIFY, That I attended deceased from Sept 18 1922 to Sept 29 1922that I last saw him alive on Sept 29 1922and that death occurred on the date stated above, at 12:45 M.

The CAUSE OF DEATH* was as follows:

Septic-hepatitisUræmia

(Duration)

Yrs.

mos.

20 ds.Contributory
(Secondary)Same

(Duration)

Yrs.

mos.

ds.

(Signed)

Sept 22 1922

(Address)

Edgar L. White M. D.
Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

Coeur d'Alene

19. PLACE OF BURIAL OR REMOVAL

Coeur d'Alene

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

Lewiston Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

39727

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Jefferson*City of *Jefferson*

If death occurs away from usual residence, give facts called for under special information.

Registration District No. *92*Primary Registration District No. *2170*(No. *John Dawson Atkinson* St.)File No. *7*Registered No. *4*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed *Oct 10* 19*22**E. E. Watts*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

19*22* (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 4 19*22*, to *Oct 9* 19*22*that I last saw him alive on *Oct 8* 19*22*and that death occurred on the date stated above, at *1:30 P.* M.

The CAUSE OF DEATH* was as follows:

Albuminuria(Duration) *6* Yrs. *6* mos. *6* ds.Contributory
(Secondary)(Duration) *6* yrs. *6* mos. *6* ds.

(Signed)

E. E. Watts

M. D.

10-10-1922 (Address)*Jefferson*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death *6* yrs. *6* mos. *6* days. In the State *6* yrs. *6* mos. *6* days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

39728

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *My Perer*
City of *Peck Ida*Registration District No. *92*Primary Registration District No. *3170*

(No. _____ St.)

File No. *7*Registered No. *3*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Agnes M. Henderson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-OWED OR DIVORCED

*F**white**married*
(Write the word.)

6. DATE OF BIRTH

Aug *31* *1901*
(Month) (Day) (Year)

7. AGE

31 Yrs. *1* Mos. *5* ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)*House*

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Ed Hardy

11. BIRTHPLACE OF FATHER

(State or Country)

—

12. MAIDEN NAME OF MOTHER

Grace Ellis

13. BIRTHPLACE OF MOTHER

(State or Country)

Ark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Grace Henderson

(Address)

Peck Idaho

15.

Filed *10-6* *1922**E.E. Watts*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

28

16. DATE OF DEATH

Oct *5* *1922*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 1 *1922*, to *Oct 1* *1922*that I last saw her alive on *Oct 1* *1922*
and that death occurred on the date stated above, at *4 P* M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis(Duration) *1* Yrs. *1* mos. *—* ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

E.E. Watts

M. D.

10-6-1922 (Address) *Gifford*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Maplewood

DATE OF BURIAL

10-7 *1922*

20. UNDERTAKER

H.E. Stoddard

ADDRESS

Gifford

CERTIFICATE OF DEATH

39729

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *My Perce*City of *Reubens*Registration District No. *92*Primary Registration District No. *2170*

(No. St.)

File No. *7*Registered No. *5*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Olava Bells Staley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

Wh

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

widow

(Write the word.)

6. DATE OF BIRTH

Jan *31* *1864*
(Month) (Day) (Year)

7. AGE

58 Yrs. *8* Mos. *20* ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

house wife

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

John Yeering

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Mary

13. BIRTHPLACE OF MOTHER

(State or Country)

W Va

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. H. Staley

(Address)

Reubens Ida

15.

Filed

10-21 *1921**E. E. Watts*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct *21* *1922*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 17 *1921* to *Oct 21* *1922*that I last saw her alive on *Oct 10* *1922*and that death occurred on the date stated above, at *7 a.* M.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia(Duration) *1* Yrs. *6* mos. *-* ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

E. E. Watts

M. D.

10-21-1922 (Address) *Reubens Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Lookout Ida

DATE OF BURIAL

10-22-1922

20. UNDERTAKER

W. E. Stoddard

ADDRESS

Reubens

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39730**
Registered No. _____

1. PLACE OF DEATH

County of Payette Registration District No. _____
City of Idaho Falls Primary Registration District No. _____
St. _____

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Daniel Joseph Driscoll

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Single

6. DATE OF BIRTH

_____ 1920
(Month) (Day) (Year)

7. AGE

2 Yrs. 1 Mos. 1 ds. IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer).

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

J. J. Driscoll

11. BIRTHPLACE OF FATHER

(State or Country) Iowa

12. MAIDEN NAME OF MOTHER

Elizabeth Scholes

13. BIRTHPLACE OF MOTHER

(State or Country) Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. J. Driscoll
(Address) Idaho Falls, Idaho

15.

Filed Oct 19 - 1922 C. C. Paxton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 17 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 17 1922 to Oct 17 1922
that I last saw him alive on Oct 1 1922
and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Drowned
by demented mother

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

10/17 (Signed) William Weese M. D.

1922 (Address) Ontario Ore

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted
if not at place of death?

Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Ontario Oregon

DATE OF BURIAL

Oct 19 1922

20. UNDERTAKER

C. C. Paxton ADDRESS Ontario Ore

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Boyette Registration District No.
City of Idaho Primary Registration District No.
City of Idaho St.If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Raymond John DriscollIf death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDMWhiteSingle

6. DATE OF BIRTH

September 22 1922
(Month) (Day) (Year)

7. AGE

25
Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho10. NAME OF
FATHERJ. J. Driscoll11. BIRTHPLACE
OF FATHER

(State or Country)

Idaho12. MAIDEN NAME
OF MOTHERElizabeth Scholes13. BIRTHPLACE
OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. J. Driscoll
Idaho

15.

Filed 19

Local Registrar

16. DATE OF DEATH

Oct 17 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 17 1922 to Oct 17 1922
that I last saw him alive on Oct 1 1922
and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Drowned
by demented mother

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) William J. Weese M. D.1922 (Address) Ontario Ore*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Ontario, Oregon

DATE OF BURIAL

Oct 19 1922

20. UNDERTAKER

Peterson Ontario Ore

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH
in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39732**

1. PLACE OF DEATH
County of Payette
City of _____
Registration District No. _____
Primary Registration District No. _____
(No. _____) St. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Olwin Knutson

Registered No. _____
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)
6. DATE OF BIRTH October 17 - 1922
(Month) (Day) (Year)

7. AGE 35 Yrs. 6 Mos. 27 ds.
IF LESS than 1 day
how many _____ hrs.
or _____ min. ?

8. OCCUPATION laborer
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE Drafton, No Dakota
(State or Country)

10. NAME OF FATHER Oven Knutson

11. BIRTHPLACE OF FATHER Norway
(State or Country)

12. MAIDEN NAME OF MOTHER Gerene Kittleson

13. BIRTHPLACE OF MOTHER Wisconsin (Dodge County)
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Miss _____
(Address) Fruitland Idaho

15. Filed Oct 17 - 1922 G. B. Paxton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October 17 - 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 19 _____ to _____ 19 _____
that I last saw him alive on Oct 17 - 1922
and that death occurred on the date stated above, at 610 AM.
The CAUSE OF DEATH* was as follows:

Not determined
Very sharp (Duration) _____ Yrs. _____ mos. _____ ds.
Contributory (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) G. B. Paxton M. D.
17/18 1922 (Address) Fruitland Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death _____ yrs _____ mos _____ days. In the State _____ yrs _____ mos _____ days.
Where was disease contracted if not at place of death? _____
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Payette Idaho DATE OF BURIAL Oct 19 1922
20. UNDERTAKER D. N. Cedar ADDRESS Payette Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39733**
Registered No.
If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

1. PLACE OF DEATH
County of *Dupuyer*
City of *Siler*
If death occurs away from
usual residence, give facts
called for under special
information.
2. FULL NAME *Willard Davidson*
Registration District No. *38*
Primary Registration District No. *2086*
(No. St.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male*
4. COLOR OR RACE *white*
5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.
(Write the word.)
6. DATE OF BIRTH. *Dec 11 1911*
(Month) (Day) (Year)
7. AGE *—* Yrs. *10* Mos. *6* ds.
IF LESS than 1 day
how many hrs. or
.... min.?

8. OCCUPATION
(a) Trade, profession or
particular kind of work
(b) General nature of in-
dustry, business, or estab-
lishment in which em-
ployed (or employer)

9. BIRTHPLACE
(State or Country) *Idaho*

10. NAME OF FATHER *J. H. Davidson*

11. BIRTHPLACE OF FATHER *Calo.*
(State or Country)

12. MAIDEN NAME OF MOTHER *Hattie Norton*

13. BIRTHPLACE OF MOTHER *Washington*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *J. H. Davidson*
(Address) *Siler*

15. *Oct 17 1911*
Filed *1911*
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *Oct 17 1922*
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from
Oct 9 1911 to *Oct 17 1911*
that I last saw him alive on *Oct 17 1911*
and that death occurred on the date stated above, at *2 P.* M.

The CAUSE OF DEATH* was as follows:
Acute Enteric Intoxication
(Duration) Yrs. mos. ds.

Contributory
(Secondary)
(Duration) Yrs. mos. ds.
(Signed) *A. A. Newberry* M. D.
Oct 17 1911 (Address) *Siler*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days, State yrs. mos. days
Where was disease contracted if not at place of death?

Former or usual residence
19. PLACE OF BURIAL OR REMOVAL *St. Mary's* DATE OF BURIAL *Oct 18 1922*
20. UNDERTAKER *J. H. Davidson* ADDRESS *Siler*

1. PLACE OF DEATH
 County of Jewett District No. 36
 City of Kimberly Idaho Registration District No. 36 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Alice M Howard

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 39734Registered No. 11

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single

6. DATE OF BIRTH

Apr 8 1922
 (Month) (Day) (Year)

7. AGE

9 Yrs. 5 Mos. ds.

IF LESS than 1 day
 how many..... hrs.
 or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

Schoolgirl

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

John Howard

11. BIRTHPLACE OF FATHER

(State or Country)

N.Y.

12. MAIDEN NAME OF MOTHER

Zephie Perkins

13. BIRTHPLACE OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

John Howard
Kimberly Idaho

15.

Filed

Sept 10 1922 J. D. Davis
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 9 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 9 - 1922 to Sept 9 - 1922
 that I last saw him alive on Sept 9 1922
 and that death occurred on the date stated above, at 2:30 A.M.

The CAUSE OF DEATH* was as follows:

Spinal Paralysis (?)
(Bulbar)

(Duration) Yrs. mos. 2 ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) J. D. Davis M. D.

9/9 1922 (Address) Kimberly Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Jewett 9-10 1922

20. UNDERTAKER

ADDRESS

J. D. Grossman Jewett

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39736**
Registered No.

1. PLACE OF DEATH **RECEIVED**
County of Twin Falls Registration District No. 39
City of Twin Falls (No. 1 St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ralph William Franklin
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single

6. DATE OF BIRTH

June 5 1907
(Month) (Day) (Year)

7. AGE

15 Yrs. 3 Mos. 18 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Colo.

10. NAME OF FATHER

C. W. Franklin

11. BIRTHPLACE OF FATHER

(State or Country) Ind.

12. MAIDEN NAME OF MOTHER

Lena Blick

13. BIRTHPLACE OF MOTHER

(State or Country) Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address) Boise Idaho

15.

Filed

Sept 24 1922

J. H. Murphy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 23 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 20 1922 to Sept 23 1922
that I last saw h. live alive on Sept 23 1922
and that death occurred on the date stated above, at 6:45 PM.
The CAUSE OF DEATH* was as follows:

Pneumonia
Large areas on both sides

(Duration) Yrs. mos. 10 ds.

Contributory (Secondary)

Para Typhoid

(Duration) Yrs. mos. 20 ds.

(Signed)

A. F. Trullinger M. D.

9/25/1922 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BERAL OR REMOVAL

DATE OF BURIAL

Boise Cemetery Sept 25 1922

20. UNDERTAKER

ADDRESS

Howells Drug Store Boise, Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39737**
Registered No. _____

1. PLACE OF DEATH

County of Twin Falls
City of Twin FallsRegistration District No. 59
Registration District No. 2087
(No. 7) _____ (St.) _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Elizabeth McQuitt

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED _____
(Write the word.)6. DATE OF BIRTH Oct 2 1919
(Month) (Day) (Year)7. AGE 2 Yrs. 11 Mos. 25 ds. IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country) Ohio

10. NAME OF FATHER

Harry McQuitt

11. BIRTHPLACE OF FATHER

(State or Country) Ohio

12. MAIDEN NAME OF MOTHER

Edna Perkins

13. BIRTHPLACE OF MOTHER

(State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harry McQuitt
(Address) Roseworth

15.

Filed 9-28 1927Local Registrar J. J. Murphy

16. DATE OF DEATH

Sept 27 1927
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from 9-22-1927 to 9-27-1927
that I last saw him alive on 9-27-1927
and that death occurred on the date stated above, at 12³⁰ M.

The CAUSE OF DEATH* was as follows:

Gun Shot wound of skull(Duration) _____ Yrs. _____ mos. 5 ds.Contributory
(Secondary) _____

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Dr. J. J. Murphy M. D.9-27-1927 (Address) Buhl Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. 5 days. In the State _____ yrs. _____ mos. _____ daysWhere was disease contracted if not at place of death? Roseworth IdahoFormer or usual residence Roseworth, Idaho

19. PLACE OF BURIAL OR REMOVAL

Buhl

DATE OF BURIAL

9/28 1927

20. UNDERTAKER

L. Johnson

ADDRESS

Buhl Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Blaine Registration District No. 39
City of Buhl Primary Registration District No. 2087
(No. St.)

File No. _____
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Richard Brewer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single

6. DATE OF BIRTH

Feb 16 1922
(Month) (Day) (Year)

7. AGE

7 Yrs. 14 Mos. 14 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

C. A. Brewer

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Lotty McCubbins

13. BIRTHPLACE OF MOTHER

(State or Country)

Wash

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

C. A. Brewer
Buhl

15.

Filed 10-1 1922

J. H. McConley
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 30 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 26 1922 to Sept 30 1922
that I last saw him alive on Sept 30 1922
and that death occurred on the date stated above, at 49 M.
The CAUSE OF DEATH* was as follows:

Summer Complaint

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) J. A. Marsh M. D.

9:30 1922 (Address) Buhl, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

Buhl Cemetery Nov. 2 1922
Herzli & Pegg Buhl, Ida.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH
in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

Section
CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Ada*
City of *St. Paul*

RECORDED
NOV 8
BUREAU
STATE

Registration District No.

Primary Registration District No.

(No. *4* *mi. S.E. of Boise* St.)

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

William D. Gregory

39739
State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

*White*5. SINGLE, MARRIED, WID-
OWED OR DIVORCED*Married*

6. DATE OF BIRTH

May 3 1863
(Month) (Day) (Year)

7. AGE

57 Yrs. *5* Mos. *10* ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.

Farmer.

(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer).

9. BIRTHPLACE

(State or Country)

*Kentucky.*10. NAME OF
FATHER*James W. Gregory.*11. BIRTHPLACE
OF FATHER

(State or Country)

*Kentucky.*12. MAIDEN NAME
OF MOTHER*Susan B. Buchanan.*13. BIRTHPLACE
OF MOTHER

(State or Country)

Kentucky.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. H. Gregory

(Address)

13 mi. S.E. of Boise

15.

Filed *10-13 1922*

R. H. Hall
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 13 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

10-10-1922 to *10-13-1922*

that I last saw him alive on *10-10-1922*and that death occurred on the date stated above, at *11:45* P. M.The CAUSE OF DEATH* was as follows: *Apoplexy.*

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

C. R. Sutton

M. D.

19 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Parville Kentucky *Oct 21 1922*

20. UNDERTAKER

ADDRESS

Summers & Krebs *Boise Idaho*

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

39740

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of IdahoCity of Idaho

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7 CPrimary Registration District No. 10 11

(No. St.)

File No. 39740Registered No. 77

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Fred Caglione

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

single
(Write the word.)

6. DATE OF BIRTH

May 8 1892
(Month) (Day) (Year)

7. AGE

30 Yrs. 3 Mos. 23 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Li

(b) General nature of industry, business or establishment in which employed (or employer)

Forestry service

9. BIRTHPLACE

(State or Country)

not known

10. NAME OF FATHER

not known

11. BIRTHPLACE OF FATHER

(State or Country)

not known

12. MAIDEN NAME OF MOTHER

not known

13. BIRTHPLACE OF MOTHER

(State or Country)

not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. K. Mc Harg Jr.(Address) Coe Office Bldg.15. 8-7 1922 IdahoFiled Benewah County Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 1st 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 1st 1922 to Aug 1st 1922that I last saw him alive on Aug 1st 1922

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Struck by falling tree
striking head causing
death instantly accidentally

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

H. S. Mowbray Idaho
1922 (Address) Walla Walla

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St Marys Idaho Mar 1st 1922

20. UNDERTAKER

ADDRESS

Mitchell & Merag St Marys

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 2
County of Ada Primary Registration District No. 1004
City of Boise (No. 1212, North 5th St.)File No. 39741
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Charley David Mendenhall

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH

December 24 1871
(Month) (Day) (Year)

7. AGE

50 Yrs. 10 Mos. 14 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).NoneNone

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

Arthur W Mendenhall

11. BIRTHPLACE OF FATHER

(State or Country)

Iowa

12. MAIDEN NAME OF MOTHER

Ella Harrison

13. BIRTHPLACE OF MOTHER

(State or Country)

Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Walter D Mendenhall(Address) Boise Idaho, 1007 North 6th

15.

Filed 11-9 1922R. H. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Dec 14 1921, to Nov 8 1922that I last saw him alive on Nov 8 1922

and that death occurred on the date stated above, at.....M.

The CAUSE OF DEATH* was as follows:

Tubercular Hip(Duration) 45 Yrs.mos.ds.
Contributory (Secondary) Tubercular septicemia(Duration)yrs. 3 mos.ds.(Signed) J. H. Brastan M. D.Nov 9, 1922 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.mos.days. In the State.....yrs.mos.days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery1922

20. UNDERTAKER

ADDRESS

Mendenhall

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39742**
Registered No. **1518**

1. PLACE OF DEATH **Boise** Registration District No. **3**
County of **Ada** DEC 4 1922 Primary Registration District No. **1004**
City of **Boise** (No. **306**, **5th** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

James. David Gillilan

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **M.** 4. COLOR OR RACE **W.** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Single**
(Write the word.)

6. DATE OF BIRTH **Oct 30 1922**
(Month) (Day) (Year)

7. AGE **21** yrs. **71** mos. **1** ds. IF LESS than 1 day how many **his.** min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Boise Idaho.

10. NAME OF FATHER

L.C. Gillilan

11. BIRTHPLACE OF FATHER

(State or Country)

Utah.

12. MAIDEN NAME OF MOTHER

Hazel Marie Johnston

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Wm. McBratney
Boise Idaho.

15.

Filed

Nov. 21 1922

R. N. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov 21st 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Nov 18th 1922** to **Nov 20 1922** that I last saw him alive on **Nov 20 1922** and that death occurred on the date stated above, at **7-15 AM**.

The CAUSE OF DEATH* was as follows:

Malnutrition & Tenuis

(Duration) yrs. mos. **3** ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) **Mrs. H. Hardy** M. D.

Nov 21 1922 (Address) **Boise Idaho.**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death. yrs. mos. ds. State. yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Marion Hill Cemetery

11/21/22 1922

20. UNDERTAKER

ADDRESS

Wm. McBratney

Boise Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39743**
Registered No. **273**

1. PLACE OF DEATH *Idaho* Registration District No. _____
County of *Boise* Primary Registration District No. _____
City of *Boise* (No. *St. Lukes Hospital* St.) _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jonah P. Rudisill

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *m.* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*

6. DATE OF BIRTH

Feb. 27 1865
(Month) (Day) (Year)

7. AGE

58 Yrs. *9* Mos. — ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Salisman

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) *Iowa*

10. NAME OF FATHER

Jonah P. Rudisill

11. BIRTHPLACE OF FATHER

(State or Country) *Iowa*

12. MAIDEN NAME OF MOTHER

Mary A. Burnett

13. BIRTHPLACE OF MOTHER

(State or Country) *Ohio*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *B. H. Blaine*
(Address) _____

15.

Filed *11-28* 19*22*

R. H. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 27 19*22*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 30 19*22* to *Nov 27* 19*22*

that I last saw him alive on *Nov 27* 19*22*

and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

*Thrombophlebitis of saphena
veins of both legs*
(Duration) Yrs. mos. *28* ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) *Dr. H. H. Blaine* M. D.

11/28/22 (Address) *Boise Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Memorial Hill Cem.

DATE OF BURIAL

Nov 29 19*22*

20. UNDERTAKER

Seaman & Co.

ADDRESS

Boise Idaho

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
DEC 4 1922
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1. PLACE OF DEATH
County of Ada
City of Stanley
Registration District No. 8
Primary Registration District No. 2008
Miles west of Boise St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 39744
Registered No. 102

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

John Jay Coffey

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX M. 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married

6. DATE OF BIRTH

Oct 10 1853
(Month) (Day) (Year)

7. AGE

69 Yrs. 0 Mos. 29 ds.
IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Farmer
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Indiana

10. NAME OF FATHER

Judson Coffey

11. BIRTHPLACE OF FATHER

(State or Country) Unknown

12. MAIDEN NAME OF MOTHER

Ross

13. BIRTHPLACE OF MOTHER

(State or Country) No Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ora Coffey
(Address) P.O. Boise

15.

Filed 11-10 19 22 R. H. Pratt
Local Registrar

16. DATE OF DEATH

Nov 9 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 22 to Nov 9 1922
that I last saw him alive on Nov 7 1922
and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Dropsy caused by heart lesions

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

Harry L. Stenback M. D.
19 22 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Shice Cem. Nov. 11 1922

20. UNDERTAKER

ADDRESS

Sumner & Sebe Boise Ida.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39745**
Registered No. **261**

1. PLACE OF DEATH

County of **Ada**
City of **Boise**

Registration District No. **2**Primary Registration District No. **1004**(No. **1405** W **15**)

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Abbie E. Freeman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

F. White

Widow
(Write the word.)

6. DATE OF BIRTH

Feb. 26, 1842
(Month) (Day) (Year)

7. AGE

80 Yrs. **8** Mos. **5** ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

At Home

9. BIRTHPLACE

(State or Country)

Vermont

10. NAME OF FATHER

James Marden

11. BIRTHPLACE OF FATHER

(State or Country)

Vermont

12. MAIDEN NAME OF MOTHER

Catherine Rosebrook

13. BIRTHPLACE OF MOTHER

(State or Country)

Vermont

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Dr. Carrie Freeman

(Address) **1405 N. 15th**

15.

Filed

11-2 19.22

R. H. Rath
Local Registrar

MEDICAL CERTIFICATE OF DEATH

91

16. DATE OF DEATH

Nov. 1 19.22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct. 29 19.22, to **Nov. 1** 19.22
that I last saw her alive on **Nov. 1** 19.22
and that death occurred on the date stated above, at **9 A.M.**

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) **Dr. Carrie Freeman** M. D.

11/2 19.22 (Address) **220 Idaho Bldg**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Liep County **Nov. 3** 19.22

20. UNDERTAKER

ADDRESS

Sumner & Krebs Boise Idaho

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Ada
City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2

Primary Registration District No. 1004
(No. 412 Washington St.)

2. FULL NAME

Francis Fletcher

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 39746Registered No. 24

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widower
(Write the word.)

6. DATE OF BIRTH

October 12 1922
(Month) (Day) (Year)

7. AGE

90723

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Retired

9. BIRTHPLACE

(State or Country)

Malden Canada

10. NAME OF FATHER

Edward Fletcher

11. BIRTHPLACE OF FATHER

(State or Country)

Liverpool, England

12. MAIDEN NAME OF MOTHER

Lucinda Burns

13. BIRTHPLACE OF MOTHER

(State or Country)

United States

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Jeannette Fletcher
412 Washington St

15.

Filed

11-81922

P. H. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

November 5 1922
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from Nov. 5th 1922 to Nov. 5th 1922 that I last saw him alive on Nov. 5th 1922 and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Accident

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

Dr. C. C. Back M. D.
11-6-1922 (Address) Boise, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

Boise Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Woods Hill Cemetery11/7/1922

20. UNDERTAKER

ADDRESS

Schnecker & Widenfaden Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 149.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

(No. 313)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 39747
Registered No. 2

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary Shuey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

F

White

Widow
(Write the word.)

6. DATE OF BIRTH

Nov. 23, 1849
(Month) (Day) (Year)

7. AGE

72 Yrs. 11 Mos. 13 ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

At Home

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

John Minnis

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Harriet Hunt

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Walter S. Avery

(Address)

313 S 4th Boise

15.

Filed

11-9 1922

R. H. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

11 6 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct. 13 1922 to Nov 6 1922

that I last saw him alive on 11/6 1922

and that death occurred on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was*as follows:

Cerebral Hemorrhage

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Frederick A. Rungt M. D.

11/6 1922 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery Nov 8 1922

20. UNDERTAKER

ADDRESS

Summers & Tref Boise Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39748**
Registered No. **2**

1. PLACE OF DEATH

County of **Ada**City of **Boise**Registration District No. **2**Primary Registration District No. **1004**(No. **410** State **Idaho** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John D. O'Brien

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

About 1859
(Month) (Day) (Year)

7. AGE

About 63
Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

Retired Farmer

9. BIRTHPLACE

(State or Country)

Ireland

10. NAME OF FATHER

Wm. O'Brien

11. BIRTHPLACE OF FATHER

(State or Country)

"**"**

12. NAME OF MOTHER

"

13. BIRTHPLACE OF MOTHER

(State or Country)

"

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. Schreiber

(Address)

Boise

15.

Filed

11-70**1922****R. H. Pratt**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 8
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 24 1922 to Nov 7 1922that I last saw him alive on **Nov 7 1922**and that death occurred on the date stated above, at **3 P. M.**

The CAUSE OF DEATH* was as follows:

Probably cerebral hemorrhage

(Duration) Yrs. mos. ds.

Contributory (Secondary)*

Compensated failure of liver & lungs

(Duration) Yrs. mos. ds.

(Signed)

A. H. G. M. D.**Nov 10 1922** (Address) **Boise Idaho**

*State the Disease Causing Death; or in death from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Louis Mo.**Nov 10 22**

20. UNDERTAKER

ADDRESS

Schreiber & Hildebrand Boise

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

Ada

City of

Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

2

Primary Registration District No.

1004

(No. Residence South Boise St.)

File No.

39749

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Millard A. L. Eby

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

M.

W.

Widower

(Write the word.)

6. DATE OF BIRTH

Aug - 25 - 1861

(Month)

(Day)

(Year)

7. AGE

61 Yrs.

7 Mos.

14 ds.

IF LESS than 1 day

how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

Andrew Eby

11. BIRTHPLACE OF FATHER

(State or Country)

Pa.

12. MAIDEN NAME OF MOTHER

Sarah Albright

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. M. McBratney

(Address)

Boise Idaho

15.

Filed

11-10

1922

R. H. Pratt

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov. 9 - 1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 7 1922 to November 9 1922

that I last saw him alive on November 8 1922

and that death occurred on the date stated above, at 10³⁰ A. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolism

(Duration)

Yrs.

mos.

ds.

Contributory (Secondary)

Chronic nephritis

(Duration)

Yrs.

mos.

ds.

(Signed)

Harold W. Stone

M. D.

11/10 1922 (Address) Boise, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Toledo - Iowa

19

20. UNDERTAKER

ADDRESS

W. M. McBratney

Boise Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39750**
Registered No. **22**

1. PLACE OF DEATH

County of **Ada**
City of **Boise** **Id.**

Registration District No. **2**Primary Registration District No. **1004**(No. **1806 W 15** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Eliza Ann Gardner

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widow
(Write the word.)

6. DATE OF BIRTH

October 11, 1855
(Month) (Day) (Year)

7. AGE

67 Yrs. **0** Mos. **29** ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

At Home

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

Trigg

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Edward Garman

(Address)

1806 W 15 street

15.

Filed **11-12** 19 **22**

R. N. Paul

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov. 10 19 **22**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept. 10 19 **22** to **Nov. 10** 19 **22**

that I last saw her alive on **Nov. 8th** 19 **22**

and that death occurred on the date stated above, at **4:20** A. M.

The CAUSE OF DEATH* was as follows:

Dilatation of heart.

(Duration) Yrs. mos. ds.

Contributory **Decompensation**
(Secondary) **mitral insufficiency**

(Duration) Yrs. mos. ds.

(Signed) **E. L. Sutton** M. D.

19 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Morris Hill Cemetery

DATE OF BURIAL

Nov. 13, 1922

20. UNDERTAKER

Summers & Krebs

ADDRESS

Boisedale

1. PLACE OF DEATH **RECEIVED**County of Ada DEC 4City of Boise

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No. 2Primary Registration District No. 1004(No. 411, State Idaho St.)William CarneyState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 39751Registered No. 26

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

Not Known

(Month) (Day) (Year)

7. AGE

80

Yrs.

Mos.

ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

Miner

9. BIRTHPLACE

(State or Country)

Ireland

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Sister M. Fontana

(Address)

St. Alphonsus Hospital

15.

Filed 11-12 19 22

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 10

(Month)

(Day)

19 22
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 10 19 22 to Nov 10 19 22that I last saw him alive on Nov 10 19 22and that death occurred on the date stated above, at 5-8 A. M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis.(Duration) 3 Yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

M. H. Tallman

M. D.

11/11 19 22 (Address) Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

St. Johns Cemetery

DATE OF BURIAL

11/12 19 22

20. UNDERTAKER

Shuck & Widak

ADDRESS

Boise

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. East Branch St.)

2. FULL NAME

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 39752

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of name and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED
(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed 11-11-1922

Local Registrar

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from Nov. 6 1922, to Nov. 10 1922, that I last saw her alive on Nov. 9 1922, and that death occurred on the date stated above, at 4:30 P.M. The CAUSE OF DEATH* was as follows:

Contributory (Secondary)

(Signed) M. J. Sweeney, M. D.

1922 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs mos days In the State yrs mos days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

1. PLACE OF DEATH

County of *Ada*City of *Boise*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No. *2*Primary Registration District No. *1004*(No. *315* Sub *64* St.)*Henry Clay Branstetter*State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *39753*Registered No. *10*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*

6. DATE OF BIRTH

January fifth 1887
(Month) (Day) (Year)

7. AGE

85 Yrs. *10* Mos. *6* ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

Retired Merchant

9. BIRTHPLACE

(State or Country)

Ray county, Missouri

10. NAME OF FATHER

Daniel Branstetter

11. BIRTHPLACE OF FATHER

(State or Country)

Pennsylvania

12. MAIDEN NAME OF MOTHER

Margaret Slaughter

13. BIRTHPLACE OF MOTHER

(State or Country)

Tennessee

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Alice Branstetter, Kansas

(Address)

318 N. 6th St. Boise, Idaho

15.

Filed *Nov. 11 1922**R. M. Prater*
Local Registrar

16. DATE OF DEATH

Nov. 11 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

*Aug 15 1922 to Nov. 11 1922*that I last saw him alive on *Nov 7th 1922*and that death occurred on the date stated above, at *9 A. M.*

The CAUSE OF DEATH* was as follows:

Uremic Poison

(Duration) Yrs. mos. ds.

Contributory (Secondary) *enlarged prostate*

(Duration) yrs. mos. ds.

(Signed) *J. Springer* M. D.*Nov 13 1922* (Address) *Boise, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Pioneer Cemetery**11/12 1922*

20. UNDERTAKER

ADDRESS

Shubert & Hadenfeldt Boise

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of AdaCity of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2Primary Registration District No. 11004(No. St. Alphonsus Hospital, St.)File No. 39754Registered No. 271

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Mrs Mary Yarnes

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

403. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widowed
(Write the word.)

6. DATE OF BIRTH

January 13 1868
(Month) (Day) (Year)

7. AGE

54 Yrs. 10 Mos. 5 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Housekeeping

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

John Bruner

11. BIRTHPLACE OF FATHER

(State or Country)

Kirkville, Mo.

12. MAIDEN NAME OF MOTHER

Suzanne Franklin

13. BIRTHPLACE OF MOTHER

(State or Country)

Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Samuel P. Yarnes

(Address)

Boise Idaho

15.

Filed

Nov 19 1922R. N. Rad
Local Registrar

16. DATE OF DEATH

Nov - 18 - 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Oct 19 1922, to Nov 18 1922,that I last saw her alive on Nov 18 5 PM 1922, and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Cancer of Liver.

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

11/20/22

(Address)

Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery11/20/22

20. UNDERTAKER

ADDRESS

W. M. McBratneyBoise Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39755**Registered No. **274**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of **Ada**City of **Boise**

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. **410** **State** St.)

2. FULL NAME

Mary Richeson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female White

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Nov. 20 1880
(Month) (Day) (Year)

7. AGE

42 Yrs. **7** Mos. **7** ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

Housekeeper

9. BIRTHPLACE

(State or Country)

Emery Id.

10. NAME OF FATHER

Howell Richeson

11. BIRTHPLACE OF FATHER

(State or Country)

Id.

12. MAIDEN NAME OF MOTHER

Laura Guthrie

13. BIRTHPLACE OF MOTHER

(State or Country)

Id.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

B. Geo Richeson

(Address)

New Meadows

15.

Filed **25** 19 **22**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

November 27 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from **Nov. 10 1922**, to **Nov 27 1922**that I last saw her alive on **Nov 27 1922**, and that death occurred on the date stated above, at **11 A.M.**

The CAUSE OF DEATH* was as follows:

Pneumonia following ten days after operation.(Duration) Yrs. mos. **8** ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. P. Venners M. D.**11/27 1922** (Address) **Boise Id.**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

New Meadows

19. PLACE OF BURIAL OR REMOVAL

New Meadows

DATE OF BURIAL

11/29 1922

20. UNDERTAKER

Schneider & Widentaker Boise

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39756**
Registered No. **275**

1. PLACE OF DEATH

Registration District No. **2**
County of **Ada**
Primary Registration District No. **1004**
City of **Boise** (No. **20** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Frank Forrester Church

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Married**
(Write the word.)

6. DATE OF BIRTH

July 7 1850
(Month) (Day) (Year)

7. AGE

72 Yrs. 3 Mos. 27 ds.
IF LESS than 1 day
how many **4** hrs.
or **min.**?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Bookkeeper
Coal & Seed Co.

9. BIRTHPLACE

(State or Country) **Cherryfield, Maine**

10. NAME OF FATHER

Albert S. Church

11. BIRTHPLACE OF FATHER

(State or Country) **Manchester, Mass**

12. MAIDEN NAME OF MOTHER

Jane L. Ward

13. BIRTHPLACE OF MOTHER

(State or Country) **Milbridge, Maine**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Evangeline Church**

(Address) **200 East Idaho Street**

15. **Dec 1 - 1922**

R. H. Trask
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

11/20 19**22** to **11/28** 19**22**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **11/20** 19**22** to **11/28** 19**22**

that I last saw him alive on **11/28** 19**22**

and that death occurred on the date stated above, at **7:57** M.

The CAUSE OF DEATH* was as follows:

Bunchel Asthma
(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) **Frank A. Puryear**

19 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **St. John's Cemetery** DATE OF BURIAL **Dec 1 1922**

20. UNDERTAKER **Emmeline & Widenfaden** ADDRESS **Boise**

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of AdaCity of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 6Primary Registration District No. 2008(No. 14 miles Southwest of City, St.)File No. 39757Registered No. 104

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

William Jerry Moody

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

Nov, 12 - 1852

(Month)

(Day)

(Year)

7. AGE

70 Yrs. 16 Mos. 16 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Illinois

10. NAME OF FATHER

Wm Moody

11. BIRTHPLACE OF FATHER

(State or Country)

Don't Know

12. MAIDEN NAME OF MOTHER

Miss. Blunt

13. BIRTHPLACE OF MOTHER

(State or Country)

4

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wm McBratney

(Address)

Boise, Idaho.

15.

Filed Dec 1 19 22R. H. Train
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov. 28 - 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 25 1922, to Nov 28 1922that I last saw him alive on Nov 25 1922and that death occurred on the date stated above, at 11:45 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma Superior Maxillary

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Chas. A. P.

M. D.

11/29 1922

(Address)

Boise, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery12/1 1922

20. UNDERTAKER

ADDRESS

W. McBratneyBoise - Idaho.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Ada

City of _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No. _____

Primary Registration District No. 2008No. 1 1/2 mile North of Eagle St.William GoodallState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 3975Registered No. 103

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

Nov-1-1859
(Month) (Day) (Year)

7. AGE

63 Yrs. 0 Mos. 7 ds.

IF LESS than 1 day

how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

Farmer

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

Ebram Goodall

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Susan Gore

13. BIRTHPLACE OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

C. E. Summers
Bozart Idaho

15.

Filed Nov 9 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov
(Month)8
(Day)1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 15 1921, to Nov 8 1922that I last saw him alive on Nov 7 1922and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(Duration) 10 Yrs. — mos. — ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) George H. Hall M. D.Nov 9 1922 (Address) Eagle Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Morris Hill Cemetery

DATE OF BURIAL

Nov 10 1922

20. UNDERTAKER

Summers & Tunks

ADDRESS

Bozart Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

39759 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH *Idaho* Registration District No. *9+10*
County of *Star* Primary Registration District No. _____
City of *Star* (No. _____, _____ St.)

File No. *25*
Registered No. *25*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Emma Connor*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *7 M* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. *Married*

6. DATE OF BIRTH *May 21 1880*
(Month) (Day) (Year)

7. AGE *77* yrs. *6* mos. *5* ds.
IF LESS than 1 day how many _____ hrs. or _____ mins.

8. OCCUPATION *Housewife*
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE *Cornettsville Penn*
(State or Country)

10. NAME OF FATHER *William Halford*

11. BIRTHPLACE OF FATHER _____
(State or Country)

12. MAIDEN NAME OF MOTHER *Elizabeth Connor*

13. BIRTHPLACE OF MOTHER _____
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *May LaBate*
(Address) *Star Idaho*

15. Filed *Nov 10* 191*2* *Connel Jackson*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *Nov 10 1912*
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from *Nov 1* 191*2* to *Nov 9* 191*2*
that I last saw him alive on *Nov 9* 191*2*
and that death occurred on the date stated above, at *2:26 PM*

The CAUSE OF DEATH* was as follows:
Laryngoma larynx
Stomach
(Duration) *several* yrs. mos. ds.

Contributory *Excision uterus*
(Secondary)
(Duration) *many* yrs. mos. ds.
(Signed) *W. H. Gale* M. D.
H-9 19 22 (Address) *Star Idaho*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL *Canyon Hill* DATE OF BURIAL *Nov 13* 191*2*

20. UNDERTAKER *Fry* ADDRESS *Bona*

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH **RECEIVED**
 County of **Ada** Registration District No. _____
 City of **Meridian** Primary Registration District No. _____
BUREAU OF VITAL STATISTICS St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Orlando J. Singrey

File No. **39760**
 Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Married**

6. DATE OF BIRTH

July 30 1924
 (Month) (Day) (Year)

7. AGE

68
68 Yrs. **1** Mos. **7** ds.

IF LESS than 1 day
 how many _____ hrs.
 or _____ min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

Carpenter

9. BIRTHPLACE

(State or Country)

Ohio - Morris Co

10. NAME OF FATHER

A. J. Singrey

11. BIRTHPLACE OF FATHER

(State or Country)

Penn.

12. MAIDEN NAME OF MOTHER

Mary A. Shuler

13. BIRTHPLACE OF MOTHER

(State or Country)

Penn. Adams Co

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

E. J. A. Singrey
Meridian, Idaho

15.

Filed **Sept 7 1924**

H. F. Zuercher
 Local Registrar

16. DATE OF DEATH

Sept. 7 1924
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec. 1921 to **Sept 7 1924**

that I last saw him alive on **Sept 6 1924**

and that death occurred on the date stated above, at **8:40 A.M.**

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) _____ Yrs. _____ mos. **1** ds.

Contributory
 (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

J. B. Numbers Jr. M. D.

Sept 7 1924 (Address) **Meridian, Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hampden, Idaho **Sept 8 1924**

20. UNDERTAKER

ADDRESS

W. B. Mather **Meridian**

CERTIFICATE OF DEATH

39761 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock
City of ParatilleRegistration District No. 28Registration District No. 216File No. 54Registered No. 3930

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Daniel Adolph Tichert

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Child
(Write the word.)

6. DATE OF BIRTH

June 19 1922
(Month) (Day) (Year)

7. AGE

2 Yrs. 3 Mos. 15 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Child

9. BIRTHPLACE

(State or Country)

Abundum Idaho

10. NAME OF FATHER

Adolph Tichert

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Mary Strang

13. BIRTHPLACE OF MOTHER

(State or Country)

So Dakota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs Adolph Tichert

(Address)

Abundum

15.

Filed

1075 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

October 4 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Oct 4 1922 to Oct 4 1922 that I last saw him alive on Oct 4 1922 and that death occurred on the date stated above, at 10:30 M. The CAUSE OF DEATH* was as follows:Shock
Acute appendicitis with
general suppurative peritonitis
(operated) (Duration) Yrs. mos. 3 ds.

Contributory (Secondary)

Shock(Duration) yrs. mos. 1/4 ds.

(Signed)

W. J. Howard M. D.10/5 1922 (Address) Paratille Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Abundum Idaho10/7 1922

20. UNDERTAKER

Schumacher & Hall

ADDRESS

Paratille

1. PLACE OF DEATH

County of Bannock Registration District No. 28
 City of Pocatello (No. Emergency Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Allen Wyman Baugh

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 54

Registered No. 39762

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married

6. DATE OF BIRTH

Oct 4 1899
 (Month) (Day) (Year)

7. AGE

23 Yrs. 3 Mos. 3 ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Manifest Clerk in
 (b) General nature of industry, business or establishment in which employed (or employer) C. S. L. yards.

9. BIRTHPLACE

(State or Country) Mercer, Idaho

10. NAME OF FATHER

Craig J. Baugh

11. BIRTHPLACE OF FATHER

(State or Country) Missouri

12. MAIDEN NAME OF MOTHER

Mamie Crandall

13. BIRTHPLACE OF MOTHER

(State or Country) Washington, D. C.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mamie Baugh

(Address) 606 N. Harvard St. Pocatello

15.

Filed Oct 7 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 7 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct. 3 1922 to Oct. 7 1922

that I last saw him alive on Oct. 7 1922

and that death occurred on the date stated above, at 1 A. M.

The CAUSE OF DEATH* was as follows:

Protein acidosis

(Duration) Yrs. 3 mos. 3 ds.

Contributory (Secondary) Crushing injury R. thigh

(Duration) Yrs. 3 mos. 3 ds.

(Signed) Dr. J. J. Jones M. D.

Oct 7, 1922 (Address) Pocatello, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 5 yrs. 3 mos. 3 days. In the State Idaho yrs. 3 mos. 3 days

Where was disease contracted if not at place of death?

Former or usual residence Pocatello, Idaho

19. PLACE OF BURIAL OR REMOVAL

MT View Cem DATE OF BURIAL Oct 8 1922

20. UNDERTAKER

H. L. McHarr ADDRESS Pocatello, Idaho

FORM V. S. No. 5-25 M. 1-19.

NOV 18 1922

CERTIFICATE OF DEATH

39763 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bennett
City of PocatelloRegistration District No. 28Primary Registration District No. 2161
(No. Pocatello Gen Hos St.)File No. 54
Registered No. 3932

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Elmore Sidney Thomas

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED, DIVORCED

Married

6. DATE OF BIRTH

March 12 1890
(Month) (Day) (Year)

7. AGE

32 Yrs. 6 Mos. 29 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

Assistant yard master
at Glens Ferry, Id.

9. BIRTHPLACE

(State or Country)

Brantford Ont. Canada

10. NAME OF FATHER

U. S. Thomas

11. BIRTHPLACE OF FATHER

(State or Country)

Canada

12. MAIDEN NAME OF MOTHER

Emma Hogen

13. BIRTHPLACE OF MOTHER

(State or Country)

Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) N. S. Thomas(Address) Vancouver B.C., CanadaFiled 17 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 10 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Oct. 4 1922 to Oct. 10 1922that I last saw him alive on Oct. 7 1922and that death occurred on the date stated above, at 12:10 P.M.

The CAUSE OF DEATH* was as follows:

General peritonitis

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Duration) Yrs. mos. ds.

(Signed)

10/11/1922 (Address) Pocatello Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. 6 In the State 5 yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence Canada

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Mt View Pocatello Ida. Oct 19 1922

20. UNDERTAKER ADDRESS

McHone & Sons Co Pocatello Ida

FORM V. S. No. 5-A-25 M. 1-19.

RECEIVED NOV 18 1922
CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bannock Registration District No. 216City of Pocatello STATISTICAL DISTRICT No. 506

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William Joseph Kerr38764
State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 34Registered No. 3933

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDWidowed (use word.)

6. DATE OF BIRTH

June 28th 1847
(Month) (Day) (Year)

7. AGE

76 Yrs. 3 Mos. 9 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Lawyer

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Ireland

10. NAME OF FATHER

John Kerr

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Mary Wilson

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Anna Lynne Kerr

(Address)

506 N. Arthur

15.

Filed

791922J. Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct. 8 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar 20 1922 to Oct 7 1922that I last saw him alive on Oct 7 1922and that death occurred on the date stated above, at 12 P.M.

The CAUSE OF DEATH* was as follows:

Deafness(Duration) 46 Yrs. — mos. — ds.Contributory
(Secondary)red eye(Duration) — yrs. — mos. — ds.

(Signed)

D. L. Linn

M. D.

10-9 1922 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mountain ViewOct 9 1922

20. UNDERTAKER

ADDRESS

SchumacherPocatello

CERTIFICATE OF DEATH

38765

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bonneville Registration District No. 18City of Pocatello Primary Registration District No. 2161File No. 54Registered No. 3934

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William Thompson
Enroute to Salt Lake City

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married

6. DATE OF BIRTH

Dec 2 1868
(Month) (Day) (Year)

7. AGE

53 Yrs. 9 Mos. 9 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)Farmer

9. BIRTHPLACE

(State or Country)

Salt Lake City Ut.

10. NAME OF FATHER

William Thompson

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Matilda Commando

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Elijah Thompson
(Address) Salt Lake City, Utah15. Filed Oct 11 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 11 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19..... to 19.....

that I last saw him..... alive on..... 19.....

and that death occurred on the date stated above, at 3:30 a.m.

The CAUSE OF DEATH* was as follows:

Unknown but natural

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) S. S. Ferguson M. D.10-11-1922 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death in Idaho yrs. mos. days. State 5 yrs mos. days.

Where was disease contracted if not at place of death?

Former or usual residence Salt Lake City, Utah

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Blackfoot Idaho Oct 11 1922

20. UNDERTAKER ADDRESS

H. L. MC Kean Pocatello Ida

CERTIFICATE OF DEATH

39766

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FILE NO.

Registration District No.

Registration District No.

File No.

Registered No.

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF
FATHER11. BIRTHPLACE
OF FATHER

(State or Country)

12. MAIDEN NAME
OF MOTHER13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from
Oct. 11 1922, to Oct. 12 1922

that I last saw her alive on Oct. 12 1922

and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) M. D.

319.22 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH
in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECEIVED

NOV 18 1922

CERTIFICATE OF DEATH

39767

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. —) (St.)

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 11

(Month)

(Day)

1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 11 1922 to Oct 11 1922

that I last saw him alive on Oct 11 1922

and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Senility (Myocarditis)

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed)

M. D.

(Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

RECEIVED
CERTIFICATE OF DEATH28 39768 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock Registration District No. 2101
City of Idaho Falls St. Anthony's Hospital
If death occurs away from usual residence, give facts called for under special information.File No. 33
Registered No. 3437

2. FULL NAME

Dr. Edmund Beaudette

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED married
(Write the word.)6. DATE OF BIRTH Aug 6 - 1869
(Month) (Day) (Year)7. AGE 59 Yrs. 2 Mos. 7 ds. IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Dentist
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Canada

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country) Canada

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country) Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Melvin B. Beaudette(Address) Idaho Falls, Idaho

15.

Filed 1914 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct. 14 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from 9-16 1922 to 10-13 1922
that I last saw him alive on Oct. 13 1922
and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

uremia(Duration) Yrs. mos. ds. 1 Yrs. 0 Mos. 0 Ds.
Contributory (Secondary) Prostatic abscess(Duration) Yrs. mos. ds. 1 Yrs. 0 Mos. 0 Ds.
(Signed) Dr. Beaudette M. D.
10/14/1922 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mountain View Oct 16 1922

20. UNDERTAKER

ADDRESS

Schweitzer & Co Idaho Falls

FORM V. S. No. 5-12

RECEIVED

CERTIFICATE OF DEATH

39789

State of Idaho
BOARD OF HEALTH

Bureau of Vital Statistics

File No. 33

Registered No. 3938

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH NOV 18 1922

County of Bannock Registration District No.City of Pocatello Primary Registration District No.(No. Pocatello General Hos. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Helen Louise Kerr

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female whiteSingle

6. DATE OF BIRTH.

Oct 51922

(Month) (Day) (Year)

7. AGE

8 Yrs. 8 Mos. 8 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

Infant

9. BIRTHPLACE

(State or Country)

Pocatello, Ida.

10. NAME OF FATHER

Chester H. Kerr

11. BIRTHPLACE OF FATHER

(State or Country)

South Dakota

12. MAIDEN NAME OF MOTHER

Gladys McGillicuddy

13. BIRTHPLACE OF MOTHER

(State or Country)

California

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Chester H. Kerr
219 So. Main St. Pocatello, Ida.

15.

Filed

Oct 14 1922H. Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 12121922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 51922

to

Oct 121922that I last saw her alive on Dec 12 1922and that death occurred on the date stated above, at 11 P M.

The CAUSE OF DEATH* was as follows:

Patient fractured skull

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed)

[Signature]

M. D.

Oct 14 1922 (Address) Pocatello, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Left In the Yrs. mos. days State Yrs. mos. daysWhere was disease contracted Left in Pocatello If not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mt View Cem. PocatelloOct 14 1922

20. UNDERTAKER

ADDRESS

McHawdrott & Co. Pocatello

CERTIFICATE OF DEATH

39770

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35

Registered No. 3939

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of *Lamar*City of *Pocatello*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No. 28

Primary Registration District No. 146

No. 1

Shirah L Zumbo

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married

6. DATE OF BIRTH

July 12 1890

7. AGE

52 Yrs. *3* Mos. *3* ds.IF LESS than 1 day
how many.....hrs.
or.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

Aguilla Bennett

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15. Filed

*1914**1922*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 15 1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY That I attended deceased from *Oct 10 1922* to *Oct 15 1922*that I last saw her alive on *Oct 15 1922*and that death occurred on the date stated above, at *10 A.M.*

The CAUSE OF DEATH* was as follows:

Stones in both kidneys and pyonephrosis double

(Duration) Yrs. mos. ds.

Contributory (Secondary)

Toxaemia from pyonephrosis

(Duration) Yrs. mos. ds.

(Signed)

Dr. Lynn

M. D.

Oct 15th 1922

(Address)

Pocatello, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Lamar, Ida.

DATE OF BURIAL

10/16 1922

20. UNDERTAKER

M. Wacker

ADDRESS

Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH **RECEIVED**
 County of **Campana** 1922
 City of **Bozeman** **Bureau of Vital Statistics**
 If death occurs away from usual residence, give facts called for under special information.

Registration District No. _____
 Primary Registration District No. _____
 St. _____

2. FULL NAME **Dorcas Marie Clever**

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. **33**
 Registered No. **3940**
 If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female**
 4. COLOR OR RACE **White**
 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Married**
 6. DATE OF BIRTH **March 17 1906**
 (Month) (Day) (Year)
 7. AGE **16** Yrs. **7** Mos. **1** ds.
 IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION **Housewife**
 (a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE **Utah**
 (State or Country)

10. NAME OF FATHER **W. H. Bailey**

11. BIRTHPLACE OF FATHER **Utah**
 (State or Country)

12. MAIDEN NAME OF MOTHER **Laura A. Harris**

13. BIRTHPLACE OF MOTHER **Michigan**
 (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) **W. H. Bailey**
 (Address) **Bozeman, Montana**

15. Filed **1918** 1922
 Local Registrar **J. H. H. H.**

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **Oct 18 1922**
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Oct 17 1922** to **Oct 18 1922**
 that I last saw him alive on **Oct 18 1922**
 and that death occurred on the date stated above, at **3 P. M.**

The CAUSE OF DEATH* was as follows:
Ruptured appendix

(Duration) _____ Yrs. _____ mos. _____ ds.
 Contributory (Secondary) **General peritonitis**
miscarriage
 (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) **W. H. H. H.** M. D.
 (Address) **Bozeman, Ida**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL **Bozeman, Ida** DATE OF BURIAL **10/18 1922**

20. UNDERTAKER **M. Wacker** ADDRESS **Bozeman**

RECEIVED
JUL 18 1922
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

39773

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

Registration District No.

Registration District No.

(No.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1920 - 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from July 2, 1922, to Oct 19, 1922, that I last saw her alive on Oct 19, 1922, and that death occurred on the date stated above, at 6:00 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast.
(inoperable)

(Duration) 10 Yrs. mos. ds.
Contributory (Secondary) metastasis throughout body.
(Duration) yrs. mos. ds.

19 (Signed) J. H. Young M. D.
120 19.22 (Address) Pocatello, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER P. H. Wacker Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

39774
28State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock Registration District No. 18City of Pocatello Primary Registration District No. 261If death occurs away from usual residence, give facts called for under special information. (No. St Anthony Hospital St.)File No. 55Registered No. 3943

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Royal Doney Parkinson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Infant
(Write the word.)

6. DATE OF BIRTH

September 26 1921
(Month) (Day) (Year)

7. AGE

1 Yrs. — 24 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Pryburg

10. NAME OF FATHER

F. S. Parkinson

11. BIRTHPLACE OF FATHER

(State or Country)

Franklin Idaho

12. MAIDEN NAME OF MOTHER

Bessie Doney

13. BIRTHPLACE OF MOTHER

(State or Country)

Franklin Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) F. S. Parkinson

(Address)

Pryburg

15.

Filed

10/201922J. J. Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

October 20 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct. 9 1922, to Oct. 20 1922that I last saw him alive on Oct. 20 1922and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Infectious Diarrhoea.(Duration) Yrs. mos. 21 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. M. Sprague

M. D.

at W. 1922 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted, if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Pryburg Idaho

DATE OF BURIAL

10/22 1922

20. UNDERTAKER

Schumacher & Hall

ADDRESS

Pocatello

CERTIFICATE OF DEATH

39775

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock Registration District No. 28City of Pocatello 18 1922 Emergency Registration District No. 2161If death occurs away from usual residence, give facts called for under special information. Emergency Hospital

2. FULL NAME

R. J. StephensFile No. 53
Registered No. 3944
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widowed

6. DATE OF BIRTH

Dec 25 1887
(Month) (Day) (Year)

7. AGE

34 Yrs. 9 Mos. 26 ds.IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ogden Utah

10. NAME OF FATHER

Constance Stephens

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Francis Thompson

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edmond A. Stephens(Address) Burley Idaho

15.

Filed

Oct 24 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 19 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Oct 19 1922 to Oct 19 1922that I last saw him alive on Oct 19 1922and that death occurred on the date stated above, at 12 00 A.M.

The CAUSE OF DEATH* was as follows:

Compound comminuted skull fracture

(Duration) Yrs. mos. ds.

Contributory Accidental death
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) W. J. Gorkes M. D.219 22 (Address) Pocatello Utah

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 1 hour 15 min
of death Yrs. mos. days State Yrs. mos. daysWhere was disease contracted Hospital
if not at place of death?Former or usual residence Idaho Wyoming

19. PLACE OF BURIAL OR REMOVAL

Burley Idaho

DATE OF BURIAL

Oct 24

20. UNDERTAKER

H. L. McHAN

ADDRESS

POCATELLO, IDAHOWRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

39777
28State of Idaho
BOARD OF HEALTH

Bureau of Vital Statistics

File No. 35

Registered No. 3946

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Barnack Registration District No.City of POCATELLO, IDAHO Registration District No.If death occurs away from usual residence, give facts called for under special information. Pocatello General Hosp2. FULL NAME Theodore David Nettleship

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single (Write the word.)

6. DATE OF BIRTH.

Aug 23 1901
(Month) (Day) (Year)

7. AGE

21 Yrs. 2 Mos. 1 ds.IF LESS than 1 day
how many ... hrs. or
... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

House labor

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Kansas

10. NAME OF FATHER

C. A. Nettleship

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Cora Fisk

13. BIRTHPLACE OF MOTHER

(State or Country)

Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Herbert D. Johnson(Address) Pocatello, IdahoFiled Oct 23 19122 J. Young
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

October 22 19122
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 17 19122 to Oct 22 19122that I last saw him alive on Oct 22 19122and that death occurred on the date stated above, at 8:30 P. M.

The CAUSE OF DEATH* was as follows:

Heart Appendicitis

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

Oct 13 1922 (Address) Pocatello, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. 5 In the ... days, State ... yrs. 4 mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence Pocatello, Idaho

19. PLACE OF BURIAL OR REMOVAL

Pocatello, Idaho

DATE OF BURIAL

Oct 23 19122

20. UNDERTAKER

McNair, Smith & Co. POCATELLO, IDAHO

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH
in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

39778 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 55
Registered No. 3947

1. PLACE OF DEATH

County of Bannock Registration District No. 23
City of Pocatello Primary Registration District No. 2101
St. Idaho

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Kenneth C Sallenburg
If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Male White Single
(Write the word.)

6. DATE OF BIRTH

Sept 16 1902
(Month) (Day) (Year)

7. AGE

20 Yrs. 1 Mos. 10 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Nebraska

10. NAME OF FATHER

W. C. Sallenburg

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Emma J. Evans

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

W. C. Sallenburg
Blackfoot Idaho.

15.

Filed 24 1922

W. C. Sallenburg
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

October 26 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Oct 23 1922 to Oct. 26 1922

that I last saw him alive on Oct. 26 1922

and that death occurred on the date stated above, at 5 A.

The CAUSE OF DEATH* was as follows:

B. chloride poisoning

(Duration) Yrs. 7 mos. 3 1/2 ds.

Contributory (Secondary)

(Duration) yrs. 1 mos. 1 ds.

(Signed) A. C. Laurie M. D.

1926 1922 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Blackfoot Idaho 10/27 1922

20. UNDERTAKER

ADDRESS

Ed. Burk Blackfoot Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

39779 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Banner Registration District No. 18City of Pocatello Registration District No. 2167

If death occurs away from usual residence, give facts called for under special information.

File No. 53
Registered No. 3948

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Jack Philmore Pernenter

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male white Single (Write the word.)

6. DATE OF BIRTH

Aug 28 1914
(Month) (Day) (Year)

7. AGE

8 Yrs. 2 Mos. 4 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

Student

9. BIRTHPLACE

(State or Country)

California

10. NAME OF FATHER

Ed Pernenter

11. BIRTHPLACE OF FATHER

(State or Country)

Texas

12. MAIDEN NAME OF MOTHER

Kate Byers

13. BIRTHPLACE OF MOTHER

(State or Country)

North Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ed Pernenter(Address) 208 N. Grant St.

15.

Oct 26 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct. 24 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
Oct. 23 1922 to Oct. 24 1922that I last saw him alive on Oct. 24 1922and that death occurred on the date stated above, at 9:45 A.M.

The CAUSE OF DEATH* was as follows:

Accidental crushing injury
to left chest(Duration) Yrs. _____ mos. 1 ds.Contributory
(Secondary)(Duration) yrs. _____ mos. 1 ds.

(Signed)

M. D.Oct 26 1922 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. 2 mos. _____ days. In the State yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

Wyoming

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Mt View Cem Oct 26 1922

20. UNDERTAKER

ADDRESS

McHann & Co. Pocatello Id.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

39780

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock
City of Pocatello

Registration District No. _____

Primary Registration District No. _____

(No. _____)

Pocatello General Hosp

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Annie JohnsonFile No. 35Registered No. 3949

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED widow

6. DATE OF BIRTH

April 17 1843
(Month) (Day) (Year)

7. AGE

79 Yrs. 6 Mos. 9 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

none

(b) General nature of industry, business or establishment in which employed (or employer).

County poor farm Charge

9. BIRTHPLACE

(State or Country)

Sweden

10. NAME OF FATHER

Johan Johnson

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME OF MOTHER

not known

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Matilda Rasmussen
(Address) 1001 So. Harrison St.Filed Oct 26 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 25 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from 10-20-22 to 10-20-22that I last saw her alive on 10-20-22and that death occurred on the date stated above, at 5:20 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia (terminal)(Duration) Yrs. _____ mos. 2 ds.Contributory (Secondary) Senility(Duration) 10 yrs. _____ mos. _____ ds.(Signed) C. W. Clark M. D.Oct 26 1922 (Address) Pocatello, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 29 yrs. in mos. 10 days. State Pocatello yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence Pocatello, Idaho19. PLACE OF BURIAL OR REMOVAL Pocatello, Idaho DATE OF BURIAL Oct 27 192220. UNDERTAKER McHann & Co. ADDRESS Pocatello, Idaho

RECEIVED

CERTIFICATE OF DEATH

39781

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

Registration District No.

Primary Registration District No.

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Signed)

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

1. PLACE OF DEATH

County of Bannock
City of Pocatello

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No. 28Primary Registration District No. 2161(No. General Hosp St.)

39782

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 55Registered No. 3957

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male white

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Oct 26 1922
(Month) (Day) (Year)

7. AGE

No Yrs. No Mos. No ds.IF LESS than 1 day
how many 4 hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

None

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Pocatello Ida.

10. NAME OF FATHER

Carl P. Fleiderer

11. BIRTHPLACE OF FATHER

(State or Country)

Kansas

12. MAIDEN NAME OF MOTHER

Mary Shiner

13. BIRTHPLACE OF MOTHER

(State or Country)

Texas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Carl P. Fleiderer

(Address)

255 S. Hayes

15.

Filed

1927 1922J. H. Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 26 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 26 1922 to Oct 26 1922that I last saw him alive on Oct 26 1922and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Atelectasis

(Duration)

Yrs. mos. ds.

Contributory
(Secondary)Pneumonia

(Duration)

Yrs. mos. ds.

(Signed)

Wm. Brothman M. D.Oct 26 1922 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Mt. View

DATE OF BURIAL

Oct 27 1922

20. UNDERTAKER

W. F. McEwan

ADDRESS

Pocatello Idaho

CERTIFICATE OF DEATH

39783

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock
City of POCATELLO, IDAHORegistration District No. 28Primary Registration District No. 2101
(No. Pocatello General Hosp.)File No. 55Registered No. 3952

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

James Freeman Ogden

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married

6. DATE OF BIRTH

August 8 1865
(Month) (Day) (Year)

7. AGE

57 Yrs. 2 Mos. 20 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Kansas

10. NAME OF FATHER

Joseph Ogden

11. BIRTHPLACE OF FATHER

(State or Country)

Ill.

12. MAIDEN NAME OF MOTHER

Samantha Bobbitt

13. BIRTHPLACE OF MOTHER

(State or Country)

Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs Minnie Ogden

(Address)

Carthage, Missouri

15.

Filed Oct 28 1922Local Registrar
W. H. H. H.
POCATELLO, IDAHO

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 27 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 18 1922 to Oct 27 1922that I last saw him alive on Oct 27 1922and that death occurred on the date stated above, at 12:45 P.M.

The CAUSE OF DEATH* was as follows:

Peritonitis general.(Duration) Yrs. mos. 3 ds.Contributory
(Secondary)(Duration) yrs. mos. 4 ds.

(Signed)

W. N. Clark

M. D.

Oct 28 1922(Address) POCATELLO, IDAHO

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. 9 days.

Where was disease contracted if not at place of death?

Former or usual residence

Burley Idaho.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Carthage Mo.Oct 28 1922

20. UNDERTAKER

ADDRESS

McKanduff & Co.

POCATELLO, IDAHO

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

Feb. 25, 1922, to July 10, 1922,

that I last saw him alive on July 10, 1922,

and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Signed)

7/10/1922,

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

20. UNDERTAKER

ADDRESS

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 82County of Boo LakePrimary Registration District No. 2136City of Montpelier(No. 1111)

St.)

File No. 39785

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ellen Chugg

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDFemaleWhiteMarried
(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

87
(Year)

7. AGE

51

Yrs.

Mos.

ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

Wife

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Pari Idaho

10. NAME OF FATHER

Evon Williams

11. BIRTHPLACE OF FATHER

(State or Country)

Neb.

12. MAIDEN NAME OF MOTHER

Don't Know

13. BIRTHPLACE OF MOTHER

(State or Country)

Neb.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Philip Chugg
Montpelier

(Address)

15.

Filed 8-29-22

19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

92
(Year)

17. I HEREBY CERTIFY That I attended deceased from

Aug 28 1922 to Aug 28 1922that I last saw him alive on Aug 28 1922and that death occurred on the date stated above, at 7 M.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

8/29 1922

(Address)

Montpelier, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Pari Idaho8/30/22

20. UNDERTAKER

ADDRESS

J. H. WilliamsMontpelier

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. **39786**
 Registered No.
 If death occurred in a hos-
 pital, institution or camp,
 give its NAME instead of
 street and number.

1. PLACE OF DEATH
 County of **Bear Lake** Registration District No. **52**
 City of **Montpelier** Primary Registration District No. **2138**
 If death occurs away from
 usual residence, give facts
 called for under special
 information.

2. FULL NAME **Rose Sparks**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED. **Widow**
 (Write the word.)

6. DATE OF BIRTH **Jan 19 1870**
 (Month) (Day) (Year)

7. AGE **52** Yrs. **7** Mos. **10** ds.
 IF LESS than 1 day
 how many hrs. or
 min.?

8. OCCUPATION

(a) Trade, profession or
 particular kind of work
 (b) General nature of in-
 dustry, business, or estab-
 lishment in which em-
 ployed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Samson Kate

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Mary Ann Cottrell

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Henry Sparks

(Address)

215 E. 1st St. Idaho

15.

Filed **11-15-1922**

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **Sept 1 1922**
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Sept 1, 1922 to **191**

that I last saw h. alive on **191**
 and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Heart Trouble
(myocardial)

(Duration) Yrs. mos. ds.

Contributory
 (Secondary)

(Duration) Yrs. mos. ds.

(Signed)

Dr. F. C. Bailey M. D.

Address **Montpelier**

*State the Disease Causing Death; or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
 of death yrs. mos. days, State yrs. mos. days

Where was disease contracted
 if not at place of death?

Former or
 usual residence

19. PLACE OF BURIAL OR REMOVAL

Single Idaho

DATE OF BURIAL

Sept 3. 1922

20. UNDERTAKER

F. M. Williams

ADDRESS

Montpelier Idaho

WHILE FILLING, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 39787

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 52

Primary Registration District No. 2136

(Nov 1922)

St.)

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many 9 hrs.

or ~ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed 11-15 1922

Local Registrar

16. DATE OF DEATH

(Month)

(Day)

19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at 3:39 M.

The CAUSE OF DEATH* was as follows:

Immaturity - 7 mos
Baby

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 52
County of Dear Lake Primary Registration District No. 2136
City of Montpelier St. IdahoFile No. 39788
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John A. Hancock

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widower
(Write the word.)6. DATE OF BIRTH July (Month) 24 (Day) 1843 (Year)7. AGE 79 Yrs. 1 Mos. 21 ds. IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Farmer

9. BIRTHPLACE

(State or Country)

Illinois

10. NAME OF FATHER

Thomas Hancock

11. BIRTHPLACE OF FATHER

(State or Country)

Massachusetts

12. MAIDEN NAME OF MOTHER

Annie Boie

13. BIRTHPLACE OF MOTHER

(State or Country)

Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Walter A. Hancock
Montpelier, Idaho

15.

Filed 11-15-22 19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept. 15, 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Sept. 7, 1922 to Sept. 15, 1922 that I last saw him alive on Sept. 15, 1922 and that death occurred on the date stated above, at 1 P.M. The CAUSE OF DEATH* was as follows:Old Age(Duration) Yrs. _____ mos. 30 ds.

Contributory (Secondary)

(Duration) Yrs. _____ mos. 7 ds.

(Signed)

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. Yrs. _____ mos. _____ days. In the State. Yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

Montpelier, Ida9-17-1922Wm WilliamsMontpelier

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39789**
Registered No.

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

1. PLACE OF DEATH

County of *Bear Lake* Registration District No. *52*
City of *Montpelier* Primary Registration District No. *7136*
If death occurs away from
usual residence, give facts
of death for under special
notification. *St.)*
Nov 2 1922
STATES
Social Ralph

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED. *Married*
(Write the word.)

6. DATE OF BIRTH. *Don't know*
(Month) (Day) (Year)

7. AGE *55 about* IF LESS than 1 day
Yrs. Mos. ds. how many hrs. or
min.?

8. OCCUPATION
(a) Trade, profession or
particular kind of work *Farmer*
(b) General nature of in-
dustry, business, or estab-
lishment in which em-
ployed (or employer)

9. BIRTHPLACE
(State or Country) *Idaho*

10. NAME OF
FATHER *Don't know*

11. BIRTHPLACE
OF FATHER " "

12. MAIDEN NAME
OF MOTHER " "

13. BIRTHPLACE
OF MOTHER " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *H. M. Williams*
(Address) *Montpelier, Idaho*

15. Filed *11-15-22* 191 *22*
Local Registrar. *H. M. Williams*

16. DATE OF DEATH *Sept 16 1922*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Sept 14 1922 to *Sept 16 1922*
that I last saw him alive on *Sept 16 1922*
and that death occurred on the date stated above, at *4 P. M.*

The CAUSE OF DEATH* was as follows:
Kidney trouble
(nephritis)
(Duration) Yrs. mos. ds.
Red age
(Signed) *W. F. Lusk* M. D.

Sept 14, 1922 Address *Idaho*
*State the Disease Causing Death; or in deaths from Violent
Causes, state (1) Means of injury; and (2) whether Accidental,
Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place In the
of death yrs. mos. days, State yrs. mos. days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Idaho Wyoming *Sept 18 1922*

20. UNDERTAKER ADDRESS

W. M. Williams *Montpelier, Idaho*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS
should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement
of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 39790

Registered No.

1. PLACE OF DEATH

County of Bear Lake Registration District No. 52
City of Bernington Primary Registration District No. 2136 St.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Harmonits Harnulson
If death occurred in a hospital, institution or camp, give its NAME instead of name and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

Jan 28 1922
(Month) (Day) (Year)

7. AGE

74 Yrs. 7 Mos. 24 ds.IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Farmer & rancher.

9. BIRTHPLACE

(State or Country)

Denmark.

10. NAME OF FATHER

Lars Monviken

11. BIRTHPLACE OF FATHER

(State or Country)

Denmark

12. MAIDEN NAME OF MOTHER

Don't know

13. BIRTHPLACE OF MOTHER

(State or Country)

Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

David Mountain

(Address)

Montpelier

15. Filed

11-15-22 W. H. Hugg

Local Registrar

16. DATE OF DEATH

Sept 24 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 19 20 to Sept 24 19 22
that I last saw him alive on Sept 19 22
and that death occurred on the date stated above, at 6:00 A.M.
The CAUSE OF DEATH* was as follows:
apoplexy

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed)

W. H. Hugg D.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death... yrs... mos... days. In the State... yrs... mos... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bernington Id 9-25-1922

20. UNDERTAKER

ADDRESS

J. M. Williams Montpelier

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Beauregard Registration District No. 53
 City of Montpelier Primary Registration District No. 2136
 If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John W. WedellState of Idaho
BOARD OF HEALTH

Bureau of Vital Statistics

File No. 39791
 Registered No.
 If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH.

March 3 1863
 (Month) (Day) (Year)

7. AGE

59 Yrs. 7 Mos. 6 ds.

 IF LESS than 1 day
 how many hrs. or
 min.?

8. OCCUPATION

 (a) Trade, profession or particular kind of work
 (b) General nature of industry, business, or establishment in which employed (or employer)

Merchant
(Retired 3 yrs)

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

Don't know

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Don't know

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

L. S. Wedell
Montpelier, Ida.

15.

Filed 11-15-22 1922

Local Registrar.

16. DATE OF DEATH

Oct 9 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 15 1922 to Oct 9 1922
 that I last saw him alive on Oct 9 1922
 and that death occurred on the date stated above, at 7:45 A.M.

The CAUSE OF DEATH* was as follows:

Acute Pempfigus
 (Duration) 0 Yrs. 3 mos. 0 ds.
Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) A. S. Neuhues M. D.Oct 10 1922 (Address) Montpelier, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Montpelier
Mr. Williams

DATE OF BURIAL

Oct 11 1922

20. UNDERTAKER

ADDRESS

Montpelier, Idaho

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Bear Lake Registration District No. 32
City of Geneva Registration District No. 2136
(Not a City) (Not a Town) (Not a Village) (Not a Hamlet) (Not a Station) (Not a Post Office)
If death occurs away from usual residence, give facts called for under special information.

File No. 39792

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Bushong

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH

11/12 1895
(Month) (Day) (Year)

7. AGE

74 Yrs. 11 Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Switzerland

10. NAME OF FATHER

John Bushong

11. BIRTHPLACE OF FATHER

(State or Country)

Switzerland

12. MAIDEN NAME OF MOTHER

Stamer

13. BIRTHPLACE OF MOTHER

(State or Country)

Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Edward Bushong

(Address)

Geneva, Idaho

15.

Filed 11-18-22 W. H. King

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 10 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 10 1922 to Oct 10 1922
that I last saw him alive on Sept 10 1922

and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

cause of liver

(Duration) Yrs. mos. ds.
Contributory (Secondary) Red eye

(Duration) Yrs. mos. ds.
(Signed) W. H. King M. D.

Oct 11 1922 (Address) Geneva, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Geneva, Idaho10-13-22

20. UNDERTAKER

ADDRESS

Geneva, IdahoGeneva, Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. **39793**
 Registered No.
 If death occurred in a hos-
 pital, institution or camp,
 give its NAME instead of
 street and number.

1. PLACE OF DEATH

County of **Blaine** Registration District No. **52**
 City of **Montpelier** Primary Registration District No. **2136**
 If death occurs away from
 usual residence, give facts
 called for under special
 information.

2. FULL NAME **Thos. J. Curry**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED. **Married.**
 (Write the word.)

6. DATE OF BIRTH. **October 30 1880**
 (Month) (Day) (Year)

7. AGE **42** Yrs. **6** Mos. **6** ds. IF LESS than 1 day
 how many hrs. or
 min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work **Railroad Switchman.**
 (b) General nature of in-
 dustry, business, or estab-
 lishment in which em-
 ployed (or employer) **(Oregon Short Line)**

9. BIRTHPLACE

(State or Country) **Missouri.**

10. NAME OF FATHER

Sanford M. Curry.

11. BIRTHPLACE OF FATHER

(State or Country) **Indiana.**

12. MAIDEN NAME OF MOTHER

Nancy E. Green.

13. BIRTHPLACE OF MOTHER

(State or Country) **Missouri.**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Mrs. J. J. Curry**

(Address) **Montpelier, Idaho.**

15.

Filed **11-15-1922** **A. H. King**

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov. 5, 1922.
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Nov 1 1922 to **Nov 5 1922**

that I last saw him alive on **Nov 5 1922**
 and that death occurred on the date stated above, at **8:15 a.m.**

The CAUSE OF DEATH* was as follows:

Peritonitis -

(Duration) Yrs. mos. ds.

Contributory
 (Secondary)

Appendicitis

(Duration) Yrs. mos. ds.

(Signed)

Nov 6 1922 (Address) **Montpelier, Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted

if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

St. John's Episcopal

DATE OF BURIAL

Nov. 6 1922

20. UNDERTAKER

J. M. Williams

ADDRESS

Montpelier, Idaho

should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bear Lake
City of MontpelierRegistration District No. 52Primary Registration District No. 2136File No. 39794

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ivy A. Logan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

(Write the word.)

6. DATE OF BIRTH

Aug
(Month)3
(Day)1890
(Year)

7. AGE

32 yrs. 3 mos. 11 ds.

IF LESS than 1 day

how many _____ hrs.

or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

School Teacher

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

H. P. Logan

11. BIRTHPLACE OF FATHER

(State or Country)

Illinois

12. MAIDEN NAME OF MOTHER

Mary W Wadsworth

13. BIRTHPLACE OF MOTHER

(State or Country)

Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

H. P. Logan

(Address)

Montpelier, Idaho

15.

Filed 11-14-1922N. H. King
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov
(Month)14
(Day)1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 51922

to

Nov 141922that I last saw him alive on Nov 14 1922and that death occurred on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

Acute dilatation of heart following appendectomy Nov 11th

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

J. P. Gaestgen M. D.11-15-1922(Address) Montpelier

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Larkin Mo.

DATE OF BURIAL

Nov 19, 1922

20. UNDERTAKER

F. McWilliam

ADDRESS

Montpelier Idaho

RECEIVED

CERTIFICATE OF DEATH.

39795

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

NOV 18 1922

Registration District No. 53

County of Bear Lake

Primary Registration District No.

City of Bloomington

File No. 324

Registered No.

If death occurs away from
usual residence, give facts
called for under special
information.If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

2. FULL NAME

Charles E. Taylor

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.Single
(Write the word.)

6. DATE OF BIRTH.

Dec 1st 1849
(Month) (Day) (Year)

7. AGE

73 Yrs. 10 Mos. 27 ds.

IF LESS than 1 day
how many.....hrs. or
.....min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work...
(b) General nature of in-
dustry, business, or estab-
lishment in which employ-
ed (or employer).....

Rancher

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF
FATHER

Charles B. Taylor

11. BIRTHPLACE
OF FATHER

(State or Country)

England

12. MAIDEN NAME
OF MOTHER

Mary Edwards

13. BIRTHPLACE
OF MOTHER

(State or Country)

Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Geo C. Piggott

(Address)

Bloomington Idaho

15.

Filed

Oct 29

1922

Mary L. Skinner
Local Registrar

16. DATE OF DEATH

Oct
(Month)27
(Day)1922
(Year)17. I HEREBY CERTIFY, That I attended deceased from
Oct 20 1922, to Oct 27 1922,
that I last saw him alive on Oct 27 1922
and that death occurred on the date stated above, at 8:30 P.M.
The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration)

Yrs.

mos. 2 ds.

Contributory
(Secondary)

(Duration)

Yrs.

mos. ds.

(Signed)

Oct 28 1922 (Address) C. D. Moore
Paris Idaho M. D.*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted
if not at place of death?.....Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Bloomington Idaho

DATE OF BURIAL

Oct 30 1922

20. UNDERTAKER

Alfred A Hart

ADDRESS

Bloomington

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly understood. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

39796

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 0-3

County of _____

Primary Registration District No. _____

City of _____

(No. _____)

St. _____

File No. 23

Registered No. _____

If death occurs away from
usual residence, give facts
called for under special
information.

2. FULL NAME

Ernest RichIf death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.Male WhiteSingle
(Write the word.)

6. DATE OF BIRTH

Sep 30 1910
(Month) (Day) (Year)

7. AGE

12 Yrs. 23 Mos. 23 ds.IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work...
(b) General nature of in-
dustry, business, or estab-
lishment in which employ-
ed (or employer).....

9. BIRTHPLACE

(State or Country)

Paris Idaho10. NAME OF
FATHERS. M. Rich11. BIRTHPLACE
OF FATHER

(State or Country)

Paris Idaho12. MAIDEN NAME
OF MOTHERMargaret Poulson13. BIRTHPLACE
OF MOTHER

(State or Country)

Liberty Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

S. M. Rich

(Address) _____

15.

Filed

Oct 25 1922Mrs. S. L. Skinner
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 23 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
Oct 19 1922 to Oct 23 1922that I last saw him alive on Oct 23 1922and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH was as follows:

Septic Sore Throat(Duration) _____ Yrs. _____ mos. 23 ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Oct 23 1922 (Address) Paris Idaho*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted
if not at place of death?.....Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Paris IdahoOct 25 1922

20. UNDERTAKER

ADDRESS

E. J. Stucki

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

39797

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bear Lake
City of ParisRegistration District No. 53

Primary Registration District No. _____

File No. 25

Registered No. _____

If death occurs away from
usual residence, give facts
called for under special
information.

2. FULL NAME

RECEIVED
NOV 18 1922
BUREAU OF VITAL STATISTICSDavid Nelson LowIf death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.Widowed
(Write the word.)

6. DATE OF BIRTH.

Dec 7 1858
(Month) (Day) (Year)

7. AGE

63 Yrs. 10 Mos. 27 ds.IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
(b) General nature of in-
dustry, business, or estab-
lishment in which employ-
ed (or employer)Salesman

9. BIRTHPLACE

(State or Country)

Scotland10. NAME OF
FATHERWilliam W. Low11. BIRTHPLACE
OF FATHER

(State or Country)

Scotland12. MAIDEN NAME
OF MOTHERHelen Budge13. BIRTHPLACE
OF MOTHER

(State or Country)

Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) X Morris D. Low(Address) Paris, Idaho

15.

Filed _____ 191 _____

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 3 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 25 1922 to Nov 3 1922
that I last saw him alive on Nov 3 1922and that death occurred on the date stated above, at 1.30 P.M.

The CAUSE OF DEATH* was as follows:

Cardio-Vascular-Renal
Disease(Duration) Yrs. 5 mos. _____ ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) G. D. Moore M. D.44 1922 (Address) Paris Idaho*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted
if not at place of death? _____Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Paris Nov 6 1922

20. UNDERTAKER

ADDRESS

Int Low Paris

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Bernwal Registration District No. 31
City of Hermat Primary Registration District No. 122
(No. 122 St.)

File No. 39798
Registered No. 23

If death occurs away from usual residence, give facts called for under special information.

DEATH CERTIFICATE

2. FULL NAME Mary Eugenie Janis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH July 4 1887
(Month) (Day) (Year)

7. AGE 65 Yrs. 4 Mos. 6 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Sister of Charity
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Unknown

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mary L. Beaz
(Address) Hermat, Idaho

15. Filed Nov. 11 1922 H. L. Bigham
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 10 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1922 to 1922
that I last saw her alive on Nov. 10 1922
and that death occurred on the date stated above, at 2 A. M.

The CAUSE OF DEATH* was as follows:
Accidental Runaway -
Fracture of skull

(Duration) 10 Yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Fred. J. Barbeau M. D.
11/11/1922 (Address) Hermat Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Hermat Ida DATE OF BURIAL 11/12/1922

20. UNDERTAKER J. Fabeur ADDRESS Hermat Ida

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 239799
Registered No. 24

1. PLACE OF DEATH

County of Bennett Registration District No. 31
Primary Registration District No. 2
City of Bennett St.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Maria Barker

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

7.

White

(Write the word.)

6. DATE OF BIRTH

Nov. 16 1922
(Month) (Day) (Year)

7. AGE

Two hours
Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Bennett, Ida

10. NAME OF FATHER

Frank Barker

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank Barker
(Address) Bennett, Idaho

15. Nov 17 1922 J. E. Bihan
Filed Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov. 16 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

.....19....., to19.....
that I last saw h..... alive on19.....
and that death occurred on the date stated above, atM.
The CAUSE OF DEATH* was as follows:

.....(Duration)Yrs.mos.ds.

Contributory
(Secondary)

.....(Duration)Yrs.mos.ds.

(Signed)M. D.

.....19..... (Address).....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.mos.days. In the State.....yrs.mos.days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Bennett Nov 17 1922

20. UNDERTAKER

ADDRESS

J. E. Bihan Bennett

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics1. PLACE OF DEATH *General* Registration District No. *32*
County of *Bernah* Primary Registration District No. *2049*
City of *St. Maries* (St.)File No. *39800*
Registered No. *52*

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME *George Albert Mc Cabe*

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *single*
(Write one word.)6. DATE OF BIRTH *May 17 1859*
(Month) (Day) (Year)7. AGE *63* Yrs. *5* Mos. *13* ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)*Logger*
*woodman*9. BIRTHPLACE *Ontario Canada*
(State or Country)10. NAME OF FATHER *James Mc Cabe*11. BIRTHPLACE OF FATHER *Canada*
(State or Country)12. MAIDEN NAME OF MOTHER *not known*13. BIRTHPLACE OF MOTHER *Ireland*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mrs. Elan Porter*
(Address) *St. Maries Ida*15. Filed *Nov. 1st 1922* *Smuggin*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *Oct 30 1922*
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *July 1922* to *Oct 30 1922*
that I last saw him alive on *Oct 29 1922*
and that death occurred on the date stated above, at *11:30 a.m.*

The CAUSE OF DEATH* was as follows:

Carcinoma of mouth(Duration) *6* Yrs. *6* mos. *6* ds.Contributory
(Secondary)(Duration) *6* yrs. *6* mos. *6* ds.(Signed) *St. Maries* M. D.1922 (Address) *St. Maries*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death *6* yrs. *6* mos. *6* days. In the State *6* yrs. *6* mos. *6* days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Woodlawn Catholic* DATE OF BURIAL *Nov 1st 1922*20. UNDERTAKER *Mitchell & Meraguer* ADDRESS *St. Maries Ida*

DECEASED CERTIFICATE OF DEATH

1. PLACE OF DEATH *St. Mary, Idaho*
 County of *Benedict* Registration District No. *32*
 City of *St. Mary, STATISTICS* Registration District No. *2147* St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Martha Jane Hill

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. *39801*
 Registered No. *3*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *female* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *married*
 (Write the word.)

6. DATE OF BIRTH *July 30 1878*
 (Month) (Day) (Year)

7. AGE *44 Yrs. 2 Mos. 18 ds.* IF LESS than 1 day
 how many..... hrs.
 or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE (State or Country) *Pittsburg Kansas*

10. NAME OF FATHER *John Robinett*

11. BIRTHPLACE OF FATHER (State or Country) *Don't Know*

12. MAIDEN NAME OF MOTHER *Don't Know*

13. BIRTHPLACE OF MOTHER (State or Country) *Don't Know*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Henry M. Hill*
 (Address) *St. Mary, Ida.*

15. Filed *Dec 20 1922* *C. J. Menger*
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct. 18 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Oct 17 1922* to *Oct 18 1922*
 that I last saw her alive on *Oct 18 1922*
 and that death occurred on the date stated above, at..... M.
 The CAUSE OF DEATH* was as follows:

Septicemia, probably due to Respiratory tract infection
 (Duration)..... Yrs..... mos. *5* ds.

Contributory (Secondary)

(Duration)..... yrs..... mos..... ds.
 (Signed) *H. Menger* M. D.
10/18 1922 (Address) *St. Mary, Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Benedict, Ida.* DATE OF BURIAL *Oct. 21 1922*

20. UNDERTAKER *Mitchell & Menger* ADDRESS *St. Mary, Ida.*

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39802**
Registered No. **54**

1. PLACE OF DEATH
County of **Burnham** Registration District No. **32**
City of **Santa** Primary Registration District No. **2049** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Elizabeth H. Renfro

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **widowed**
(Write the word.)

6. DATE OF BIRTH **April 13 1879**
(Month) (Day) (Year)

7. AGE **43** Yrs. **6** Mos. **3** ds. IF LESS than 1 day how many..... hrs. or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. **keeping house**
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE **Iowa**
(State or Country)

10. NAME OF FATHER **Elisha W. Nelson**

11. BIRTHPLACE OF FATHER **Ohio**
(State or Country)

12. MAIDEN NAME OF MOTHER **Anna Nelson**

13. BIRTHPLACE OF MOTHER **Sweden**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Lucy Renfro**
(Address) **Santa, Idaho**

15. Filed **Oct 19 1922** **O. G. Mearns**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **Oct 16 1922**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **1921** to **Oct 16 1922**
that I last saw him alive on **1922**
and that death occurred on the date stated above, at **7:30 A.M.**
The CAUSE OF DEATH* was as follows:

Diabetes mellitus

(Duration) **5** Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) **Edmund** M. D.

10/18/1922 (Address) **H. Mearns**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **Santa Cemetery** DATE OF BURIAL **10-19 1922**

20. UNDERTAKER **Mitchell & Mearns** ADDRESS **St. Maries, Ida.**

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1922

Local Registrar

CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

(St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

I HEREBY CERTIFY, That I attended deceased from
Oct 13th 1922, to Oct 15th 1922
that I last saw her alive on Oct 18th 1922
and that death occurred on the date stated above, at 1:30 P.M.
The CAUSE OF DEATH* was as follows:(Duration) Yrs. mos. 3 ds.
Contributory (Secondary) Abortion
Produced (Duration) yrs. mos. 7 ds.
(Signed) Owen O. Platt M. D.
@ 15th 1922 (Address) Anderson, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **99805**
Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Bennett
City of Romer StationRegistration District No. 32Primary Registration District No. 2049

Mile west Romer station

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Joe Augustine

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

not known
(Write the word.)

6. DATE OF BIRTH

871
(Month) (Day) (Year)

7. AGE

51

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Laborer

(b) General nature of industry, business or establishment in which employed (or employer)

Lumbering

9. BIRTHPLACE

(State or Country)

not known

10. NAME OF FATHER

not known

11. BIRTHPLACE OF FATHER

(State or Country)

not known

12. MAIDEN NAME OF MOTHER

not known

13. BIRTHPLACE OF MOTHER

(State or Country)

not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. J. Ross

(Address)

St. Marie, Ida.

15.

Filed

Oct 11

19

22Osmurgen

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Found dead Oct. 6, 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 6th 1922, to Oct 6th 1922
that I last saw him dead on Oct 6th 1922and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Back broken Lumber
regimen: Probable caused by
falling off moving train

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) H. K. Alcorn Coroner10/11 1922 (Address) St. Marie, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Woodlawn

DATE OF BURIAL

10-13 1922

20. UNDERTAKER

Mitchell & Mearns

ADDRESS

St. Marie, Ida.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39806**Registered No. **5**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of **Bennett**Registration District No. **32**City of **St. Maries**Primary Registration District No. **2049**No. **St. Maries Hospital** St.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **George Jones**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

divorced
(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

(Year)

7. AGE

52

Yrs.

Mos.

ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Pumper

(b) General nature of industry, business or establishment in which employed (or employer)

C.M. & St. P.

9. BIRTHPLACE

(State or Country)

Wisconsin

10. NAME OF FATHER

not known

11. BIRTHPLACE OF FATHER

(State or Country)

not known

12. MAIDEN NAME OF MOTHER

not known

13. BIRTHPLACE OF MOTHER

(State or Country)

not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

William Cummins

(Address)

St. Maries, Ida.

15.

Filed **Oct 10****1922****Quinn**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

October

(Month)

(Day)

8th 19**22** (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 7th 1922 to **October 8th 1922**that I last saw him alive on **October 8th 1922**and that death occurred on the date stated above, at **1:10 P.M.**

The CAUSE OF DEATH was as follows:

Diabetes MellitusContributory
(Secondary)**Came to Hospital in coma.**

(Duration)

Yrs.

mos.

ds.

(Signed)

C. A. Robinson, D.**10/8 1922** (Address) **St. Maries, Ida.**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos. **2** In the..... days..... State..... yrs..... mos..... daysWhere was disease contracted if not at place of death? **Unknown**

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Woodlawn

DATE OF BURIAL

10-10 1922

20. UNDERTAKER

Mitchell & McQuinn

ADDRESS

St. Maries, Ida.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

Registration District No.

Primary Registration District No.

St.)

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Signed)

Oct 7, 1922 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39808**
Registered No. **48**

1. PLACE OF DEATH

Registration District No. **32**
County of **Blaine** Primary Registration District No. **2049**
City of **St. Maries** (No. **St. Maries**) Hospital St.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Olle Sorlie

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **widowed**
(Write the word.)

6. DATE OF BIRTH

Apr. 25 1854
(Month) (Day) (Year)

7. AGE

68

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

Mill hand
Lumber mill

9. BIRTHPLACE

(State or Country)

Norway

10. NAME OF FATHER

not known

11. BIRTHPLACE OF FATHER

(State or Country)

Norway

12. MAIDEN NAME OF MOTHER

not known

13. BIRTHPLACE OF MOTHER

(State or Country)

Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Pete R. Linrud

(Address)

Fernwood Ida.

15.

Filed

Oct 8 1922

Deminger

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

October 5th 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Aug 21st 1922** to **Oct 5th 1922** that I last saw him alive on **Oct 5th 1922** and that death occurred on the date stated above, at **12:07** P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Liver

(Duration) **Unknown** mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

C. R. Robins M. D.
6/8 1922 (Address) **St. Maries, Ida.**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. **1** mos. **16** In the State **?** yrs. mos. days

Where was disease contracted if not at place of death? **Unknown**

Former or usual residence **Fernwood, Ida.**

19. PLACE OF BURIAL OR REMOVAL

Woodlawn

DATE OF BURIAL

10-8 1922

20. UNDERTAKER

Mitchell & Mager

ADDRESS

St. Maries

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bennett Registration District No. 32
City of St. Mari Primary Registration District No. 2047
(No. 11145)
St.)File No. 39802
Registered No. 47

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Arthur Neil Pierce

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDMale white X
(Write the word.)

6. DATE OF BIRTH

Sept 26 1922
(Month) (Day) (Year)

7. AGE

7 Yrs. 7 Mos. 7 ds.
IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. X
(b) General nature of industry, business or establishment in which employed (or employer) X

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Archie Aderile Pierce

11. BIRTHPLACE OF FATHER

(State or Country)

Washington

12. MAIDEN NAME OF MOTHER

Laura Ramsey
Ray Lake

13. BIRTHPLACE OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Archie A. Pierce(Address) St Mari Id

15.

Filed 10/3 1922 Osmerager

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 2 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept. 26 1922 to Oct. 2 1922that I last saw him alive on Sept. 28 1922and that death occurred on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Unknown(Duration) Yrs. mos. 6 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

O. P. Platt

M. D.

Oct 2 1922 (Address) St Mari, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Woodlawn

DATE OF BURIAL

10-4 1922

20. UNDERTAKER

Hutchell & Muray

ADDRESS

St Mari Id

1. PLACE OF DEATH

County of *Benevolence*
City of *St. Maries*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Van B. White

CERTIFICATE OF DEATH

Registration District No. *32*Primary Registration District No. *2049*(No. 118) *St. Maries Hospital* St.)State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *39810*Registered No. *187*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the words)

6. DATE OF BIRTH

(Month) *1* (Day) *8* (Year) *1860*

7. AGE

62 Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Teamster

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

not known

11. BIRTHPLACE OF FATHER

(State or Country)

not known

12. MAIDEN NAME OF MOTHER

not known

13. BIRTHPLACE OF MOTHER

(State or Country)

not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

George Bush

(Address)

St. Maries - Ida

15.

Filed

*10-3*19*22**Osmeray*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

October 1st 19*22*
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *Sept 16* 19*22*, to *Oct 1st* 19*22*that I last saw him alive on *Oct 1st* 19*22*, and that death occurred on the date stated above, at *6 A.M.*

The CAUSE OF DEATH* was as follows:

Compound fracture femur(Duration) Yrs. mos. *15* ds.Contributory
(Secondary)*Seizure*

(Duration) Yrs. mos. ds.

(Signed)

DeBourville

M. D.

(Address)

St. Maries

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. *16* days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Woodlawn Catholic

DATE OF BURIAL

19*22*

20. UNDERTAKER

Mitchell & Morgan

ADDRESS

St. Maries Ida

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 121County of BinghamPrimary Registration District No. 2194City of Blackfoot

(No. _____ St.)

File No. 39812Registered No. 168

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lorraine Sessions

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female4. COLOR OR RACE White5. SINGLE, MARRIED, WIDOWED OR DIVORCED Infant
(Write the word.)6. DATE OF BIRTH Nov. 18 1922
(Month) (Day) (Year)7. AGE 7 Mos. 17 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?8. OCCUPATION Infant

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE Bingham Co Idaho
(State or Country)10. NAME OF FATHER Arbia Sessions11. BIRTHPLACE OF FATHER Idaho
(State or Country)12. MAIDEN NAME OF MOTHER Violet Kilian13. BIRTHPLACE OF MOTHER Utah
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) L. Sessions(Address) Goshute, Idaho15. Filed Nov. 6 1922Mrs. Walter E. Peters
Local Registrar16. DATE OF DEATH Nov. 4 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Nov. 4 1922 to Nov. 4 1922, that I last saw her alive on Nov. 4 1922 and that death occurred on the date stated above, at 5:30 P.M.
The CAUSE OF DEATH* was as follows:
Cholera Infantum(Duration) _____ Yrs. _____ mos. _____ ds.
Contributory (Secondary) None

(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed) F. E. Peters M. D.Nov. 4 1922 (Address) Shelley, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ Yrs. _____ mos. _____ days. In the State _____ Yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Goshute, IdahoDATE OF BURIAL Nov 6 1922

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 39813
Registered No. 963

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Bingham
City of BlackfootRegistration District No. 121
Primary Registration District No. 107
(No. West Judicial St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Vern Thamer Larson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male White Single
(Write the word.)

6. DATE OF BIRTH

Nov. 16 1922
(Month) (Day) (Year)

7. AGE

X Yrs. X Mos. 12 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)none

9. BIRTHPLACE

(State or Country)

Blackfoot Idaho

10. NAME OF FATHER

Richard W Larson

11. BIRTHPLACE OF FATHER

(State or Country)

Wisconsin

12. MAIDEN NAME OF MOTHER

Edna Jones

13. BIRTHPLACE OF MOTHER

(State or Country)

Oklahoma

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs Edna Larson

(Address)

Blackfoot

15. Filled

Nov. 28 1922Mrs. Thamer Larson

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov. 27 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to Nov 26 1922
that I last saw him alive on Nov 26 1922and that death occurred on the date stated above, at 7:30 M.

The CAUSE OF DEATH* was as follows:

Premature birth

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. B. Davis

M. D.

11/28 1922 (Address) Blackfoot Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Grove City Cem,

DATE OF BURIAL

Nov 28 1922

20. UNDERTAKER

E. D. Egli

ADDRESS

Blackfoot

WRITE PLAINLY, WITH UNFADEING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bingham
City of Blackfoot

Registration District No. 121Primary Registration District No. 1007

(No. _____)

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Seefried

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 39814Registered No. 161

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

male white single
(Write the word.)

6. DATE OF BIRTH

nov 6 1922
(Month) (Day) (Year)

7. AGE

— Yrs. — Mos. — ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

none

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

John Seefried

11. BIRTHPLACE OF FATHER

(State or Country)

Russia

12. MAIDEN NAME OF MOTHER

Matilda Teckner

13. BIRTHPLACE OF MOTHER

(State or Country)

So Dak.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

John Seefried
Blackfoot, Idaho

15.

Filed

Nov-9

19

Matilda E. Teckner

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

nov 6 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

nov 6 1922 to nov 6 1922
that I last saw him alive on nov 6 1922
and that death occurred on the date stated above, at 6 p.m.

The CAUSE OF DEATH* was as follows:

Shangulation

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory (Secondary)

Birth presentation
suppuration

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

H. J. Simmons D.11/9 1922 (Address) Blackfoot, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Grove City Cem.11-9 1922

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of BinghamCity of Blackfoot

If death occurs away from usual residence, give facts called for under special information.

RECEIVED

DEC 8 1922

Registration District No. 121Primary Registration District No. 2194

(No.)

(St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 39815Registered No. 162

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Charles E. Adams

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

Caucasian5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDSingle
(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

1867
(Year)

7. AGE

55 Yrs.

Mos.

ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Unknown

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

+ Asylum Deprad
(Informant) Martha E. High - Bookkeeper(Address) Idaho Insane Asylum, Blackfoot

15.

Filed Nov. 22 19 22 Mrs Helen E. Paten

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

November 20 19 22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 6 19 20, to Nov. 20, 19 22.that I last saw him... alive on Nov. 20, 19 22.and that death occurred on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH* was as follows:

Exhaustion of Psychosis
Excite(Duration) 6 Yrs. 6 mos. 12 ds.Contributory (Secondary) Maniac Excite
Recurrent(Duration) 8 yrs. 8 mos. 14 ds.(Signed) W. J. Thompson M. D.12-21-1922 (Address) Blackfoot, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 2 yrs. 6 mos. 14 days. In the State 17 yrs. mos. daysWhere was disease contracted if not at place of death? UnknownFormer or usual residence Quincy, Idaho

19. PLACE OF BURIAL OR REMOVAL

Wetmore Kansas 19 22

20. UNDERTAKER

E. J. Ruck Blackfoot

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Bingham*
City of *Blackfoot*

Registration District No. *121*Primary Registration District No. *2194*

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Ida Pearl Kelley*File No. *39816*Registered No. *164*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

(Write the word.)

6. DATE OF BIRTH

May 31 1905
(Month) (Day) (Year)

7. AGE

17 Yrs. *5* Mos. *27* ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

School girl

9. BIRTHPLACE

(State or Country) *Idaho*

10. NAME OF FATHER

John E. Kelley

11. BIRTHPLACE OF FATHER

(State or Country) *Utah*

12. MAIDEN NAME OF MOTHER

Lena Gough

13. BIRTHPLACE OF MOTHER

(State or Country) *Utah*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

John E. Kelley
Blackfoot Idaho

15. FILED

*Nov 28 1922**Mrs Helen E. Palmer*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

10

16. DATE OF DEATH

Nov 27 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Oct 15 1922* to *Nov 27 1922*

that I last saw him alive on *Nov 27 1922*

and that death occurred on the date stated above, at *11 A.M.*

The CAUSE OF DEATH* was as follows:

Influenza
intestinal type

(Duration) Yrs. mos. *35* ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. B. Davis M. D.*11/28/1922* (Address) *Blackfoot Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Home City Cem. Blackfoot *Nov 29 1922*

20. UNDERTAKER

E. L. Egli

ADDRESS

Blackfoot

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 39817

Registered No. 169-

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

1. PLACE OF DEATH.

Registration District No. 121
County of Bingham
City of Blackfoot (No. No. E Main St.)
Primary Registration District No. 2194If death occurs away from
usual residence, give facts
called for under special
information.

2. FULL NAME

Mary Elizabeth Keeley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.Single
(Write the word.)

6. DATE OF BIRTH.

June 17 1903
(Month) (Day) (Year)

7. AGE

9 5 13
Yrs. Mos. ds.IF LESS than 1 day
how many.....hrs. or
.....min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.....
(b) General nature of in-
dustry, business, or estab-
lishment in which employ-
ed (or employer).....at home

9. BIRTHPLACE

(State or Country)

Blackfoot Ida10. NAME OF
FATHERJohn E. Keeley11. BIRTHPLACE
OF FATHER

(State or Country)

Utah12. MAIDEN NAME
OF MOTHERIra Gough13. BIRTHPLACE
OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

John E. Keeley
Blackfoot

15.

Filed

here - 1

1922

Mrs. Helen E. P.

Local Registrar

MEDICAL CERTIFICATE OF DEATH

10

16. DATE OF DEATH

Nov 30 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 20 1922 to Nov 30 1922that I last saw her alive on Nov 30 1922and that death occurred on the date stated above, at 7:40 P.M.

The CAUSE OF DEATH was as follows:

Influenza
Intestinal flu(Duration) Yrs. mos. 4/0 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) B. Davis M. D.1922 (Address) Blackfoot Ida*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted
if not at place of death?.....Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Blackfoot Ida12/3 1922

Local Registrar

ADDRESS

Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS
should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement
of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 121

County of Blaine

Primary Registration District No. 2194

City of Shelley

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Wayne Hyrum Adams

File No. 39818

Registered No. 986

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH 110

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Infant

(Write the word.)

6. DATE OF BIRTH

May

26

1922

(Month)

(Day)

(Year)

7. AGE

Yrs. 6 Mos. 20 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

Infant

9. BIRTHPLACE

(State or Country)

Jackson Wyoming

10. NAME OF FATHER

Joseph Adams Jr.

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Maude M. Brink

13. BIRTHPLACE OF MOTHER

(State or Country)

Hyrum Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. H. Adams, Shelley, Idaho

15.

Filed Dec. 1 1922

Local Registrar

16. DATE OF DEATH

Oct.

19

1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct. 8 1922 to Oct. 11 1922

that I last saw him alive on Oct. 19 1922

and that death occurred on the date stated above, at 10:30 A.M.

The CAUSE OF DEATH* was as follows:

Intestinal Intoxication

(Duration)

Yrs.

mos.

14 ds.

Contributory (Secondary)

Malnutrition

(Duration)

Yrs.

mos.

1 ds.

(Signed)

J. P. Egbert

M. D.

1922

(Address)

Shelley, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Shelley, Ida. 19

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 39810
Registered No. 167

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Bingham
City of ShelleyRegistration District No. 121
Primary Registration District No. 2194
(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Joe Harker

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH

Apr 1 1844
(Month) (Day) (Year)

7. AGE

78 Yrs. 7 Mos. 76 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min. 7

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)Farmer

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

Jos. Harker

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Susanna Smith

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Jos Harker
Shelley Ida15. Filed Dec. 1 1922 Mrs. Harker E. P. Harker
Local Registrar

16. DATE OF DEATH

Oct 27 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from May 4 1922 to Oct 27 1922 that I last saw him alive on Oct 26 1922 and that death occurred on the date stated above, at 8 A.M.
The CAUSE OF DEATH* was as follows:apoplexy(Duration) Yrs. 3 mos. 9 ds.Contributory (Secondary) Arterio Sclerosis(Duration) 3 yrs. 3 mos. 3 ds.(Signed) F. McVitt M. D.
10/28/22 (Address) Shelley Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Shelley, Ida DATE OF BURIAL 10/30 192220. UNDERTAKER W. H. Woodley ADDRESS Idaho FallsW. H. Woodley

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39820**
Registered No. **1285**

1. PLACE OF DEATH
County of Bingham Registration District No. 121
City of Blackfoot Registration District No. 2194 St.)
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME Robert H. Coule

RECEIVED
DEC 8 1922
BUREAU OF VITAL STATISTICS

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE Caucasian 5. SINGLE, MARRIED, WIDOWED OR DIVORCED widower
(Write the word.)
6. DATE OF BIRTH 1839
(Month) (Day) (Year)
7. AGE 83 Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?
8. OCCUPATION Leabrer
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).
9. BIRTHPLACE Illinois
(State or Country)
10. NAME OF FATHER ✓
11. BIRTHPLACE OF FATHER ✓
(State or Country)
12. MAIDEN NAME OF MOTHER ✓
13. BIRTHPLACE OF MOTHER ✓
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
according to anyone (Informant) Martha E. High-Bookman
(Address) Idaho Square, Blackfoot

15. Filed Nov. 11 1922 Wm. H. Allen E. Felt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 11 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 27 1922, to Nov. 11 1922
that I last saw him alive on Nov. 10 1922
and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:
Exhaustion of Senility

(Duration) Yrs. 2 mos. ds.
Contributory (Secondary) Senility with Epilepsy
(Duration) Yrs. 3 mos. ds.
(Signed) W. H. Allen M. D.
11-11-1922 (Address) Blackfoot, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. 9 mos. 15 days. In the State yrs. mos. days
Where was disease contracted if not at place of death? Unknown
Former or usual residence Pocatello, Idaho

19. PLACE OF BURIAL OR REMOVAL Pocatello Idaho DATE OF BURIAL _____
20. UNDERTAKER E. J. Reek ADDRESS Blackfoot

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bingham
City of BlackfootRegistration District No. 121
Primary Registration District No. 1007
(No. West Bridge St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Marion E JordanState of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 39821
Registered No. 169

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED divorced
(Write the word.)

6. DATE OF BIRTH

the 22 1870
(Month) (Day) (Year)

7. AGE

51 Yrs. 10 Mos. 22 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Laborer

9. BIRTHPLACE

(State or Country)

Ill

10. NAME OF FATHER

Wm F Jordan

11. BIRTHPLACE OF FATHER

(State or Country)

Maryland - USA

12. MAIDEN NAME OF MOTHER

Wenly A Winn

13. BIRTHPLACE OF MOTHER

(State or Country)

Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W E Jordan

(Address)

Blackfoot Ida

15.

Filed

Nov - 15 - 1922 Mrs Helen E. Patric

Local Registrar

16. DATE OF DEATH

Nov 14 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19..... to Nov 15 1922
that I last saw him alive on Nov 14 1922
and that death occurred on the date stated above, at 10⁴⁵ A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage - apoplexy following operation for relief of strangulated hernia(Duration) Yrs. mos. 7 ds.Contributory Right inguinal hernia
(Secondary)(Duration) yrs. 6 mos. ds.(Signed) W E Patric M. D.11/14 1922 (Address) Blackfoot Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos. 7 days. In the State..... yrs..... mos..... daysWhere was disease contracted if not at place of death? at ResidenceFormer or usual residence West Bridge St. Blackfoot Ida

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Inver City Can. 11-15-1922

20. UNDERTAKER

ADDRESS

E J Thurb Blackfoot
Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 121
County of Bingham Primary Registration District No. 1007
City of Blackfoot (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

File No. 39822
Registered No. 170

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Willard Walters

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDmale white Single
(Write the word.)

6. DATE OF BIRTH

Nov 14 1922
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Albert E. Walters

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Francis Steedman

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Albert E. Walters

(Address)

Blackfoot

15.

Filed

Nov. 14 1922Willard Walters

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 14 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 14 1922 to Nov 14 1922that I last saw him alive on Nov 14 1922and that death occurred on the date stated above, at 8 AM.

The CAUSE OF DEATH* was as follows:

Premature Birth
5 months

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

H. J. Linnemore M. D.Nov 14 1922 (Address) Blackfoot Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Blackfoot12-13-22

20. UNDERTAKER

ADDRESS

Albert E. Walters

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 121
County of Bingham Primary Registration District No. 2194
City of Blackfoot Ida (No. 3 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Phlegmonia
Helmine NielsenFile No. 39823Registered No. 171

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-OWED OR DIVORCED

Female White married (Write the word.)

6. DATE OF BIRTH

July 20 1855
(Month) (Day) (Year)

7. AGE

67 Yrs. 3 Mos. 27 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

House wife

9. BIRTHPLACE

(State or Country) Skelland Denmark

10. NAME OF FATHER

Andres Peterson

11. BIRTHPLACE OF FATHER

(State or Country) Skelland Denmark

12. MAIDEN NAME OF MOTHER

Margurite Peterson

13. BIRTHPLACE OF MOTHER

(State or Country) Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Margurite Peterson(Address) Blackfoot Ida Box 595Filed Nov 16 3 22 PM Walter E. Peterson

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

November 14 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 15 1922 to Nov 14 1922that I last saw her alive on Nov 1 1922and that death occurred on the date stated above, at 10:30 M.

The CAUSE OF DEATH* was as follows:

Myocarditis
(Duration) 1 Yrs. — mos. — ds.Contributory (Secondary) Mitral insufficiency with stenosis
(Duration) 20 yrs. — mos. — ds.(Signed) W. W. Beck M. D.11/17 1922 (Address) Blackfoot Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Edna Taylor (Finke) Nov 17 1922

20. UNDERTAKER ADDRESS

Amie C. Savage Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bingham
City of BlackfootRegistration District No. 121
Primary Registration District No. 1007
(No. Nash, Maple & Washington St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Maria BarnatState of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 39824
Registered No. 172

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH

Jan 26 1885
(Month) (Day) (Year)

7. AGE

37 Yrs. 9 Mos. 20 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Housewife

9. BIRTHPLACE

(State or Country)

Austria Hungary

10. NAME OF FATHER

Kaspar Blazek

11. BIRTHPLACE OF FATHER

(State or Country)

Austria Hungary

12. MAIDEN NAME OF MOTHER

Not Known

13. BIRTHPLACE OF MOTHER

(State or Country)

Austria Hungary

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

John Barnat
Blackfoot

15.

Filed

Nov 18 1922 W. A. E. Robert

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 16 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
Nov. 15 1922 to Nov. 16 1922
that I last saw her alive on Nov. 16 1922
and that death occurred on the date stated above, at 11 A.M.
The CAUSE OF DEATH* was as follows:Mitral Insufficiency
(Duration) 4 Yrs. — mos. — ds.Contributory
(Secondary)(Duration) yrs. mos. ds.
(Signed) F. W. Mitchell M. D.
11/17/1922 (Address) Blackfoot, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Green City Cemetery 19

20. UNDERTAKER

ADDRESS

Ed Park Blackfoot
Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bingham
City of BellevueRegistration District No. 121Primary Registration District No. 2194

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lester BeebeFile No. 39825Registered No. 173

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Sept 16
21922

(Month)

(Day)

(Year)

7. AGE

Yrs. 2Mos. 1ds. —

IF LESS than 1 day

how many _____ hrs.

or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. _____

(b) General nature of industry, business or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country) Bellevue RFD

10. NAME OF FATHER

Thomas Beebe

11. BIRTHPLACE OF FATHER

(State or Country) Missouri

12. MAIDEN NAME OF MOTHER

Laura Horvarton

13. BIRTHPLACE OF MOTHER

(State or Country) Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thomas Beebe(Address) Bellevue RFD 1

15. Filled

Nov 181922Mr. Helen E. Fawcett

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov1722

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 10 1922, to Nov 17 1922that I last saw him alive on 12 Nov 1922and that death occurred on the date stated above, at 4:30 AM.

The CAUSE OF DEATH* was as follows:

Malnutrition(Duration) Yrs. 2 mos. _____ ds.

Contributory (Secondary) _____

(Duration) yrs. _____ mos. _____ ds.

(Signed) J. B. Davis

M. D.

11/18 1922 (Address) Bellevue RFD

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

T. J. BeebeNov 19 1922

20. UNDERTAKER

ADDRESS

West Fifth Cemetery, Bellevue, Idaho

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Bingham
City of Blackfoot

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No. 127Primary Registration District No. 2194

(No. _____)

St. _____

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 39826Registered No. 174

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Nov. 18 1922M. H. H. Paton

Local Registrar

16. DATE OF DEATH

Nov. (Month) 17 (Day) 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov. 14 1922 to Nov. 17 1922that I last saw her alive on Nov. 14 1922and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia(Duration) _____ Yrs. _____ mos. 8 ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

F. W. Mitchell M. D.418 1922 (Address) Blackfoot Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Carey Idaho19

20. UNDERTAKER

ADDRESS

E. J. HuntBlackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bingham
City of Belfor RFD

Registration District No. 121

Primary Registration District No. 2194

(No.)

St.)

File No. 39827

Registered No. 1922

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Chester Beebe

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Sept 16 1922
(Month) (Day) (Year)

7. AGE

Yrs. 2 Mos. 2 ds. —

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Belfor RFD 1

10. NAME OF FATHER

Thomas Beebe

11. BIRTHPLACE OF FATHER

(State or Country)

Missouri

12. MAIDEN NAME OF MOTHER

Laura Howerton

13. BIRTHPLACE OF MOTHER

(State or Country)

Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Thos Beebe

(Address)

RFD 1 - Belfor Ida

15. Filed

Nov 18 1922 Mr. Halsey E. Pattee

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 18 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 10 1922 to Nov 18 1922

that I last saw him alive on Nov 12 1922

and that death occurred on the date stated above, at 1:30 A.M.

The CAUSE OF DEATH* was as follows:

Malnutrition

(Duration)

Yrs. 2 mos. 2 ds.

Contributory (Secondary)

(Duration)

yrs. mos. ds.

(Signed)

J. B. Deming M. D.

11/18 1922 (Address) Belfor Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

J. Beebe

Nov 19 1922

20. UNDERTAKER

ADDRESS

West Fork Cemetery West Fork Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 39828

Registered No. 176

1. PLACE OF DEATH

County of Bingham
City of BlackfootRegistration District No. 121
Primary Registration District No. 1007
(No. 302 Indian Maple St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Price Nelson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

Oct 19 1878
(Month) (Day) (Year)

7. AGE

44 Yrs. 1 Mos. 8 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

Carpenter
car repairer for
D & R Ry

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

J S Nelson

11. BIRTHPLACE OF FATHER

(State or Country)

Id

12. MAIDEN NAME OF MOTHER

Hannah J Tallen

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Jos S Nelson

(Address)

Blackfoot Idaho

15.

Filed Nov 28 1922 W H Nelson E. V. Talen

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 27 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 24 1922 to Nov 27 1922that I last saw him alive on Nov 26 1922and that death occurred on the date stated above, at 2:15 A.M.

The CAUSE OF DEATH* was as follows:

Edema lungs
from influenza(Duration) Yrs. 1 mos. 20 ds.
Contributory (Secondary) Subacute Bright's disease(Duration) Yrs. 6 mos. 6 ds.
(Signed) M. E. Putrie M. D.19 (Address) Blackfoot Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Blackfoot In the State Idaho yrs. 20 mos. 20 daysWhere was disease contracted if not at place of death? IdahoFormer or usual residence Idaho

19. PLACE OF BURIAL OR REMOVAL

Blackfoot Idaho

DATE OF BURIAL

Nov 29 1922

20. UNDERTAKER

E. Talen

ADDRESS

Blackfoot

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of *Boise*City of *Centerville*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William B. Wilson

CERTIFICATE OF DEATH

Registration District No. *12*Primary Registration District No. *12*

No.

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

39830

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

single

(Write the word.)

6. DATE OF BIRTH

unknown

(Month)

(Day)

(Year)

7. AGE

about 40

Yrs. Mos. ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

logger

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

William Wilson

11. BIRTHPLACE OF FATHER

(State or Country)

unknown

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

*Sept 30th 1922**Jess E. S. Robinson*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 10

(Month)

(Day)

1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19

to 19

that I last saw him alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

killed instantly by rolling log

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

M. D.

19

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Utah

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH *Home* NOV 18 1922
 County of *Boise* Registration District No. *12*
 City of *Boise* Registration District No. *12*
 (No. _____) (St. _____)

File No. *39831*
 Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Arem Woods

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Widowed*
 (Write the word.)

6. DATE OF BIRTH

July (Month) *1837* (Year)
 (Day) _____

7. AGE

85 Yrs. _____ Mos. _____ ds. _____
 IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work *farmer*
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) *Kansas*

10. NAME OF FATHER

Lucian Woods

11. BIRTHPLACE OF FATHER

(State or Country) *unknown*

12. MAIDEN NAME OF MOTHER

11

13. BIRTHPLACE OF MOTHER

(State or Country) *11*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(Address) _____

15. Filed *Nov 1* 19 *22* *Mrs E. S. Rohsen*
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 20 (Month) *22* (Day) *22* (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 19____, to _____ 19____,

that I last saw him alive on _____ 19____, and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

apoplexy. lived about 15 minutes
 (Duration) _____ Yrs. _____ mos. _____ ds.

Contributory (Secondary)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

_____ 19____ (Address) _____

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Home Shrub

DATE OF BURIAL

Oct 22 1922

20. UNDERTAKER

ADDRESS

FORM V. S. No. 5-25 M. 1-19.

NOV 18 1922

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Boise

City of Grove Garden Valley

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Billy Haynes

Registration District No. 12

Primary Registration District No. 12

(No. St.)

File No. 39832

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

(Write the word.)

6. DATE OF BIRTH

unknown

(Month) (Day) (Year)

7. AGE

about 45

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Trapper

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

unknown

10. NAME OF FATHER

"

11. BIRTHPLACE OF FATHER

(State or Country)

"

12. MAIDEN NAME OF MOTHER

"

13. BIRTHPLACE OF MOTHER

(State or Country)

"

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed Oct 15 1922

Mrs E J Robinson
Local Registrar

16. DATE OF DEATH

Sept 18th

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19

that I last saw him alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

found dead near road.
Heart failure cause.

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

19 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Garden Valley

DATE OF BURIAL

Sept 17 1922

20. UNDERTAKER

ADDRESS

RECEIVED

NOV 18 1922

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 39833

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No.

Primaries on District No.

(No.

St.)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

6. DATE OF BIRTH.

7. AGE

IF LESS than 1 day
how many.....hrs. or
.....min.2

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15.

Filed

Sept 30 1922

Mrs E S Korison

Local Registrar

16. DATE OF DEATH

(Month)

(Day)

1912 2.
(Year)17. I HEREBY CERTIFY, That I attended deceased from
Sept 23 1922, to Sept 23 1922.

that I last saw him alive on Sept 23 1922.

and that death occurred on the date stated above, at 11-30 P.M.

The CAUSE OF DEATH* was as follows:

Fell into shaft at
Quartzburg Idaho.
Cold still mine

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

M. D.

19..... (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death.....Yrs.....mos.....days

In the

State.....Yrs.....mos.....days

Where was disease contracted
if not at place of death?.....Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Boise Idaho.

Sept 26 1922

20. UNDERTAKER

ADDRESS

Sumner & McBo. Boise Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH

County of Boise Registration District No. 12
 City of Garden Valley Primary Registration District No. 12
 (State)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Henry Clark

CERTIFICATE OF DEATH

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 39834

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widowed
 (Write the word.)

6. DATE OF BIRTH May 1 1922
 (Month) (Day) (Year)

7. AGE 65 IF LESS than 1 day
 how many _____ hrs.
 or _____ min. ?
 _____ Yrs. _____ Mos. _____ ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

Jess Clark

11. BIRTHPLACE OF FATHER

(State or Country)

unknown

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15. Filed Oct 15 1922 Mrs E S Robinson
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 6 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 6 1922 to Sept 6 1922
 that I last saw him alive on Sept 6 1922

and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

fell from scaffold. lived about 4 hours.

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
 (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

M. D.

19. (Address) 99 Tully

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Garden Valley Sept 8 1922
 20. UNDERTAKER ADDRESS

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of BurseCity of LaramieRegistration District No. 12Registration District No. 12File No. 39835

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Herman Edger Ingers

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

65

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

farmer

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

unknown

11. BIRTHPLACE OF FATHER

(State or Country)

11

12. MAIDEN NAME OF MOTHER

11

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed Oct 25 1922

Mrs E S Rohson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 17
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 14 1922, to Sept 17 1922

that I last saw h. _____ alive on _____ 19 _____

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Bright's disease

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) G G Fitz M. D.

19 _____ (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Garden Valley

DATE OF BURIAL

Sept 19 22

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39836**
Registered No. _____

1. PLACE OF DEATH **DEC 4 1922** Registration District No. **76**
County of **Bonner** Primary Registration District No. **2155**
City of **Glenary** (St.) _____
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME **Ole Hanson**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Single**
(Write the word.)

6. DATE OF BIRTH **Unknown** 1873
(Month) (Day) (Year)

7. AGE **49** Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Norway

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

Norway

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Floyd G. Wendle

15.

Filed **Dec 4** 19 **22**

Local Registrar

Floyd G. Wendle

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov. 15 19 **22**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Did not attend 19

that I last saw him alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
(Diagnosis from information by
reliable neighbors

(Duration) Yrs. **6** mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

Floyd G. Wendle M. D.

11-17 1922

(Address)

Sandpoint Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Broten, Idaho

DATE OF BURIAL

10/17 1922

20. UNDERTAKER

Moore & Dale

ADDRESS

Sandpoint Idaho

By J. P. Moore

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 39837

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH. Registration District No. 76
County of Bonner (Primary Registration District No. 2155)
City of Sandpoint (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Unnamed. Aurand

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WID-OWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH Oct 17 1922 (Month) (Day) (Year)

7. AGE 3 mos IF LESS than 1 day how many hrs. or mins. yrs. mos. ds.

8. OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry business, or dtablissement in which employed (or employer)

9. BIRTHPLACE Idaho (State or Country)

10. NAME OF FATHER V. L. Aurand

11. BIRTHPLACE OF FATHER Ind. (State or Country)

12. MAIDEN NAME OF MOTHER Theodora Christensen

13. BIRTHPLACE OF MOTHER Wis (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) mother (Address)

15. Filed Dec 4 1922 Viola Allen Deputy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 17 1922 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-17 1922 to 10-17- 1922 that I last saw her alive on 10-17- 1922 and that death occurred on the date stated above, at 3:30 PM.

The CAUSE OF DEATH* was as follows: Premature birth - 5 mo

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) C. P. Stackhouse M. D. 11-3-1922 (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL Fossids Cemetery DATE OF BURIAL 10-17-1922

20. UNDERTAKER ADDRESS

CERTIFICATE OF DEATH

39838

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of **Bonner**City of **Priest River,**Registration District No. **85**Primary Registration District No. **2185**

(No.)

St.)

File No. **3**Registered No. **15**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Dollie Dorthy Daggett

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married

(Write the word.)

6. DATE OF BIRTH

Aug

(Month)

12

(Day)

1903

(Year)

7. AGE

19

Yrs.

2

Mos.

24

ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

W. Varg.

10. NAME OF FATHER

F.D. Holland.

11. BIRTHPLACE OF FATHER

(State or Country)

Va.

12. MAIDEN NAME OF MOTHER

Deviris Wilmoth

13. BIRTHPLACE OF MOTHER

(State or Country)

W.V.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

F.D. Holland

(Address)

324 Grand ave N. Portland

15.

Filed **Dec. 1 1922**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov.**5 1922****19**

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov. 2 1922 to **Nov 5 1922**that I last saw her alive on **Nov. 5 1922**and that death occurred on the date stated above, at **1.30 P.M.**

The CAUSE OF DEATH* was as follows:

Filvic abcess(Duration) Yrs. mos. **3** ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

E. P. Gist M. D.**Nov 6 1922** (Address) **Priest River,**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Priest River, Ida,

20. UNDERTAKER

Wm. Davis

DATE OF BURIAL

Nov 8 1922

ADDRESS

Newport

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Binner Registration District No. 85
 City of Priest River, (No. 1111 Registration District No. 2185) (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME L. Finnerty

CERTIFICATE OF DEATH

39839

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 3
Registered No. 71

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

White5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Single
(Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

50 Yrs. 0 Mos. 0 ds.

IF LESS than 1 day
how many 0 hrs.
or 0 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Lumberjack.

9. BIRTHPLACE

(State or Country) Not known

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

Not known

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Dec. 1 19 22 L. J. Gutz
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov. 19 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov. 17 1922, to Nov. 19 1922,
that I last saw him alive on Nov. 19 1922,
and that death occurred on the date stated above, at 11.30 A.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) 3 Yrs. 0 mos. 0 ds.

Contributory
(Secondary)

(Duration) 0 yrs. 0 mos. 0 ds.

(Signed)

M. D.

Nov. 19 1922 (Address) Priest River, Id.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 0 yrs. 0 mos. 0 days. In the State 0 yrs. 0 mos. 0 days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Newport Wash Nov 27 1922

20. UNDERTAKER

ADDRESS

Wendavis Newport Wash

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of BonnerCity of Priest RiverRegistration District No. 25Primary Registration District No. 2185

(No. St.)

File No. 39840

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elizabeth Martin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

F

4. COLOR OR RACE

White5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Widowed

(Write the word.)

6. DATE OF BIRTH

Aug 8 1842
(Month) (Day) (Year)

7. AGE

80

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Housekeeper

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Switzerland

10. NAME OF FATHER

John Messekli

11. BIRTHPLACE OF FATHER

(State or Country)

Switzerland

12. MAIDEN NAME OF MOTHER

Magdaline Andrist.

13. BIRTHPLACE OF MOTHER

(State or Country)

Switzerland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Dec. 1 1922

Local Registrar

16. DATE OF DEATH

Nov 26 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 24 1922 to Nov 26 1922
that I last saw her alive on Nov 25 1922and that death occurred on the date stated above, at 5 A. M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia(Duration) Yrs. mos. 4 ds.Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

M. D.

Nov 26 1922 (Address) Priest River, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bonnerville
 City of Idaho Falls

Registration District No. 73
 Primary Registration District No. 210-0
 (No. R7A #3 St.)

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 39841
 Registered No. 173

If death occurs away from usual residence, give facts called for under special information.

FULL NAME

William Edgar Curtis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED
 (Write the word.)

6. DATE OF BIRTH
November 5th 1922
 (Month) (Day) (Year)

7. AGE
 Yrs. 1 Mos. 1 ds.
 IF LESS than 1 day
 how many 1 hrs.
 or 1 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

Child.

9. BIRTHPLACE

(State or Country) Idaho Falls Ida P7A #3

10. NAME OF FATHER

Lester Curtis

11. BIRTHPLACE OF FATHER

(State or Country) Cachiballie Utah

12. MAIDEN NAME OF MOTHER

Emma Francis Kieffer

13. BIRTHPLACE OF MOTHER

(State or Country) Idaho Falls Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Father over telephone (J.M.)

(Address) Idaho Falls P7A #3 Idaho

15. Filed Dec 6 1922 W. E. Kieffer
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec. 4 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 5 1922 to Dec 4 1922
 that I last saw him alive on Dec 2 1922
 and that death occurred on the date stated above, at M.
 The CAUSE OF DEATH* was as follows:

Convulsions with
Bronchial Pneumonia.

(Duration) Yrs. 7 mos. 7 ds.
 Contributory (Secondary) Conjugal Orchitis

(Duration) yrs. 1 mos. 1 ds.
 (Signed) J. M. West M. D.
12/4 1922 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Idaho Falls Ida

DATE OF BURIAL

Dec 1 1922

20. UNDERTAKER

None

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 39842
Registered No. 39842

1. PLACE OF DEATH
County of Bonneville
City of Jarvin
Registration District No. 73
Primary Registration District No. 218-0
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James I Russell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH Nov 6 1856
(Month) (Day) (Year)

7. AGE 66 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION Farming
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE Scotland
(State or Country)

10. NAME OF FATHER James Russell

11. BIRTHPLACE OF FATHER Scotland
(State or Country)

12. MAIDEN NAME OF MOTHER Ann Adam

13. BIRTHPLACE OF MOTHER Scotland
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs J I Russell
(Address) Ida Falls

15. Filed 11/29 1922
Local Registrar

MEDICAL CERTIFICATE OF DEATH

96

16. DATE OF DEATH Nov 27 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 10 1922, to July 30 1922 that I last saw him alive on July 30 1922 and that death occurred on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH* was as follows:
asthma
(Duration) 2 Yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) J Rogers M.D.
11/29/22 (Address) Ida Falls, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence Ship

19. PLACE OF BURIAL OR REMOVAL Tooele, Utah
DATE OF BURIAL 11/29 1922

20. UNDERTAKER B B Murwood
ADDRESS Ida Falls

J Rogers

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No.

Primary Registration District No.

(No.)

(St.)

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED
(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

73

21470

39843

171

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov

19

1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 15

1922

to Oct 19

1922

that I last saw him alive on Oct 19 1922

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Hernia Plegia

(Duration)..... Yrs..... mos..... ds.

Contributory (Secondary)

Chronic nephritis

(Duration)..... Yrs..... mos..... ds.

(Signed)

D. Rogers DO

M. D.

11/24/22

(Address)

Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Meyan, Ida

11/27 1922

20. UNDERTAKER

ADDRESS

B. B. Woodward

Idaho Falls

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bonneville
City of Idaho Falls

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No. 73Primary Registration District No. 2100

(No. _____ St.)

Emmett Clyde WalkerState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 39844Registered No. 170

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Infant
(Write the word.)

6. DATE OF BIRTH

Sep 15 1922
(Month) (Day) (Year)

7. AGE

0 Yrs. 1 Mos. 9 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho Falls, Ida

10. NAME OF FATHER

Emmett C. Walker

11. BIRTHPLACE OF FATHER

(State or Country) Idaho

12. MAIDEN NAME OF MOTHER

Mary E Adams

13. BIRTHPLACE OF MOTHER

(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Emmett C. Walker(Address) Idaho Falls, Ida

15.

Filed 11/29 19 22 W. J. Walker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 24 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 22 19 22 to Nov 24 19 22
that I last saw him alive on Nov 24 19 22
and that death occurred on the date stated above, at 5:00 M.

The CAUSE OF DEATH* was as follows:

Pneumonia(Duration) 5 mos. 5 ds.Contributory
(Secondary)Measles, Respiratory(Duration) 1 yrs. 9 mos. 9 ds.

(Signed)

11/25/22 (Address) Idaho Falls M. D.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Idaho Falls, Ida

DATE OF BURIAL

11/26 19 22

20. UNDERTAKER

B. B. Woodward

ADDRESS

Idaho Falls

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bannock
City of Idaho Falls

Registration District No. 73

Primary Registration District No. 21V-0
(No. Spencer St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Minna F. Anderson

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 39845Registered No. 767

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

Oct 7 1901
(Month) (Day) (Year)

7. AGE

20 Yrs. 7 Mos. 1 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Housewife

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

Geo W French

11. BIRTHPLACE OF FATHER

(State or Country)

Iowa

12. MAIDEN NAME OF MOTHER

Francis A. Leustra

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa, Wise

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Harry Anderson

(Address)

Idaho Falls Ida.

15.

Filed

11/241922

Winnifred
Local Registrar

16. DATE OF DEATH

Nov 24 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov-22 1922 to Nov-24 1922
that I last saw him alive on Nov-23 1922
and that death occurred on the date stated above, at 4:30 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy
following misadventure

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. J. French M. D.Nov 27 1922 (Address) Idaho Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Idaho Falls Ida

DATE OF BURIAL

Nov 26 1922

20. UNDERTAKER

W. J. French

ADDRESS

Idaho Falls

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bonneville
City of Idaho FallsRegistration District No. 73
Primary Registration District No. 214-D
(No. Ridge ave St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Gregg AstorgasState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 39846
Registered No. 164

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE Brown 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH

June 5 1922
(Month) (Day) (Year)

7. AGE

2 Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. no.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Gregg Astorgas

11. BIRTHPLACE OF FATHER

(State or Country) Mexico

12. MAIDEN NAME OF MOTHER

Cena

13. BIRTHPLACE OF MOTHER

(State or Country) Colorado

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. G. S. Sampson(Address) Idaho Falls

15.

Filed 11/23 1922 Al Krum

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov. 8 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov. 6 1922 to Nov. 8 1922that I last saw him alive on Nov. 7 1922and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Pneumo-pneumonia(Duration) Yrs. 7 mos. ds.Contributory
(Secondary)(Duration) Yrs. mos. ds.(Signed) John O. Mellor M. D.19. (Address) Idaho Falls, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rose Hill Nov 10 1922

20. UNDERTAKER

ADDRESS

Chiff House Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39848**
Registered No. **166**

1. PLACE OF DEATH
County of **Bonneville** Registration District No. **73**
City of **Idaho Falls** Primary Registration District No. **214-0**
(No. **6 miles West Idaho Falls** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Becelia Jeanine Bertrand**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Single**
(Write the word.)

6. DATE OF BIRTH **May 3 1922**
(Month) (Day) (Year)

7. AGE **3** Yrs. **3** Mos. **3** ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION **no.**
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE **Idaho Falls**
(State or Country)

10. NAME OF FATHER **E. W. Bertrand**

11. BIRTHPLACE OF FATHER **Idaho**
(State or Country)

12. MAIDEN NAME OF MOTHER **Ellen Burk**

13. BIRTHPLACE OF MOTHER **Netrock**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) **E. W. Bertrand**
(Address) **New Sweden, Ida**

15. Filed **11/23** 19 **22** **W. J. Anderson**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **Aug 7 1922**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Aug 6-1922** to **Aug 7-1922** that I last saw her alive on **Aug 6-1922** and that death occurred on the date stated above, at **10:30 A.M.**
The CAUSE OF DEATH* was as follows:

Acute Gastro-intestinal Intoxication
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) **J. H. Halliburton, M. D.**
19. (Address) **Idaho Falls, Ida.**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **Rose Hill Cemetery** DATE OF BURIAL **Aug 8 1922**

20. UNDERTAKER **Chas. Hays** ADDRESS **Idaho Falls, Ida.**

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bonneville Registration District No. 73
 City of Idaho Falls Primary Registration District No. 2150
 (No. General Hosp St.)

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Gladys WoodsFile No. 39849Registered No. 164

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH

May 1 1898
(Month) (Day) (Year)

7. AGE

33

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

School Teacher

9. BIRTHPLACE

(State or Country)

Id.

10. NAME OF FATHER

Warr Woods

11. BIRTHPLACE OF FATHER

(State or Country)

Id.

12. MAIDEN NAME OF MOTHER

Ada Wright

13. BIRTHPLACE OF MOTHER

(State or Country)

Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mr. Warr Woods

(Address)

Idaho Falls Ida

15.

Filed

11/11

19

22

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 22 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Oct 21 1922 to Oct 21 1922
that I last saw him alive on Oct 21 1922
and that death occurred on the date stated above, at 1:45 PM,
The CAUSE OF DEATH* was as follows:

Paralysis Vaso Motor Centers

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

H. D. Williams

M. D.

Nov 1 1922 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Buried in cemetery

DATE OF BURIAL

Oct 26 1922

20. UNDERTAKER

Jeffrey

ADDRESS

Idaho Falls

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 39854
Registered No. 764

1. PLACE OF DEATH

County of Bonneville Registration District No. 73
City of Idaho Falls Primary Registration District No. 2140
(No. 2 Street St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Miss Agnes Harder

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widow
(Write the word.)

6. DATE OF BIRTH

Oct 19 1851
(Month) (Day) (Year)

7. AGE

71 Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

House wife

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Switzerland

10. NAME OF FATHER

Bempsee

11. BIRTHPLACE OF FATHER

(State or Country)

Switzerland

12. MAIDEN NAME OF MOTHER

Don't know

13. BIRTHPLACE OF MOTHER

(State or Country)

" "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Marie Messer

(Address)

Twinn Falls

15.

Filed 11/1519 22W. J. ...
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 21 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

.....19..... to19.....

that I last saw h..... alive on.....19.....

and that death occurred on the date stated above, at.....M.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Dr. J. H. ...

19

(Address)

Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Twinn FallsNov 22 1922

20. UNDERTAKER

ADDRESS

ChaffinIdaho Falls

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bonneville
 City of Idaho Falls

Registration District No. 73
 Primary Registration District No. 2140
 (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Thomas. Conan

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 39851
 Registered No. 13

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED single
 (Write the word.)

6. DATE OF BIRTH

Apr. 6, 1922
 (Month) (Day) (Year)

7. AGE

47 yrs. 13 mos. 3 days IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

none

9. BIRTHPLACE

(State or Country)

York Idaho.

10. NAME OF FATHER

Frank Conan

11. BIRTHPLACE OF FATHER

(State or Country)

S.D.

12. MAIDEN NAME OF MOTHER

Viola Wadsworth

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Frank Conan

(Address)

York. Idaho.

15.

Filed 11/14 19 22

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov. 9, 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 3, 1922 to Nov 9, 1922
 that I last saw him alive on Nov 5, 1922
 and that death occurred on the date stated above, at 9 M.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(Duration) Yes _____ mos. _____ ds.

Contributory (Secondary)

Impaction of Stomach

(Duration) Yes _____ mos. _____ ds.

(Signed)

J. J. Weeks M. D.

1922 (Address) Shelley Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Rose Hill Cemetery Nov 10, 1922

20. UNDERTAKER

Coffey ADDRESS Idaho Falls

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 73
County of Bonnerville Primary Registration District No. 214-0
City of Idaho Falls (No. _____) St. _____

File No. 39852Registered No. 162

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Agnes Johnson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX _____ 4. COLOR OR RACE _____ 5. SINGLE, MARRIED, WIDOWED OR DIVORCED _____

Female White Married (Write the word)

6. DATE OF BIRTH

July 12 1881
(Month) (Day) (Year)

7. AGE

41 Yrs. 2 Mos. 23 ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

House-Wife

9. BIRTHPLACE

(State or Country)

Michigan

10. NAME OF FATHER

Geo Rowley

11. BIRTHPLACE OF FATHER

(State or Country)

Michigan

12. MAIDEN NAME OF MOTHER

Dorith Knorr

13. BIRTHPLACE OF MOTHER

(State or Country)

Michigan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Laurence Johnson

(Address)

Henry, Idaho.

15.

Filed 11/20 1922 W. J. Quinn

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct. 6 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct. 4, 1922 to Oct. 6, 1922

that I last saw him alive on Oct. 6, 1922

and that death occurred on the date stated above, at 8:30 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) _____ Yrs. _____ mos. 4 ds.

Contributory
(Secondary)

Chronic Nephritis

(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed)

Jno. O. Miller M. D.

19

(Address)

Idaho Falls, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. 2 days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Henry, Ida

Former or

usual residence

Henry, Ida.

19. PLACE OF BURIAL OR REMOVAL

Pegby, Idaho

DATE OF BURIAL

10-8-1922

20. UNDERTAKER

E. D. Gillies

ADDRESS

Pegby, Ida.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 39853
Registered No. 161

1. PLACE OF DEATH FEEL Registration District No. 73
County of Bonneville Primary Registration District No. 21470
City of Leahurst (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Gaur Arthur Prestgard

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-OWED OR DIVORCED Infant
(Write the word.)

6. DATE OF BIRTH Nov 7 1922
(Month) (Day) (Year)

7. AGE 0 Yrs. 0 Mos. 13 ds. IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

J. A. Prestgard

11. BIRTHPLACE OF FATHER

(State or Country) Id

12. MAIDEN NAME OF MOTHER

Virgie Cassler

13. BIRTHPLACE OF MOTHER

(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. A. Prestgard
(Address) Id

15. Filed 11/20 1922 W. K. Kinnard
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 20 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 15 1922, to Nov 19 1922 that I last saw him alive on Nov 20 1922 and that death occurred on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:

Brachopneumonia

(Duration) _____ Yrs. _____ mos. 5 ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Geo. W. Applegate D. O.

19 _____ (Address) Idaho Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Idaho Falls

DATE OF BURIAL

11/21/1922

20. UNDERTAKER

W. B. Deenwoodley

ADDRESS

Idaho Falls

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of

City of

Registration District No.

Primary Registration District No.

(No.

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED
(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bonner Registration District No. 73
City of Leahurst Primary Registration District No. 214-0
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lester E. PetersenFile No. 39855
Registered No. 11-9

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Infant
(Write the word.)

6. DATE OF BIRTH

Oct 13 1922
(Month) (Day) (Year)

7. AGE

23
Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Edwin Petersen

11. BIRTHPLACE OF FATHER

(State or Country)

Wis.

12. MAIDEN NAME OF MOTHER

Valeria Reynolds

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

C. J. Reynolds
Idaho Falls

15.

Filed 11/12 19 22 C. J. Reynolds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 5 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19

that I last saw him alive on 19
and that death occurred on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:

no physician

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) C. J. Reynolds M. D.19 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Idaho Falls

DATE OF BURIAL

11-6-1922

20. UNDERTAKER

C. J. Reynolds

ADDRESS

Idaho Falls

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39856**
Registered No. **11/2**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of **Blaineville**
City of **Idaho Falls**Registration District No. **73**Primary Registration District No. **214-0**

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Hyrum Davidson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WID-OWED OR DIVORCED

Infant
(Write the word.)

6. DATE OF BIRTH

Sep 28 1922
(Month) (Day) (Year)

7. AGE

18 ds.
Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho Falls

10. NAME OF FATHER

A. L. Davidson

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Ely Pearce

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. L. Davidson
Idaho Falls

(Address)

15.

Filed

11/20

19

22**Utah**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 16 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from **Oct 11 1922** to **Oct 16 1922**
that I last saw her alive on **Oct 14 1922**
and that death occurred on the date stated above, at **11:30 P.M.**

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

10/18/22(Address) **Idaho Falls**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho Falls, Ida **10/18 1922**

20. UNDERTAKER

ADDRESS

B. B. Woodward **Idaho Falls**

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39857**
Registered No. **18-7**

1. PLACE OF DEATH

County of **Bannock**City of **Ucon**Registration District No. **73**Primary Registration District No. **215-0**

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Annie Kate Ritchie

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married

(Write the word.)

6. DATE OF BIRTH

Sep 17 1880
(Month) (Day) (Year)

7. AGE

47 0 27
Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

at home

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

Mark Jones

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Ellen Milton

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wm Ritchie

(Address)

Ucon, Ida

15.

Filed

11/21 1922**W. J. J. J.**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 12 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 1 1917 to **Oct 12 1922**

that I last saw him alive on **Oct 12 1922**

and that death occurred on the date stated above, at **6 A.M.**

The CAUSE OF DEATH* was as follows:

Chronic sub. cardiac

(Duration) **10** Yrs. mos. ds.
Contributory (Secondary) **Chronic nephritis**

(Duration) **Indefinite** Yrs. mos. ds.

(Signed) **John A. Keller** M. D.

10/12/22 (Address) **Idaho Falls**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Ucon, Ida

DATE OF BURIAL

10/15/22

20. UNDERTAKER

E. J. J. J.

ADDRESS

Idaho Falls

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
 County of Bannock
 City of Idaho Falls
 Registration District No. 73
 Primary Registration District No. 2150
 (No. St.)

File No. 39859
 Registered No. 7089

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Geo. C. Holland

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
 (Write the word.)

6. DATE OF BIRTH

Aug 16 1853
 (Month) (Day) (Year)

7. AGE

69 Yrs. 2 Mos. 2 ds.
 IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer)

none

9. BIRTHPLACE

(State or Country)

New York

10. NAME OF FATHER

Geo. Holland

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Katherine McDonald

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. C. J. Holland
 (Address) Swan Valley, Ida

15. Filed 11/21 1922 C. J. Holland
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 7 22
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 7 1922 to Nov 7 1922
 that I last saw him alive on Nov 7 1922
 and that death occurred on the date stated above, at 10.9 M.

The CAUSE OF DEATH* was as follows:

Acute Dilatation Heart

(Duration) Yrs. few hrs mos. 0 ds.

Contributory (Secondary) Pneumonia

(Duration) yrs. 5 mos. 5 ds.

(Signed) H. D. Miller M. D.

19. (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Idaho Falls DATE OF BURIAL 11 10 19 22

20. UNDERTAKER B. B. Woodward ADDRESS Idaho Falls

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock
City of Idaho FallsRegistration District No. 73Primary Registration District No. 21 V-0

(No. _____ St.)

File No. 39860Registered No. 1 V-4

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Margaret Irwin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH

May 11 1842
(Month) (Day) (Year)

7. AGE

80 Yrs. 5 Mos. 26 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).at Home

9. BIRTHPLACE

(State or Country)

Ireland

10. NAME OF FATHER

Chas. McCauley

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Jane Robinson

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ed Irwin

(Address)

City

15.

Filed 11/21 1922 Ed Irwin
Local Registrar

16. DATE OF DEATH

Nov 6 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Oct 28 1922 to Nov 6 1922that I last saw him alive on Nov 6 1922
and that death occurred on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:

Carcinoma (metastasis)
Stomach(Duration) 5 Yrs. mos. ds.Contributory
(Secondary)Same(Duration) yrs. mos. ds.

(Signed)

H. D. Jenkins M. D.11/9 1922 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Idaho Falls, Ida

DATE OF BURIAL

11-9 1922

20. UNDERTAKER

Ed Irwin

ADDRESS

Idaho FallsDr Jenkins

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bonneville
City of Idaho FallsRegistration District No. 73
Primary Registration District No. 210-0
(No. 3 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Eldon J LanderFile No. 39861
Registered No. 10-3

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

May 29 1908
(Month) (Day) (Year)

7. AGE

14 Yrs. 5 Mos. 10 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

A. J. Lander

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Ella C Cook

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. J. Lander
Idaho Falls

15.

Filed

11/211922C. E. Lander

Local Registrar

MEDICAL CERTIFICATE OF DEATH

9

16. DATE OF DEATH

Nov 8 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Nov 4 1922, to Nov 8 1922that I last saw him alive on Nov 7 1922, and that death occurred on the date stated above, at 12:30 M.

The CAUSE OF DEATH* was as follows:

Acute Noso-Tonsillo Diphtheria(Duration) Yrs. mos. 8 ds.

Contributory (Secondary)

Acute Nephritis(Duration) Yrs. mos. 4 ds.

(Signed)

J. J. Lander M. D.
11/8/22 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Payson, Ida

DATE OF BURIAL

11-9 1922

20. UNDERTAKER

C. E. Lander

ADDRESS

Idaho FallsSee Near

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39862**
Registered No. **111-2**

1. PLACE OF DEATH

County of **Bannock**
City of **Idaho Falls**

Registration District No. **73**
Primary Registration District No. **211-0**
(No. **73** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jona Belle Patten

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Infant**
(Write the word.)

6. DATE OF BIRTH **May 17 1922**
(Month) (Day) (Year)

7. AGE **0** Yrs. **5** Mos. **6** ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE **Butte, Mont**
(State or Country)

10. NAME OF FATHER **Harry C Patten**

11. BIRTHPLACE OF FATHER **Idaho**
(State or Country)

12. MAIDEN NAME OF MOTHER **Clair Campbell**

13. BIRTHPLACE OF MOTHER **Idaho**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) **Harry C. Patten**
(Address) **353 - 1st St City**

15. Filed **11/21** 19 **22**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

104

16. DATE OF DEATH

Oct 18 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Oct 14 1922**, to **Oct 18 1922**
that I last saw her alive on **Oct 18 1922**
and that death occurred on the date stated above, at **11 A.M.**
The CAUSE OF DEATH* was as follows:

Acute Dysentery

(Duration) Yrs. mos. ds.
Contributory (Secondary) **premature birth 7 1/2 months**
(Duration) Yrs. mos. ds.

(Signed) **W. H. Smith** M. D.
10/8 1922 (Address) **Idaho Falls, Ida**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. **4** days. In the State yrs. mos. days

Where was disease contracted if not at place of death? **Home**

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **Idaho Falls** DATE OF BURIAL **Oct 19 1922**

20. UNDERTAKER **B. L. Woodward** ADDRESS **Idaho Falls**

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39863**
Registered No. **15-1**

1. PLACE OF DEATH

County of **Bonneville**
City of **Idaho Falls**Registration District No. **73**
Primary Registration District No. **215-0**
(No. **Lincoln** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Chabey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **male** 4. COLOR OR RACE **Mexican** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Single**
(Write the word.)

6. DATE OF BIRTH

Aug 11 1924
(Month) (Day) (Year)

7. AGE

2 Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).**None**

9. BIRTHPLACE

(State or Country)

Idaho.

10. NAME OF FATHER

Antonio Chabey.

11. BIRTHPLACE OF FATHER

(State or Country)

Mexico.

12. MAIDEN NAME OF MOTHER

Conalia Portillo

13. BIRTHPLACE OF MOTHER

(State or Country)

Mexico

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

**John Chabey,
Lincoln Ida**

15.

Filed

Dec 2 1924

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 17 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19

that I last saw him alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Unknown, no medical attention

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. J. ...

M. D.

19

(Address)

Idaho Falls, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Lincoln Ida

DATE OF BURIAL

Oct 18 1924

20. UNDERTAKER

Cliff ...

ADDRESS

Idaho Falls

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

Registration District No.

Primary Registration District No.

(No.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

19

Local Registrar

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw h. alive on

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Signed)

19

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH, *Booneville*
County of *Booneville* Registration District No. *73*
City of *Idaho Falls, Ida.* (No. *See Hospital* St.)
Primary Registration District No. *21-1-0*

File No. *39865*
Registered No. *147*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Miss Bell Duncan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED *Married*
(Write the word.)

6. DATE OF BIRTH *Nov. 28, 1904*
(Month) (Day) (Year)

7. AGE *67* Yrs. Mos. ds. IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION *House wife.*
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE *Mo.*
(State or Country)

10. NAME OF FATHER *Davidson*

11. BIRTHPLACE OF FATHER *Mo.*
(State or Country)

12. MAIDEN NAME OF MOTHER *Donk know.*

13. BIRTHPLACE OF MOTHER *" "*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *Wm M. Duncan*
(Address) *Idaho Falls, Ida.*

15. Filed *Oct 1* 19 *22* *Wm M. Duncan*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *Oct 26, 1922*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Oct 16, 1922* to *Oct 16, 1922*
that I last saw h..... alive on..... 19.....
and that death occurred on the date stated above, at..... M.
The CAUSE OF DEATH* was as follows:

Bright's Disease
(Duration) *4* Yrs. mos. ds.
Contributory (Secondary).....
(Duration)..... yrs. mos. ds.
(Signed) *J. C. Deutz* M. D.
19..... (Address) *Idaho Falls, Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL *Booneville, Ida.* DATE OF BURIAL *Oct 27, 1922*
20. UNDERTAKER *Chaffin* ADDRESS *Idaho Falls*

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bonner
City of Idaho FallsRegistration District No. 73Primary Registration District No. 214-0(No. 5th St. St.)File No. 39866Registered No. 147

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Fern Yeager

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WID-OWED OR DIVORCED

single
(Write the word.)

6. DATE OF BIRTH

Nov. 9 1922
(Month) (Day) (Year)

7. AGE

1 Yrs. 11 Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

no.

9. BIRTHPLACE

(State or Country)

Victor Idaho.

10. NAME OF FATHER

Carl Yeager

11. BIRTHPLACE OF FATHER

(State or Country)

Winn.

12. MAIDEN NAME OF MOTHER

Agnes Lewis

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Carl Yeager

(Address)

Idaho Falls, Ida.

15.

Filed

Nov 1 19 22 W. F. Yeager

Local Registrar

16. DATE OF DEATH

Oct 30 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from 10/30 1922 to 10/30 1922that I last saw her alive on 10/30/22 19and that death occurred on the date stated above, at 5:30 P. M.

The CAUSE OF DEATH* was as follows:

Leukemia(Duration) Yrs. mos. ds.Contributory
(Secondary)(Duration) Yrs. mos. ds.

(Signed)

J. A. Hallister

I. M. D.

19. (Address)

Idaho Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Rose Tree Cemetery

DATE OF BURIAL

Nov 7 1922

20. UNDERTAKER

Chaffin

ADDRESS

Idaho Falls

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bonneville
City of Ida FallsRegistration District No. 73
Primary Registration District No. 2140
(No. _____ St.)File No. 39867
Registered No. 176

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Vernal James Quinton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Child
(Write the word.)

6. DATE OF BIRTH

Nov 14 1918
(Month) (Day) (Year)

7. AGE

3 Yrs. 9 Mos. 13 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Jessie L Quinton

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Minnie Merrall

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

James Quinton
Rt 5 Oriskany

15.

Filed

Oct 24 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 27 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug. 27, 1922 to Aug. 27, 1922
that I last saw him alive on Aug. 27 1922
and that death occurred on the date stated above, at 100 P M.

The CAUSE OF DEATH* was as follows:

Spinal Meningitis(Duration) _____ Yrs. _____ mos. 3 ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

John C. Mullan M. D.
Ida Falls
19 _____ (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Taylor, Ida

DATE OF BURIAL

Oct 29 1922

20. UNDERTAKER

ADDRESS

H. J. HayesIda Falls

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bainewell
City of Idaho FallsRegistration District No. 73
Primary Registration District No. 214-0
(No. _____) (St. _____)File No. 39868
Registered No. 141

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Frederick E. Reutschler

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)6. DATE OF BIRTH ?
(Month) (Day) (Year)7. AGE about 50 yrs
Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Indiana

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) B. E. Greenwood(Address) Idaho Falls15. Filed Oct 24 1922Local Registrar W. E. Greenwood

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 17 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 19____ to 19____

that I last saw him alive on 19____

and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Aortic insufficiency.
Died suddenly while at work
(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed)

B. E. Greenwood
10/19/22 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Idaho Falls

DATE OF BURIAL

10/19/22

20. UNDERTAKER

B. E. Greenwood Idaho Falls

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 39869
Registered No. 144

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of BannockCity of Idaho FallsRegistration District No. 73Primary Registration District No. 2100(No. 10 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jacob Godfrey Klingler

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

March 22 1889
(Month) (Day) (Year)

7. AGE

63 Yrs. 6 Mos. 17 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Farming

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

Fredrick Klingler

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

?

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. Klingler(Address) Preston, Ida

15.

Filed Oct 28 19 22Local Registrar W. J. Jenkins

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 9 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That attended deceased from

Sept 18 32 to Oct 9 22
that I last saw him alive on 9 Oct. 1922
and that death occurred on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Toxemia Vaso Motor Centers

(Duration) Yrs. Mos. ds.

Contributory (Secondary)

Carcinoma Liver

(Duration) Yrs. Mos. ds.

(Signed)

H. D. Jenkins M. D.19. (Address) Idaho Falls, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rexburg, Ida10/12/1922

20. UNDERTAKER

ADDRESS

B. B. DeenwooleyIdaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 39870

Registered No. 173

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

1. PLACE OF DEATH

County of Counseville
City of Ida FallsRegistration District No. 73
Primary Registration District No. 214-0
(No. _____, _____ St.)If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

George James Marler

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Child
(Write the word.)

6. DATE OF BIRTH

Oct 25 1912
(Month) (Day) (Year)

7. AGE

10 Yrs. 0 Mos. 3 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer).

9. BIRTHPLACE

(State or Country)

Canada10. NAME OF
FATHERJm Marler11. BIRTHPLACE
OF FATHER

(State or Country)

Utah12. MAIDEN NAME
OF MOTHERMary J King13. BIRTHPLACE
OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. L. Marler

(Address)

Sugar City, Ida

15.

Filed

Oct 20 1912

19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 28 1912
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 13 1912 to Oct 27 1912that I last saw him alive on Oct 27 1912and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH was as follows:

Acute faul obstructionoperation

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Thos A Ellison M. D.10/29/12 (Address) Sugar City*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sugar City, Ida10/29/12

20. UNDERTAKER

ADDRESS

Edmund Woodley Ida Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH
in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bonanza
 City of Shelby

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 73Primary Registration District No. 214-0

(No. _____ St.)

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 39871Registered No. 142

2. FULL NAME

Sylvia A. Chamberlain

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Child
(Write the word.)

6. DATE OF BIRTH

July (Month) 5 (Day) 1920 (Year)

7. AGE

2 Yrs. 3 Mos. 23 ds.

IF LESS than 1 day
 how many _____ hrs.
 or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Subais, Ida

10. NAME OF FATHER

A. S. Chamberlain

11. BIRTHPLACE OF FATHER

(State or Country) Ida

12. MAIDEN NAME OF MOTHER

Harriet Jensen

13. BIRTHPLACE OF MOTHER

(State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. S. Chamberlain(Address) Subais, Ida

15. Filed

Oct 26 19 22 Idaho

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 78 (Month) 22 (Day) 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 22 1922 to Oct 28 1922
 that I last saw h. alive on Oct 28 1922
 and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Suppurative Appendicitis(Duration) _____ Yrs. 10 mos. 10 ds.

Contributory (Secondary)

(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed) A. S. Chamberlain

M. D.

1922 (Address) Idaho Falls, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Subais, Ida

DATE OF BURIAL

10/30/1922

20. UNDERTAKER

B. B. Woodward

ADDRESS

Idaho FallsA. S. Chamberlain

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bonmerice
City of Leeds FerryRegistration District No. 73
Primary Registration District No. 215-0
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant GarryState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 39877
Registered No. 104

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE Mexican 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH

May 7 1922
(Month) (Day) (Year)

7. AGE

7 Yrs. 4 Mos. ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work None
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Arum

10. NAME OF FATHER

Antonio Garry

11. BIRTHPLACE OF FATHER

(State or Country) Mexico

12. MAIDEN NAME OF MOTHER

?

13. BIRTHPLACE OF MOTHER

(State or Country) Mexican

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. J. Porter(Address) Arum Leeds Ferry

15. Filed

Oct 17 1922 Leeds Ferry
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 17 17 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 17 1922, to Oct 17 1922
that I last saw him alive on Oct 17 1922
and that death occurred on the date stated above, at 42 M.

The CAUSE OF DEATH* was as follows:

Leads to death(Duration) Yrs. 1 mos. 4 ds.Contributory
(Secondary)Duration Yrs. 1 mos. 4 ds.(Signed) Garry

M. D.

Oct 17 1922 (Address) Leeds Ferry

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. 1 mos. 4 days. In the State Yrs. 1 mos. 4 days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Leeds Ferry

DATE OF BURIAL

Oct 17 1922

20. UNDERTAKER

Leeds Ferry

ADDRESS

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bonanza
 City of Idaho Falls

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 73
 Primary Registration District No. 214-6
 (No. Livingston St.)

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 39873
 Registered No. 146

2. FULL NAME

Romantic Leroy Giachitta

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
 (Write the word.)

6. DATE OF BIRTH

Aug 10 1922
 (Month) (Day) (Year)

7. AGE

Yrs. 1 Mos. 27 ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

no

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Romantic Giachitta

11. BIRTHPLACE OF FATHER

(State or Country) Italy

12. MAIDEN NAME OF MOTHER

Rita Caldwell

13. BIRTHPLACE OF MOTHER

(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Romantic Giachitta
 (Address) Idaho Falls Ida

15. Filed Oct 12 19 22 Livingston
 Local Registrar

16. DATE OF DEATH

Oct 5 19 22
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 4 19 22 to Oct 5 19 22
 that I last saw him alive on Oct 4 19 22
 and that death occurred on the date stated above, at 3 A.M.
 The CAUSE OF DEATH* was as follows:

Intestinal Influenza
 (Duration) 5 yrs. 5 mos. 5 ds.
 Contributory (Secondary) same
 (Duration) 5 yrs. 5 mos. 5 ds.
 (Signed) H. D. Walker M. D.
OCT 9 1922 (Address) Idaho Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Rose Hill

DATE OF BURIAL

Oct 10 19 22

20. UNDERTAKER

Cliff Hayre

ADDRESS

Idaho Falls Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bonneville
City of Idaho FallsRegistration District No. 73
Primary Registration District No. 21
(No. Peoples Hosp. St.)File No. 39874Registered No. 139

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Harold Wayne Seoville

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

single
(Write the word.)

6. DATE OF BIRTH

Jan 10 1922
(Month) (Day) (Year)

7. AGE

8 Yrs. 23 Mos. 23 ds.

IF LESS than 1 day

how many hrs.or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho Falls Ida.

10. NAME OF FATHER

Leon A Seoville

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Edith Annsworth

13. BIRTHPLACE OF MOTHER

(State or Country)

mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Leon A Seoville

(Address)

Idaho Falls Ida.

15.

Filed

Oct 10 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 3 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 26 1922 to Oct 3 1922
that I last saw him alive on Oct 3 1922
and that death occurred on the date stated above, at 9:30 AM.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia(Duration) Yrs. 2 mos. 2 ds.

Contributory (Secondary)

St. Petis.(Duration) yrs. 19 mos. 19 ds.

(Signed)

Jabez W. M. D.
Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. 19 mos. 19 days. In the State yrs. 19 mos. 19 days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rose Hill Idaho FallsOct 5 1922

20. UNDERTAKER

ADDRESS

ChaffinIdaho Falls Ida.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39875**
Registered No. **138**

1. PLACE OF DEATH

County of **Blaine**
City of **Idaho Falls**

Registration District No. **73**
Primary Registration District No. **21-0**
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Raymond William

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Child

(Write the word.)

6. DATE OF BIRTH

Nov 14 1919
(Month) (Day) (Year)

7. AGE

2 Yrs. 11 Mos. ds.

IF LESS than 1 day
how many hrs.
or min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Spencer William

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Etta Olsen

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Spencer William
Idaho Falls, Idaho

15.

Filed **Oct 6 1922** **W. W. Williams**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 11 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct. 11, 1922 to **Oct. 4, 1922**
that I last saw him alive on **Oct. 4, 1922**
and that death occurred on the date stated above, at **5 P.** M.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(Duration) Yrs. mos. **21** ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) **Wm. O. Miller** M. D.

15 (Address) **Idaho Falls, Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. Yrs. mos. days. In the State. Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Shelley, Idaho

DATE OF BURIAL

10/6 1922

20. UNDERTAKER

G. E. Woodward

ADDRESS

Idaho Falls

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County Bannock
City of Sea Falls

Registration District No. 73
Primary Registration District No. 21V-0
(No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Olga Maxine Smith

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 39876
Registered No. 137

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Infant
(Write the word.)

6. DATE OF BIRTH

Nov 74 1921
(Month) (Day) (Year)

7. AGE

0 Yrs. 11 Mos. 20 ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Jess B. Smith

11. BIRTHPLACE OF FATHER

(State or Country)

Va

12. MAIDEN NAME OF MOTHER

Ethel Walker

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Jess B. Smith
Idaho Falls

15.

Filed

11/22 1922 W. H. H. H.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 14 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 10, 1922 to Nov. 14, 1922

that I last saw him alive on Nov. 14, 1922
and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Dis-eases

(Duration) _____ Yrs. _____ mos. 14 ds.

Contributory
(Secondary)

(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed) John O. Mellar M. D.

11/16 1922 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Bassett, Ida

DATE OF BURIAL

11-17-22

20. UNDERTAKER

W. H. H. H.

ADDRESS

Idaho Falls

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bonnerville
City of Idaho FallsRegistration District No. 73
Primary Registration District No. 214-0
(No. General Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Harold L. ThompsonState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 39872Registered No. 144

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH

Dec. 24 1890
(Month) (Day) (Year)

7. AGE

37 yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)House wife

9. BIRTHPLACE

(State or Country)

Andrews Ind.

10. NAME OF FATHER

Wm. Brown

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Fannie Lowry

13. BIRTHPLACE OF MOTHER

(State or Country)

Ind.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

R. C. Thompson

(Address)

Ashton Idaho

15.

Filed

Dr. J.1922Wm. L. Thompson

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct. 15 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Oct 10 1922 to Oct 15 1922

that I last saw him alive on _____ 19____

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Acute Cholecystitis

(Duration) Yrs. mos. ds.

Contributory
(Secondary)Pericarditis

(Duration) yrs. mos. ds.

(Signed)

Wm. L. Thompson M. D.19____ (Address) Ashton Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Ashton Idaho

DATE OF BURIAL

Oct. 1922

20. UNDERTAKER

C. J. Hays

ADDRESS

Idaho Falls

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

RECEIVED

Registration District No. 73

County of Bonneville

Primary Registration District No. 214-0

City of Lincoln

St.)

File No. 39878

Registered No. 736

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lloyd J. Prestwich Jr.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male

White

Child
(Write the word.)

6. DATE OF BIRTH

Apr 26

1920

(Month)

(Day)

(Year)

7. AGE

Yrs.

4

Mos.

38

ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Lloyd Prestwich

11. BIRTHPLACE OF FATHER

(State or Country)

Lehi, Utah

12. MAIDEN NAME OF MOTHER

Josephine Barlow

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Lloyd Prestwich

(Address)

Idaho Falls

15.

Filed

Oct 4 1922

L. E. Kenna

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 21

1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19..... to 19.....

that I last saw him alive on 19.....

and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

B. E. Hummwood

9-22-22 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho Falls

9-24-22

20. UNDERTAKER

ADDRESS

B. E. Hummwood Idaho Falls

1. PLACE OF DEATH

County of Bannock Registration District No. 73
 City of Idaho Falls Primary Registration District No. 214-0
 (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

James H Jordan

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 39879
Registered No. 13V-

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
 (Write the word.)

6. DATE OF BIRTH Nov 12 1863
 (Month) (Day) (Year)

7. AGE 58 Yrs. 9 Mos. 10 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

Farming

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Joseph Jordan

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Jane Murdock

13. BIRTHPLACE OF MOTHER

(State or Country)

Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Idaho Falls

15. Filed Oct 4 19 22 W. H. Hatch
 Local Registrar

16. DATE OF DEATH

Sept 18 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 14, 1922 to Sept 18, 1922
 that I last saw him alive on Sept 18, 1922
 and that death occurred on the date stated above, at 8:30 P. M.

The CAUSE OF DEATH* was as follows:

Following Operation for Obstruction of bowel 4 days after operation for acute emphysema of gall bladder
 (Duration) Yrs. mos. 4 ds.

Contributory (Secondary)

Gall Stones

(Duration) Yrs. mos. ds.

(Signed)

W. H. Hatch M. D.
Idaho Falls (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho Falls, Ida 9-24 1922

20. UNDERTAKER

ADDRESS

B. B. Woodward Idaho Falls

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bannock
City of Idaho

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 73Primary Registration District No. 214-0RECEIVED
NOV 18 1922
BUREAU OF VITAL STATISTICSState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 39880
Registered No. 133

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jenna Rounds

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Child
(Write the word.)

6. DATE OF BIRTH

Dec 17 1920
(Month) (Day) (Year)

7. AGE

1 Yrs. 8 Mos. 26 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

A. E. Rounds

11. BIRTHPLACE OF FATHER

(State or Country) Utah

12. MAIDEN NAME OF MOTHER

Blanch O Lewis

13. BIRTHPLACE OF MOTHER

(State or Country) Australia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. E. Rounds(Address) Jenna, Ida

15.

Filed Oct 4 1922 W. E. Rounds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 17 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from 2 did not see child 1922that I last saw h. _____ alive on _____ 1922
and that death occurred on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:

acute enteritis
(Summer diarrhoea)(Duration) _____ Yrs. _____ mos. 7 ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) H. R. Hatch M. D.1922 (Address) Idaho fall.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Jenna, Ida

DATE OF BURIAL

9-14-1922

20. UNDERTAKER

W. E. Rounds

ADDRESS

Idaho fall.H. R. Hatch.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No.

Primary Registration District No.

St.)

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many.....hrs.
or.....min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work.
-
- (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

19.22

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

June 23 1922, to Aug 28 1922
that I last saw her alive on Aug 22 1922
and that death occurred on the date stated above, at 6:30 A.M.

The CAUSE OF DEATH* was as follows:

(Duration) Yrs. mos. ds.

Contributory (Secondary) Pneumonia infection

(Duration) yrs. mos. ds.

(Signed) W. J. Primrose M. D.

8/28/22 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39882**
Registered No. **131**

1. PLACE OF DEATH **RECEIVED**
County of **Bonner** Registration District No. **73**
City of **Idaho Falls** Primary Registration District No. **2156**
St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Bernice Jones

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED
(Write the word.)

6. DATE OF BIRTH

Aug 19 1922
(Month) (Day) (Year)

7. AGE

1 Yrs. **1** Mos. **ds.**

IF LESS than 1 day
how many.....hrs.
or.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

no,

9. BIRTHPLACE

(State or Country)

Idaho Falls,

10. NAME OF FATHER

Bernie Jones

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho.

12. MAIDEN NAME OF MOTHER

Hannah Johnson.

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho,

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Bernie Jones
Idaho Falls

15.

Filed

Sept 22 1922
W. J. Kimball
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 18 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Sept 11 1922** to **Sept 18 1922** that I last saw him alive on **17th Sept 1922** and that death occurred on the date stated above, at **8 9** M.

The CAUSE OF DEATH* was as follows:

fleo-colic

(Duration) Yrs. mos. **7** ds.

Contributory (Secondary)

Same

(Duration) yrs. mos. ds.

(Signed)

H. D. Kimball M. D.
Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rose Jean Paulson
Idaho Falls
Sept 19 1922

20. UNDERTAKER

ADDRESS

Chas. Hays
Idaho Falls

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39885**
Registered No. **130**

1. PLACE OF DEATH

Registration District No. **73**
County of **Bonneville** Primary Registration District No. **214**
City of **Idaho Falls Boulevard** St.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John P. Lloyd

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **male** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Single**
(Write the word.)

6. DATE OF BIRTH

March 12 1870
(Month) (Day) (Year)

7. AGE

52 Yrs. **5** Mos. **8** ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

Miner (Laborer)

9. BIRTHPLACE

(State or Country)

Nevada

10. NAME OF FATHER

Michael Lloyd

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Lizabeth X wife

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **John P. Lloyd**
(Address) **Idaho Falls, Idaho**

15. Filed **Sept 24 1922**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 20 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **May 29 1922** to **July 28 1922**
that I last saw him alive on **Early part of Aug 22**
and that death occurred on the date stated above, at **8:00** M.

The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage

(Duration) **few minutes** yrs. mos. ds.

Contributory (Secondary) **Pulmonary T.B.**

(Duration) **2 yrs.** yrs. mos. ds.

(Signed) **H. D. Miller** M. D.

19. (Address) **Idaho Falls, Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Rose Hill Cemetery

DATE OF BURIAL

Aug 23 1922

20. UNDERTAKER

W. H. Hayes

ADDRESS

Idaho Falls, Idaho

RECEIVED
NOV 18 1922

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 39884
Registered No. 129

1. PLACE OF DEATH

County of

City of

Registration District No.

Primary Registration District No.

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Signed)

M. D.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bonneville Registration District No. 73
 City of Idaho Falls Primary Registration District No. 210
 (No. Spencer Idaho St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Aale Engberson

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 39885
 Registered No. 122

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

(Write the word.)

6. DATE OF BIRTH

Feb. 5 1908
 (Month) (Day) (Year)

7. AGE

14 Yrs. Mos. ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

School boy,

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Swan Valley, Ida.

10. NAME OF FATHER

Merian Engberson

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Rosetta Burns

13. BIRTHPLACE OF MOTHER

(State or Country)

Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Helen Engberson

(Address)

Idaho Falls

15.

Filed

Sept 24 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 12 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 11 1922 to Sept 12 1922that I last saw him alive on Sept 12 1922and that death occurred on the date stated above, at 79 M.

The CAUSE OF DEATH* was as follows:

Accidental. Kicked by horse, fracturing skull

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed)

H. Engberson M. D.Idaho Falls, Ida. (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Rosetta Burns

20. UNDERTAKER

Idaho Falls

ADDRESS

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bonneville Registration District No. 73
 City of Idaho Falls Primary Registration District No. 214-D
 (No. 17-24 & Emerson, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

BUREAU OF VITAL STATISTICS

Lucy Lifefield

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 39886

Registered No. 127

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

(Write the word.)

6. DATE OF BIRTH

May 14 1900
 (Month) (Day) (Year)

7. AGE

16

Yrs. Mos. ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

School Girl

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Fairview Idaho

10. NAME OF FATHER

John Lifefield

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Lucy Hardy

13. BIRTHPLACE OF MOTHER

(State or Country)

Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

C. E. Underwood

(Address)

Idaho Falls, Ida.

15.

Filed

Sept 24 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 30 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19

that I last saw him alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Accidental struck by lightning

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

H. D. Spencer

M. D.

(Address) Idaho Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Weston Ida

DATE OF BURIAL

Sept 22 1922

20. UNDERTAKER

Chiffet Hayes

ADDRESS

Idaho Falls

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 39887
Registered No. 736

1. PLACE OF DEATH

Registration District No. 23
County of Bonneville Primary Registration District No. 210-0
City of Idaho Falls (No. 20th Street) St. Idaho Falls

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Elizabeth Robson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widow
(Write the word.)

6. DATE OF BIRTH

Dec. 1 1922
(Month) (Day) (Year)

7. AGE

67 Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

House wife

9. BIRTHPLACE

(State or Country)

Mo.

10. NAME OF FATHER

Thornley

11. BIRTHPLACE OF FATHER

(State or Country)

Don't know

12. MAIDEN NAME OF MOTHER

" "

13. BIRTHPLACE OF MOTHER

(State or Country)

" "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Jake J. Johnson
Idaho Falls, Idaho

15. FILED

Sept 24 1922

Local Registrar

16. DATE OF DEATH

Dec. 7 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 7 1922 to March 7 1922 that I last saw him alive on March 7 1922 and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart
failure

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. J. Johnson M. D.
Sept 22 1922 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Ross Hill Cemetery March 11 1922

20. UNDERTAKER

ADDRESS

W. J. Johnson Idaho Falls

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39888**
Registered No. **121**

1. PLACE OF DEATH

County of **Bonanza** Registration District No. **73**
City of **Idaho Falls** Primary Registration District No. **214-0**
Idaho Falls Eastern Ave., St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Hannah Moring

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Aug. 24 1922
(Month) (Day) (Year)

7. AGE

25
Yrs. Mos. ds.

If LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

no.

9. BIRTHPLACE

(State or Country)

Idaho Falls

10. NAME OF FATHER

Waldo Moring

11. BIRTHPLACE OF FATHER

(State or Country)

N. Y.

12. MAIDEN NAME OF MOTHER

Emily Tice

13. BIRTHPLACE OF MOTHER

(State or Country)

Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Waldo Moring
Idaho Falls, Ida.

15.

Filed

Sept 12 1922

W. Kinnaird
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 17 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Sept 16 1922** to **Sept 17 1922**

that I last saw her alive on **Sept 16 1922**

and that death occurred on the date stated above, at **6 A.M.**

The CAUSE OF DEATH* was as follows:

Hemorrhage from Stomach

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. C. Hollister

M. D.

19

(Address)

Idaho Falls, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Rose Street

DATE OF BURIAL

Sept 18 1922

20. UNDERTAKER

Chapman

ADDRESS

Idaho Falls

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Bonner*City of *Idaho Falls*Registration District No. *73*Primary Registration District No. *215-0*State of *Idaho*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Mary Margaret Ulm*State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *39889*Registered No. *124*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female white

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-OWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

July 6, 1921
(Month) (Day) (Year)

7. AGE

1 Yrs. *3* Mos. ds.IF LESS than 1 day
how many hrs.
or min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

no.

9. BIRTHPLACE

(State or Country)

Idaho & Idaho Falls

10. NAME OF FATHER

Clayde H. Ulm

11. BIRTHPLACE OF FATHER

(State or Country)

Oregon

12. MAIDEN NAME OF MOTHER

Beatrice Griner

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Clayde H. Ulm
Idaho Falls Ida.

15.

Filed

Sept 21, 1922
W. F. Fennell
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 22, 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
Sept 20, 1922 to *Sept 21, 1922*that I last saw *her* alive on *Sept 20, 1922*and that death occurred on the date stated above, at *11 P.M.*

The CAUSE OF DEATH* was as follows:

Murder

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Chas. Rogers D.D.

19

(Address)

Idaho Falls Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Rose Hill Cemetery

DATE OF BURIAL

Sept 23, 1922

20. UNDERTAKER

Cliff Haynes

ADDRESS

Idaho Falls Ida.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
NOV 16 1922

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics1. PLACE OF DEATH **BUREAU OF VITAL STATISTICS** District No. **73**
County of **Bonneville** Registration District No. **215-0**
City of **Idaho Falls** (No. **3 1/2 miles E Idaho Falls** St.)File No. **39890**Registered No. **123**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **John P. Peterson**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **married**
(Write the word.)6. DATE OF BIRTH **Jan 9 1855**
(Month) (Day) (Year)7. AGE **67**

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?8. OCCUPATION **Rancher**

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE **Denmark**

(State or Country)

10. NAME OF FATHER **Peter Peterson**11. BIRTHPLACE OF FATHER **Denmark**

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER **Denmark**

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Walter Peterson**(Address) **Idaho Falls Ida**15. **Sept 27 1922**Filed **Sept 27 1922**Local Registrar **W. C. Peterson**

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **Sept 1 1922**
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from **Aug 30 1922** to **Sept 1 1922**that I last saw him alive on **Sept 1 1922**and that death occurred on the date stated above, at **Idaho Falls** M.The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) **W. C. Peterson** M. D.(Address) **Idaho Falls, Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence **Idaho Falls**19. PLACE OF BURIAL OR REMOVAL **Ross Street** DATE OF BURIAL **Aug 5 1922**20. UNDERTAKER **Jeffrey**ADDRESS **Idaho Falls**

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bonneville Registration District No. 73
City of Idaho Falls Primary Registration District No. 2 (N) - 0
(No. Gene Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Clyde Franklin PowersFile No. 39891
Registered No. 122

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED single
(Write the word.)

6. DATE OF BIRTH

Jan. 2 1998
(Month) (Day) (Year)

7. AGE

4 Yrs. 7 Mos. ds.
IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work no.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho,

10. NAME OF FATHER

Cliff Powers.

11. BIRTHPLACE OF FATHER

(State or Country) no.

12. MAIDEN NAME OF MOTHER

Waverly Porter

13. BIRTHPLACE OF MOTHER

(State or Country) mont.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. Powers(Address) Shady Ida.

15.

Filed Oct 27 1922 L. K. Linn
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 20 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 15 1922 to Aug 20 1922
that I last saw him alive on Aug 20 1922
and that death occurred on the date stated above, at 5:00 A.M.

The CAUSE OF DEATH* was as follows:

Intestinal hemorrhage
of ulcerative colitis(Duration) Yrs. mos. 6 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) W. H. Hatch M. D.19 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rocky Mountain Aug 27 1922

20. UNDERTAKER

ADDRESS

Jeff Hays Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39892**
Registered No. **121**

1. PLACE OF DEATH
County of **Bonner** Registration District No. **23**
City of **Idaho Falls** Primary Registration District No. **210**
City of **Idaho Falls** (No. **9th**) St.)

If death occurs away from usual residence, give facts called for under special information:

2. FULL NAME **James Crandall**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Married**
(Write the word.)

6. DATE OF BIRTH **May 29 1863**
(Month) (Day) (Year)

7. AGE **59** Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION **Labourer**
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE **Ill.**
(State or Country)

10. NAME OF FATHER **Luke Crandall**

11. BIRTHPLACE OF FATHER **Don't know.**
(State or Country)

12. MAIDEN NAME OF MOTHER **Wells**

13. BIRTHPLACE OF MOTHER **Don't know.**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) **Allen Crandall**
(Address) **Idaho Falls**

15. Filed **Sept 27 1922** Local Registrar **W. J. Hatcher**

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **Sept 14 1922**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Sept 2 1922** to **Sept 14 1922** that I last saw him alive on **Sept 14 1922** and that death occurred on the date stated above, at **10:10 P.M.**

The CAUSE OF DEATH* was as follows:
Chronic myocarditis

(Duration) Yrs. **9** mos. **9** ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) **H. V. Hatcher M. D.**

19. (Address) **Idaho Falls**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **Rose Hill Cemetery** DATE OF BURIAL **Sept 18 1922**

20. UNDERTAKER **Idaho Falls** ADDRESS **Idaho Falls**

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39893**
Registered No. **120**

1. PLACE OF DEATH

Registration District No. **73**
County of **Bonneville** Primary Registration District No. **215-0**
City of **Idaho Falls** NOV 1922 St.

If death occurs away from usual residence, give facts called for under special information.

BUREAU OF VITAL STATISTICS

2. FULL NAME

Elizabeth Hauger

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female **White** **Married**
(Write the word.)

6. DATE OF BIRTH

September 19 1907
(Month) (Day) (Year)

7. AGE

64 Yrs. **11** Mos. **4** ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).**Housewife**

9. BIRTHPLACE

(State or Country)

Walling, Pa.

10. NAME OF FATHER

Joseph McCreary

11. BIRTHPLACE OF FATHER

(State or Country)

Virginia

12. MAIDEN NAME OF MOTHER

?

13. BIRTHPLACE OF MOTHER

(State or Country)

Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Grove Hauger(Address) **9th & Cramer St. Idaho Falls**

15.

Filed

Sept. 21 1922 **Leifurimund**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 1 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
1921, to **Sept 1 1922**
that I last saw him alive on **Aug 21 1922**
and that death occurred on the date stated above, at.....M.
The CAUSE OF DEATH* was as follows:
Unknown(Duration) Yrs. mos. ds.
Contributory (Secondary) **Arteriosclerosis**(Duration) Yrs. mos. ds.
(Signed) **Leifurimund** M. D.**9/21 1922** (Address) **Idaho Falls**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Rose Hill Cemetery Sept 3 1922

20. UNDERTAKER

Effie Hauger ADDRESS **Idaho Falls****Or Richard**

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bannock Registration District No. 73
 City of Idaho Falls Primary Registration District No. 2140
 (No. STATISTICS St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lillian S. Jones

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 39894
 Registered No. 119

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widowed
 (Write the word.)

6. DATE OF BIRTH Aug 17 1895
 (Month) (Day) (Year)

7. AGE 27 Yrs. 0 Mos. 25 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

at Home

9. BIRTHPLACE

(State or Country)

Okla.

10. NAME OF FATHER

A. C. Flower

11. BIRTHPLACE OF FATHER

(State or Country)

Ala.

12. MAIDEN NAME OF MOTHER

Ellen Hughes

13. BIRTHPLACE OF MOTHER

(State or Country)

Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

M. Hughes
Idaho Falls

15. Filed Sept 21 1922 C. E. Cunningham
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 10 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1922 to Sept 10 1922, that I last saw her alive on Sept 10 1922, and that death occurred on the date stated above, at 9 P. M. The CAUSE OF DEATH* was as follows:

Tuberculosis of Lung.

(Duration) 1 Yrs. — mos. — ds.

Contributory (Secondary)

(Duration) — yrs. — mos. — ds.

(Signed)

James M. Smith M. D.

9/11, 1922 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death — yrs. — mos. — days. In the State — yrs. — mos. — days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Idaho Falls DATE OF BURIAL Sept 22

20. UNDERTAKER C. E. Cunningham ADDRESS Idaho Falls

CERTIFICATE OF DEATH

1. PLACE OF DEATH
 County of Bonneville Registration District No. 73
 City of Idaho Falls Primary Registration District No. 214-0
 (No. _____) (St.) _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mr. Jessie Allen

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 39895
 Registered No. 114

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
 (Write the word.)

6. DATE OF BIRTH ?
 (Month) _____ (Day) _____ (Year) _____

7. AGE about 37
 Yrs. _____ Mos. _____ ds. _____
 IF LESS than 1 day
 how many _____ hrs.
 or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

Farming

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Frank M. Allen

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Eliza S. Singleton

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Shelton Christensen
Rt 3 Blackfoot, Idaho

(Address)

15. Filed Sept 11 19 22 Uppland
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 30 19 22
 (Month) (Day) (Year)

17. I HEREBY CERTIFY That I attended deceased from Aug 26 19 22 to Aug 30 19 22
 that I last saw him alive on Aug 30 19 22
 and that death occurred on the date stated above, at 11 a M.

The CAUSE OF DEATH* was as follows:

Hemorrhage Secondary
Hemorrhage 4 days after
Appendectomy

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
 (Secondary)

Gangrenous Appendicitis

(Duration) _____ yrs. _____ mos. 5 ds.

(Signed)

H. W. Ray Hatch M. D.
Idaho Falls, Idaho

19 _____ (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Blackfoot, Idaho

DATE OF BURIAL

9/13 19 22

20. UNDERTAKER

Calumwood

ADDRESS

Idaho Falls

CERTIFICATE OF DEATH

1. PLACE OF DEATH

Registration District No. 73
 County of Bonneville Primary Registration District No. 210-0
 City of Idaho Falls Nov 1 1922 Chamberlain & Hill St.)

If death occurs away from usual residence, give facts called for under special information.

BUREAU OF VITAL STATISTICS

2. FULL NAME

Wm. H. Frampton

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 39896
 Registered No. 117

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
 (Write the word.)

6. DATE OF BIRTH

May 20 1873
 (Month) (Day) (Year)

7. AGE

49 Yrs. 3 Mos. ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

Retired

9. BIRTHPLACE

(State or Country)

Ill.

10. NAME OF FATHER

Henry H. Frampton

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Laura B. Langley

13. BIRTHPLACE OF MOTHER

(State or Country)

Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Laura B. Langley
 (Address) San Francisco, Cal.

15.

Filed Oct 22 19 22 W. H. Frampton
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 25 19 22
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
 19 to Aug 25 19 22

that I last saw him alive on Aug 25 19 22
 and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Glanders Siver

(Duration) Yrs. 2 mos. ds.

Contributory Heart leakage
 (Secondary)

(Duration) yrs. mos. ds.

(Signed) D. Rogers M. D.

19 (Address) Idaho Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Quincy, Kan. DATE OF BURIAL Aug 19 22

20. UNDERTAKER Griffiths ADDRESS Idaho Falls, Ida.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 73
 County of Bonneville Primary Registration District No. 21
 City of Idaho Falls (No. 333) St. 1st

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Infant Robinson

File No. 39897
 Registered No. 116

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Single
 (Write the word.)

6. DATE OF BIRTH July 31 1922
 (Month) (Day) (Year)

7. AGE 3 yrs. 3 mos. 3 ds.
 IF LESS than 1 day
how many 3 hrs.
or 3 min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
 (b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer).

9. BIRTHPLACE Idaho Falls
 (State or Country)

10. NAME OF FATHER Charles Robinson

11. BIRTHPLACE OF FATHER Idaho
 (State or Country)

12. MAIDEN NAME OF MOTHER Alta Way

13. BIRTHPLACE OF MOTHER Don't know
 (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles Robinson
 (Address) Idaho Falls, Ida.

15. C. T. V. 19 22 Alfred
 Filed Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 31 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
July 31 1922 to July 31 1922
 that I last saw him alive on July 31 1922
 and that death occurred on the date stated above, at Idaho Falls M.

The CAUSE OF DEATH* was as follows:

Pseudo Epilepsia
 (Duration) 3 yrs. 3 mos. 3 ds.

Contributory (Secondary)

(Duration) 3 yrs. 3 mos. 3 ds.

(Signed) J. E. Rogers M. D.

19 (Address) Idaho Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state
 (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
 Transients or Recent Residents.)

At place of death 3 yrs. 3 mos. 3 days. In the State 3 yrs. 3 mos. 3 days

Where was disease contracted
 if not at place of death?

Former or
 usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Rose Hill Mortuary Aug 1922

20. UNDERTAKER ADDRESS

C. T. V. Idaho Falls

2. FULL NAME

MEDICAL CERTIFICATE OF DEATH

20. UNDERTAKER	ADDRESS
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CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 79.
County of Bannock Primary Registration District No. 2156
City of Leonia St.)

File No. 39899
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

STATISTICS

2. FULL NAME

Betty Rose Oase

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Female

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

May 17 1922
(Month) (Day) (Year)

7. AGE

2 26 ds.
Yrs. Mos.

If LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Henry S. Oase

11. BIRTHPLACE OF FATHER

(State or Country)

Tennessee

12. MAIDEN NAME OF MOTHER

Gertrude With

13. BIRTHPLACE OF MOTHER

(State or Country)

Tennessee

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

H. S. Oase

(Address)

Leonida Ida

15.

Filed Oct. 5 1922

SSM
Local Registrar

16. DATE OF DEATH

Aug 12 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 11 1922 to Aug 12 1922
that I last saw her alive on Aug 12 1922
and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed) H. S. Oase M. D.

19. (Address) Leonida Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ Yrs. _____ mos. _____ days. In the State _____ Yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

Leonida Ida

FORM V. S. No. 5-A-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

Registration District No. 29
 County of Boundary Primary Registration District No. 3156
 City of Bonner Ferry (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Charles M^r Donald Chambers

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 39900

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-OWED OR DIVORCED

M W widow
 (Write the word.)

6. DATE OF BIRTH

Feb 8 1842
 (Month) (Day) (Year)

7. AGE

80 Yrs. 8 Mos. 13 ds. IF LESS than 1 day
 how many _____ hrs.
 or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

Farmer

9. BIRTHPLACE

(State or Country)

North Carolina

10. NAME OF FATHER

Joshua Chambers

11. BIRTHPLACE OF FATHER

(State or Country)

Virginia

12. MAIDEN NAME OF MOTHER

Nancy M. Powell

13. BIRTHPLACE OF MOTHER

(State or Country)

North Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Eunice J. Maxwell

(Address) Bonner Ferry Ida

15. Filed Oct. 22nd 1922

E. E. Fry
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 21 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct. 1 1922 to Oct. 31 1922
 that I last saw h. in alive on Oct. 20 1922
 and that death occurred on the date stated above, at 11 A.M.
 The CAUSE OF DEATH* was as follows:

Chronic Bronchitis.

(Duration) 10 Yrs. _____ mos. _____ ds.

Contributory
 (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) E. E. Fry M. D.

10/22/22 (Address) Bonner Ferry, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Bonner Ferry Ida

DATE OF BURIAL

10/23 1922

20. UNDERTAKER

DRS. Tooley

ADDRESS

Bonner Ferry

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bonner Ferry
City of BoundaryRegistration District No. 29
Primary Registration District No. 3156File No. 39901

Registered No.

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Jane McMathorne ChambersIf death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH

March 8 1896
(Month) (Day) (Year)

7. AGE

76 Yrs. 0 Mos. 24 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer).Housewife

9. BIRTHPLACE

(State or Country)

Ind.

10. NAME OF FATHER

Pro. Wilson Harris

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Elizabeth Keeney

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Eunice J. Maxwell

(Address)

Bonner Ferry, Ida

15.

Filed

Oct. 30, 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 2 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
Sept. 27, 1922 to Oct. 3rd, 1922
that I last saw him alive on Oct. 2nd, 1922
and that death occurred on the date stated above, at 5 P. M.
The CAUSE OF DEATH* was as follows:Cerebral hemorrhage -(Duration) Yrs. mos. 7 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

10/3, 1922 (Address) Bonner Ferry*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Bonner Ferry, Ida

DATE OF BURIAL

10/4, 1922

20. UNDERTAKER

Chas. J. Jockey

ADDRESS

Bonner Ferry

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED
NOV 18 1922
BUREAU OF
STATISTICS

Registration District No.

Primary Registration District No.

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 39902

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 1922 to Oct. 4 1922

that I last saw him alive on Oct. 4 1922

and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Duration) 2 yrs. 6 mos. ds.

(Signed)

10/5/1922 (Address) Bonners Ferry, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bonanza
City of Bonanza Ferry
If death occurs away from usual residence, give facts called for under special information.Registration District No. 79
Municipal Registration District No. 3156File No. 39903
Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Anna Elizabeth Cooper

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

F W married
(Write the word.)

6. DATE OF BIRTH

May 7 1883
(Month) (Day) (Year)

7. AGE

39 Yrs. 4 Mos. 29 ds.
IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Housewife

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

Frank Owens

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

W E Cooper
Bonanza Ferry Ida15. Oct. 7th 1922
Filed Oct. 7th 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 6 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Aug 15 1922 to Oct 6 1922that I last saw her alive on Oct 5 1922and that death occurred on the date stated above, at 10 AM

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage(Duration) Yrs. mos. 18 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Oct 7 1922 (Address) Bonanza Ferry Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bonanza Ferry Ida 10/6 1922

20. UNDERTAKER

ADDRESS

W E Cooper Bonanza Ferry

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No.

BUREAU OF VITAL STATISTICS

(STATISTICS)

District No.

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 39904

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

Nov. 1, 1920, to Oct. 13, 1922
that I last saw him alive on Oct. 13, 1922
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Pernicious Anaemia

(Duration) 2 Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

10/15/22 (Address) Bonners Ferry

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bonners Ferry Ida 10/16 1922

20. UNDERTAKER

ADDRESS

Chas. L. Lohr Bonners Ferry

FORM V. S. No. 5-A-25 M. 1-19.

1. PLACE OF DEATH

County of BonnerCity of Bonner Ferry

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

BUREAU OF VITAL STATISTICS

Registration District No. 29Registration District No. 2156

(No. _____ St.)

Gladys Etelle TwitchellState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 39905

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married

(Write the word.)

6. DATE OF BIRTH

May

(Month)

16

(Day)

1883

(Year)

7. AGE

39

Yrs.

5

Mos.

4

ds.

IF LESS than 1 day

how many _____ hrs.

or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

Housewife

9. BIRTHPLACE

(State or Country)

Ill.

10. NAME OF FATHER

William Crossier

11. BIRTHPLACE OF FATHER

(State or Country)

Ill.

12. MAIDEN NAME OF MOTHER

Mary Province

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Bonner Ferry Ida

15.

Filed

Oct. 30th 1922SSJ
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct.

(Month)

20

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

August31

to

Oct. 301922that I last saw her alive on Oct. 30 1922and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma (of Breast)(Duration) 1 Yrs. 6 mos. _____ ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

10/24/22

(Address)

Bonner Ferry Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bonner Ferry Ida10/22 1922

20. UNDERTAKER

ADDRESS

Oct. 30th 1922Bonner Ferry

FORM V. S. No. 5-A-25 M. 1-19.

1. PLACE OF DEATH

County of Boundary
City of Copeland

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED
NOV 18 1922
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 29
Primary Registration District No. 3156
St.)State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 39906
Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-OWED OR DIVORCED

F W Married
(Write the word.)

6. DATE OF BIRTH

Sept 13 1872
(Month) (Day) (Year)

7. AGE

50 Yrs. 28 ds. IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

Russia

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Fried Lipp
Bombers Ferry Ida

15.

Filed

Oct. 21 st 1922

- Local Registrar

16. DATE OF DEATH

Oct 21 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19
that I last saw h. alive on 19
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Dr. John J. Bird of Spokane, Wash. reports case one of intestinal carcinoma.

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

10/21/1922 (Address) Bombers Ferry Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Copeland Ida

DATE OF BURIAL

10/22 1922

20. UNDERTAKER

O. S. Hooker

ADDRESS

Bombers Ferry

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 59

County of Butte

Primary Registration District No. _____

City of Arco

(No. _____ St.)

File No. 39907

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clara L. Morgan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married

(Write the word.)

6. DATE OF BIRTH.

Dec 9 1890
(Month) (Day) (Year)

7. AGE

32 Yrs. 10 Mos. 28 ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

House wife

9. BIRTHPLACE

(State or Country)

Vernon, Wis.

10. NAME OF FATHER

Arthur McCall

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Laurie

13. BIRTHPLACE OF MOTHER

(State or Country)

Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ed. Morgan

(Address) Arco, Idaho

15.

Filed 11/7

191 22

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 6 1912
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 4 1912 to Nov 6 1912 that I last saw her alive on Nov 6 1912 and that death occurred on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Child birth with complications of bowel

(Duration) Yrs. mos. 2 ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) E. F. McCall M. D.

19 (Address) Arco, Idaho

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Vernon, Wis

11/7 191 22

20. UNDERTAKER

ADDRESS

V. F. McCall

Arco, Idaho

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics1. PLACE OF DEATH *Butte* Registration District No. *59*
County of *Butte* Primary Registration District No. *59*
City of *Arco* (No. *59* St.)File No. *39908*Registered No. *1752*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Sam'l W. Hurst*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Widowed*6. DATE OF BIRTH *Jan 10 1847*
(Month) (Day) (Year)7. AGE *75* Yrs. *9* Mos. *26* ds. IF LESS than 1 day how many *2* hrs. or *2* min.8. OCCUPATION *Quarry man*
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).9. BIRTHPLACE *Missouri*
(State or Country)10. NAME OF FATHER *Benj. F. Hurst*11. BIRTHPLACE OF FATHER *Tenn*
(State or Country)12. MAIDEN NAME OF MOTHER *Eliza Flack*13. BIRTHPLACE OF MOTHER *Ky*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Oscar B. Hurst*
(Address) *Pocatello Ida*15. Filed *11/6/22* 191*2* *J. M. Cannon*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *11-6-22*
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *11-6-1912* to *11-6-1912* that I last saw him alive on *11-6-1912* and that death occurred on the date stated above, at *10:25 A.M.*The CAUSE OF DEATH was as follows: *Shock from injuries received from rocks caving at quarry*
(Duration) *2* hrs. *2* mos.

Contributory (Secondary)

(Duration) *2* yrs. *2* mos. *2* ds.(Signed) *F. M. Cannon* D.19. (Address) *Arco Idaho*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death....yrs....mos....days In the State....yrs....mos....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Arco* DATE OF BURIAL *11/8/22*20. UNDERTAKER *Andrews* ADDRESS *Arco*

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 39909

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

Registration District No.

County of

Primary Registration District No.

City of

(No. of ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Luella Laswell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH.

Nov. 12 1878

(Month)

(Day)

(Year)

7. AGE

44 yrs. 11 mos. 24 ds.

IF LESS than 1 day
how many ... hrs. or
... min.

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife

9. BIRTHPLACE

(State or Country)

Kansas

10. NAME OF FATHER

Wm. Frank

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Mary Ellen Capps

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Frank Laswell
Culver City, Cal.

15.

Filed

11/18/22

191

Cannon

Local Registrar

MEDICAL CERTIFICATE OF DEATH

170

16. DATE OF DEATH

11-5-1922

(Month)

(Day)

191

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191, to 191,

that I last saw him alive on 191,

and that death occurred on the date stated above, at 10:20 A.M.

The CAUSE OF DEATH* was as follows:

Self inflicted gunshot wound
of head - with suicidal
intent

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) F. M. Cannon D.

19 (Address) arca Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

191

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

PLACE OF DEATH

County of Canyon
City of Caldwell

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mrs Marie Sanderson

CERTIFICATE OF DEATH

RECEIVED
NOV 18 1922

BUREAU OF VITAL STATISTICS

Registration District No. 3County Registration District No. 2005

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 39911Registered No. 115

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widow
(Write the word.)

6. DATE OF BIRTH

1856
(Month) (Day) (Year)

7. AGE

66 Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Housekeeper

9. BIRTHPLACE

(State or Country) Sweden

10. NAME OF FATHER

----- Barkerson

11. BIRTHPLACE OF FATHER

(State or Country) Sweden

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Marion A Sanderson(Address) R 4 Caldwell Ida

15.

Filed Nov. 9 - 1922John H. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

November 9 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Nov. 8 1922, to Nov. 8 1922, that I last saw h. alive on Nov. 8 1922, and that death occurred on the date stated above, at C. A. M. The CAUSE OF DEATH* was as follows:Angina Pectoris(Duration) Yrs. mos. 2 ds.Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) J. M. Henry M. D.Nov. 9 1922 (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Santaquin IdahoDATE OF BURIAL 11-12-22

20. UNDERTAKER

Paul L. Case

ADDRESS

Caldwell Ida

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39912**
Registered No. **114**

1. PLACE OF DEATH **RECEIVED**
Registration District No. **3**
County of **Canyon** **NOV 18 1922**
Primary Registration District No. **2005**
City of **Caldwell** **BUREAU OF VITAL STATISTICS** (No.) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Byron Richardson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Married**
(Write the word.)

6. DATE OF BIRTH

July 30 1855
(Month) (Day) (Year)

7. AGE

67 Yrs **3** Mos **6** da

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Blacksmith

9. BIRTHPLACE

(State or Country)

Iowa.

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Sarah R. P. Driscoll

(Address)

Caldwell

15.

Filed

Nov. 8 - 1922, John P. Meyer -

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov. 6-22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 14 1922 to **Nov 6 1922**
that I last saw h. l. in alive on **Nov 6 1922**
and that death occurred on the date stated above, at **11:30** M.

The CAUSE OF DEATH* was as follows:

The Pneumonia

(Duration) Yrs. mos. **20** ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

J. M. Case M. D.

(Address) **Caldwell Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Canyon Hill

DATE OF BURIAL

11-9-22

20. UNDERTAKER

Paul L. Case

ADDRESS

Caldwell Ida

RECEIVED
NOV 18 1922

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Garry Registration District No. 3
City of Middleton Primary Registration District No. 2005
(No. STATISTICS) (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary Elizabeth AllenFile No. 39913
Registered No. 113

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married

6. DATE OF BIRTH

Sept 6 1848
(Month) (Day) (Year)

7. AGE

74 Yrs. 1 Mos. 29 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)House wife

9. BIRTHPLACE

(State or Country)

Illinois

10. NAME OF FATHER

McCrea

11. BIRTHPLACE OF FATHER

(State or Country)

Canada

12. MAIDEN NAME OF MOTHER

Doris Brown

13. BIRTHPLACE OF MOTHER

(State or Country)

Doris Brown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

S. D. Allen
Middleton Ida

15.

Filed

Nov. 9 - 1922John V. Meyer
Local Registrar

16. DATE OF DEATH

Nov. 5th 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY That I attended deceased from
died before I saw her
19 to 19that I last saw h. alive on 19
and that death occurred on the date stated above, at 2:30 P.

The CAUSE OF DEATH* was as follows:

died from chronic neuralgia
of the heart, died before I arrived

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Isotamer M. D.19. (Address) Middleton Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Middleton Ida 11-9-1922

20. UNDERTAKER

ADDRESS

V. Beckham Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Canyon Registration District No. 3
 City of Caldwell Primary Registration District No. 2005
 State of Idaho St.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Estella Long

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 39914

Registered No. 112

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married

6. DATE OF BIRTH

Dec 18 1889
 (Month) (Day) (Year)

7. AGE

32 Yrs. 10 Mos. 9 ds.

IF LESS than 1 day
 how many _____ hrs.
 or _____ min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

House wife

9. BIRTHPLACE

(State or Country)

Nebraska

10. NAME OF FATHER

M. J. McFarren

11. BIRTHPLACE OF FATHER

(State or Country)

Don't know

12. MAIDEN NAME OF MOTHER

Don't know

13. BIRTHPLACE OF MOTHER

(State or Country)

Tennessee

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Walter Long

(Address)

Homedale Ida.

15.

Filed Oct. 29-1922

John V. Meyers
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 27 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 26 1922 to Oct 27 1922

that I last saw him alive on Oct 27 1922
 and that death occurred on the date stated above, at 11-30 A.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) Yrs. mos. 1 ds.

Contributory (Secondary)

(Duration) yrs. mos. 30 ds.

(Signed)

W. L. McFarren M. D.
10/28/22 (Address) Caldwell, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Canyon Hill 10-29-1922

20. UNDERTAKER

ADDRESS

C. J. Beckham Caldwell

RECEIVED
CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Canyon
City of MiddletonRegistration District No. 3Primary Registration District No. 2005

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Orval Raymond PayneState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 39915Registered No. 111

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

(Write the word.)

6. DATE OF BIRTH

May 24 1911
(Month) (Day) (Year)

7. AGE

11 Yrs. 5 Mos. — ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

M. E. Payne

11. BIRTHPLACE OF FATHER

(State or Country) Iowa

12. MAIDEN NAME OF MOTHER

Lura Shaffer

13. BIRTHPLACE OF MOTHER

(State or Country) Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) M. E. Payne(Address) Middleton Idaho

15.

Filed Oct. 25 - 1922John H. Meyers
Local Registrar

16. DATE OF DEATH

Oct 24 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct. 23 - 1922 to Oct 24 - 1922that I last saw him alive on Oct. 23 - 1922and that death occurred on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Hemorrhage and shockFell into pitchfork time. Pierced abdomen
(Duration) _____ Yrs. _____ mos. _____ ds.Contributory
(Secondary)

(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed) John H. Meyers M. D.1925/1922 (Address) Caldwell Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ Yrs. _____ mos. _____ days. In the State _____ Yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Star Idaho

DATE OF BURIAL

10-26-22

20. UNDERTAKER

Paul L. Case

ADDRESS

Caldwell Idaho

RECEIVED

NOV 18 1922 CERTIFICATE OF DEATH

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of IdahoCity of Boise

(No. _____)

(St. _____)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Bessie Fay Reed

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 39916
Registered No. 110

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED — (Write the word.)

6. DATE OF BIRTH

(Month) Jan(Day) 8(Year) 1920

7. AGE

2 Yrs. 9 Mos. 15 ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work At Home
(b) General nature of industry, business or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

B. F. Reed

11. BIRTHPLACE OF FATHER

(State or Country) Oklahoma

12. MAIDEN NAME OF MOTHER

Geo. Wallis

13. BIRTHPLACE OF MOTHER

(State or Country) Oklahoma

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) B. F. Reed(Address) Caldwell, Ida15. Filed Oct. 25 - 1922

John H. Meyers
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 23 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10/22 1922 to 10/22 1922

that I last saw her alive on 10/22 1922
and that death occurred on the date stated above, at 6:10 M.

The CAUSE OF DEATH* was as follows:

Peritonitis Septic

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory abscess Gall Bladder
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) John A. Fung M. D.

10/22 1922 (Address) Boise, Id.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Canyon Hill 10-25-1922

20. UNDERTAKER

ADDRESS

Q. P. Beckham Caldwell

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Canyon
 City of Caldwell

NOV 18 1922

BUREAU OF VITAL STATISTICS

Registration District No. 3Registration District No. 1005

(No. _____)

St. _____

If death occurs away from
 usual residence, give facts
 called for under special in-
 formation.

2. FULL NAME

Bentley Martin Altizer

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 39917Registered No. 109

If death occurred in a hos-
 pital, institution or camp,
 give its NAME instead of
 street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED Married
 (Write the word.)

6. DATE OF BIRTH

April 6 1884
 (Month) (Day) (Year)

7. AGE

38
Yrs. 6 Mos. 16 da.

IF LESS than 1 day
 how many _____ hrs.
 or _____ min.?

8. OCCUPATION

(a) Trade, profession or
 particular kind of work Rancher
 (b) General nature of in-
 dustry, business or estab-
 lishment in which employ-
 ed (or employer).

9. BIRTHPLACE

(State or Country) Virginia

10. NAME OF FATHER

E. Altizer

11. BIRTHPLACE OF FATHER

(State or Country) Virginia

12. MAIDEN NAME OF MOTHER

Lucinda Altizer

13. BIRTHPLACE OF MOTHER

(State or Country) Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Eva M. Altizer
 (Address) Caldwell Idaho

15.

Filed Oct-23-1922

John H. Meyer
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

October 22-22 19____
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
October 16, 1922 to October 22, 1922
 that I last saw him alive on October 22, 1922
 and that death occurred on the date stated above, at 1:25 P.M.
 The CAUSE OF DEATH was as follows:

Double Lobar Pneumonia

(Duration) _____ Yrs. _____ mos. _____ days
 Contributory (Secondary) Cellulitis of posterior nares

(Duration) _____ Yrs. _____ mos. two ds.

(Signed) C. R. Whittenberger, D.O.

Oct 23 22 (Address) Caldwell, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state
 (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days In the State _____ yrs. _____ mos. _____ days

Where was disease contracted
 if not at place of death?

Former or
 usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Nampa Idaho

DATE OF BURIAL

10-24-22

20. UNDERTAKER

Paul L. Case

ADDRESS

Caldwell Ida

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

NOV 18 1922

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Canyon District No. 3
 City of Middleton (No. 2005 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Geo Washington Adams

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 39918
 Registered No. 108

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married

6. DATE OF BIRTH

Dec 25 1984
 (Month) (Day) (Year)

7. AGE

75 Yrs. 9 Mos. 25 ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

Rancher

9. BIRTHPLACE

(State or Country)

Indiana

10. NAME OF FATHER

Samuel Adams

11. BIRTHPLACE OF FATHER

(State or Country)

Don't know

12. MAIDEN NAME OF MOTHER

Diadema Moore

13. BIRTHPLACE OF MOTHER

(State or Country)

Don't know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ernest S. Myers

(Address)

Middleton Idaho

15.

Filed Oct 23 - 1922

Local Registrar

16. DATE OF DEATH

Oct 20 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19
 that I last saw him live on 19
 and that death occurred on the date stated above, at 6:30 P.

The CAUSE OF DEATH* was as follows:

From the report of family of
I would judge he died by
neurralgia of the heart

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

Dr. Hauer M. D.

19 (Address) Middleton - Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Middleton Cyn. 10-23-22

20. UNDERTAKER

ADDRESS

V. Beckham Caldwell

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH **RECEIVED**
 County of **Canyon** NOV 18 1922 Registration District No. **9**
 City of **Caldwell** **BUREAU OF VITAL STATISTICS** Primary Registration District No. **2005** (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Gust Kocotis**

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. **39919**
 Registered No. **107**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Single**
 (Write the word.)

6. DATE OF BIRTH

march 1 1882
 (Month) (Day) (Year)

7. AGE

40 Yrs. **7** Mos. **19** da.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

laborer

9. BIRTHPLACE

(State or Country)

Greece; Puzlada Kalavryssa

10. NAME OF FATHER

Not Known

11. BIRTHPLACE OF FATHER

(State or Country)

Greece

12. MAIDEN NAME OF MOTHER

Not Known

13. BIRTHPLACE OF MOTHER

(State or Country)

Greece

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Paul L. Case

(Address)

Caldwell Idaho

15.

Filed

Oct. 21 1922

John V. Meyers
 Local Registrar

CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct. 20-22
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Oct 11, 1921** to **Oct 20, 1922**

that I last saw him alive on **Oct 20, 1922** and that death occurred on the date stated above, at **9:30 A.M.**

The CAUSE OF DEATH* was as follows:

Arteriosclerosis of Liver

(Duration) **1** Yrs. **4** mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

M. D.

11-20-22 (Address) **Caldwell Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Canyon Hill

DATE OF BURIAL

10-21-22

20. UNDERTAKER

Paul L. Case

ADDRESS

Caldwell Ida.

1. PLACE OF DEATH

County of *Canyon*City of *Caldwell*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Ralph James Thomas*Registration District No. *3*Primary Registration District No. *1005*STATION *1005*

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *39920*Registered No. *106*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male white

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

(Year)

7. AGE

Yrs.

2

Mos.

19

ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Oct. 22 - 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct. 20 - 1922, to *Oct. 20 - 1922*that I last saw him *dead* alive on *Oct. 20 - 1922*and that death occurred on the date stated above, at *9:30 P.M.*

The CAUSE OF DEATH* was as follows:

- Smothered - found lying on face in bed -

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

(Address)

John H. Meyer M. D.
Caldwell, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....Yrs.....mos.....days. In the State.....Yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Canyon Hill**10 - 22 1922*

20. UNDERTAKER

ADDRESS

C. V. Beckham *Caldwell*

RECEIVED

NOV 18 1922

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 39921

Registered No. 105

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Canyon
City of Greenleaf

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Inez Lucile Chamberlin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Oct 17 1922
(Month) (Day) (Year)

7. AGE

Yrs. Mos. 2 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Harry E. Chamberlin

11. BIRTHPLACE OF FATHER

(State or Country) Wis.

12. MAIDEN NAME OF MOTHER

Jennie Pearl Lyons

13. BIRTHPLACE OF MOTHER

(State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harry E. Chamberlin
(Address) Greenleaf Ida

15.

Filed Oct. 19 - 1922

John H. Meyers
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 18 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 17 1922 to Oct 18 1922
that I last saw her alive on Oct 17 1922
and that death occurred on the date stated above, at 9:30 P.M.

The CAUSE OF DEATH* was as follows:

Blue Baby Failure
of the foramen to fore
between the R. & L. heart

(Duration) Yrs. mos. 2 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. H. Kelly M. D.
1019 1922 (Address) Caldwell, Id.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Greenleaf Ida

DATE OF BURIAL

10-19 1922

20. UNDERTAKER

Paul L. Case

ADDRESS

Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

NOV 10 1922

CERTIFICATE OF DEATH

1. PLACE OF DEATH

BUREAU OF VITAL STATISTICS

Registration District No. 9

County of Canyon

Primary Registration District No. 2003-1

City of Tilden

(No. 2 3/4 miles S.W. of Wilder St.)

File No. 39922

Registered No. 104

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Glinie Ruth Brown

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWER OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

May 2, 1919
(Month) (Day) (Year)

7. AGE

3 Yrs. 5 Mos. 12 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

None

9. BIRTHPLACE

(State or Country)

Kansas

10. NAME OF FATHER

J. L. Brown

11. BIRTHPLACE OF FATHER

(State or Country)

Kansas

12. MAIDEN NAME OF MOTHER

Isadora Arnold

13. BIRTHPLACE OF MOTHER

(State or Country)

Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. J. L. Brown

(Address)

Rt. 1, Wilder, Idaho

15.

Filed Oct 14, 1922

J. H. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 14, 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 5, 1922, to Oct 14, 1922, that I last saw h. e. r. alive on Oct 14, 1922, and that death occurred on the date stated above, at 8 A. M. The CAUSE OF DEATH* was as follows:

Enteritis

(Duration) Yrs. mos. 12 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) R. B. Beach M. D.

Oct 1922 (Address) Wilder, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Boise Idaho

DATE OF BURIAL

Oct 16, 1922

20. UNDERTAKER

Mummers & Sons

ADDRESS

Boise Idaho

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon Registration District No. 3
City of Baldwell Primary Registration District No. 2005
(No.) (St.)File No. 39923
Registered No. 103If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Francis Marion HartIf death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDMale white Widower
(Write the word.)

6. DATE OF BIRTH

Apr 8 1864
(Month) (Day) (Year)

7. AGE

58 Yrs. 6 Mos. 5 ds.
IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer).Rancher

9. BIRTHPLACE

(State or Country) Ind.10. NAME OF
FATHERHiram Hart11. BIRTHPLACE
OF FATHER(State or Country) Not Known12. MAIDEN NAME
OF MOTHERElizabeth Hall13. BIRTHPLACE
OF MOTHER(State or Country) Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Vivian Hart(Address) Payette Idaho

15.

Filed Oct. 14. 1922 John H. Mayes
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 13 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19. to 19.

that I last saw h. alive on 19.

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Heart Failure
Dropped dead from Chf
while talking to
friends
Duration Yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Paul L. Case M.D.19. Canyon Baldwell
Address*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Burial Idaho 10-16 1922

20. UNDERTAKER

ADDRESS

Paul L. Case Baldwell

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

NOV 18 1922

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of OrindaCity of Malad

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No.

Primary Registration District No.

(No.

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDWrite the word.

6. DATE OF BIRTH

Feb241897

7. AGE

75717ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

Wm Blandell

11. BIRTHPLACE OF FATHER

(State or Country)

Not Known

12. MAIDEN NAME OF MOTHER

Not Known

13. BIRTHPLACE OF MOTHER

(State or Country)

Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. E. Blandell

(Address)

Malad, Ida

15.

Filed

Oct 31922

R. W. Mauer M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct11922

17. I HEREBY CERTIFY, That I attended deceased from

June 1921, to Sept 29 1922
that I last saw him alive on Sept 29 1922
and that death occurred on the date stated above, at 2:30 P.M.
The CAUSE OF DEATH* was as follows:

Aortic Stenosis(Duration) 2 Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. M. Turner M.D.10-3-1922 (Address) Malad, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Centerville, Ut.

DATE OF BURIAL

10-5-1922

20. UNDERTAKER

D. E. Johnson

ADDRESS

Malad

1. PLACE OF DEATH

County of *Preside*
City of *Malad*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No. *26*Primary Registration District No. *2069*

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *39925*Registered No. *29*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

*White*5. SINGLE, MARRIED, WID-
OWED OR DIVORCED*Widow (the sp.)*

6. DATE OF BIRTH

Nov. 23 1922
(Month) (Day) (Year)

7. AGE

10 Yrs. *13* Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

Child

9. BIRTHPLACE

(State or Country)

Malad Idaho

10. NAME OF FATHER

Wm H. Jacer

11. BIRTHPLACE OF FATHER

(State or Country)

Willard Utah

12. MAIDEN NAME OF MOTHER

Amanda Holbrook

13. BIRTHPLACE OF MOTHER

(State or Country)

Bountiful Ut.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wm H. Jacer

(Address)

Malad Id.

15.

Filed

Nov 3 1922

19

R. M. Jacer M.D.

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct. 8 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

10-8 1922 to *10-8 1922*that I last saw him alive on *10-8 1922*

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Cholera Inflammation

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

*J. M. Kerns M. D.**10-11-1922* (Address) *Malad Id.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Brigham Ut. Oct. 11 1922

20. UNDERTAKER

ADDRESS

J. Guy Benson Malad Id.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Oneida Registration District No. 26
City of Malad Primary Registration District No. 2069 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Burke Reese

File No. 39926

Registered No. 39

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single

6. DATE OF BIRTH June 13 1921
(Month) (Day) (Year)

7. AGE 1 Yrs. 3 Mos. 25 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

child

9. BIRTHPLACE

(State or Country)

Malad Idaho

10. NAME OF FATHER

Lewis L. Reese

11. BIRTHPLACE OF FATHER

(State or Country)

Pocatello Ida.

12. MAIDEN NAME OF MOTHER

Nattie Abter

13. BIRTHPLACE OF MOTHER

(State or Country)

Colorado

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

L. E. Reese

(Address)

Burist Idaho

15.

Filed Nov 13 19 22

R. M. Mauer M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct. 8 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 4 1922 to Oct. 8 1922
that I last saw him alive on Oct. 8 1922
and that death occurred on the date stated above, at 5:40 P.M.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(Duration) Yrs. mos. 2 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. M. Kinsley M.D.
10-14-1922 (Address) Malad Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Malad Ida

DATE OF BURIAL

10-10-1922

20. UNDERTAKER

W. E. Johnson

ADDRESS

Malad

FORM V. S. No. 5-A-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH *Idaho* Registration District No. *26*
 County of *Blaine* Primary Registration District No. *2069*
 City of *Malad* (No. _____ St.)

File No. *39927*
 Registered No. *30*

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Louis Ann Williams

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *F* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED *Single*

6. DATE OF BIRTH *June 28 1917*
 (Month) (Day) (Year)

7. AGE *5* Yrs. *3* Mos. *13* ds. IF LESS than 1 day
 how many _____ hrs.
 or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

at Home

9. BIRTHPLACE

(State or Country)

Malad Ida

10. NAME OF FATHER

Benben Williams

11. BIRTHPLACE OF FATHER

(State or Country)

Malad Idaho

12. MAIDEN NAME OF MOTHER

Hannah Maria Tappet

13. BIRTHPLACE OF MOTHER

(State or Country)

Perry Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Benben Williams

(Address)

Malad Ida

15.

Filed *Nov 3 1922*

D. M. Mauer M.D.
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 11 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Oct 5 1922 to *Oct 11 1922*

that I last saw her alive on *Oct 11 1922*
 and that death occurred on the date stated above, at *3:45 A.M.*

The CAUSE OF DEATH was as follows:

Typhoid fever

(Duration) _____ Yrs. _____ mos. *14* ds.

Contributory
 (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

J. N. Turner M.D.

10/13 1922 (Address) *Malad Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Malad Ida

DATE OF BURIAL

10-13 1922

20. UNDERTAKER

W. E. Johnson

ADDRESS

Malad

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of oneida
City of malad

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No. 26Primary Registration District No. 2069

(No. _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 39928Registered No. 39

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-OWED OR DIVORCED Child

6. DATE OF BIRTH

Apr 27 1922
(Month) (Day) (Year)

7. AGE

3 Yrs. 17 Mos. 17 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Child

9. BIRTHPLACE

(State or Country)

Long Beach Cal.

10. NAME OF FATHER

Stanley L Ballaine

11. BIRTHPLACE OF FATHER

(State or Country)

Endicott Washington

12. MAIDEN NAME OF MOTHER

Lottie L Allen

13. BIRTHPLACE OF MOTHER

(State or Country)

Rockland Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Stanley L Ballaine
Malad Idaho

(Address)

15.

Filed

Nov 3 1922R. T. Mauer M. P.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 14 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 6 1922 to Oct 14 1922that I last saw him alive on Oct 14 1922and that death occurred on the date stated above, at 7:25 M.

The CAUSE OF DEATH* was as follows:

Cholera Infantum(Duration) _____ Yrs. _____ mos. 10 ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

J. M. Burns M. D.(Address) Malad Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Malad Idaho Oct 16 1922

20. UNDERTAKER

ADDRESS

J. M. Burns malad

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED

CERTIFICATE OF DEATH.

1. PLACE OF DEATH.

County of

City of

Registration District No.

BUREAU OF STATE Registration District No.

(No.)

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

6. DATE OF BIRTH.

7. AGE

IF LESS than 1 day
how many.....hrs. or
.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15.

Filed

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on
and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Signed)

(Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

1. PLACE OF DEATH

County of Oneida
 City of Malaga

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED
 NOV 18 1922
 BUREAU OF VITAL STATISTICS

Registration District No. 26
 Primary Registration District No. 206d
 St. _____

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 39930
 Registered No. 34

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-OWED OR DIVORCED

Female White Married
 (Write age, sex, etc.)

6. DATE OF BIRTH

June 28 1877
 (Month) (Day) (Year)

7. AGE

45 Yrs. 3 Mos. 23 ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

Housewife
Samara Idaho

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

Samuel Reese

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Mary Ann Marshall

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Tella Bingham

(Address)

15.

Filed

Oct 24 1922 P. T. Mauer
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 19 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 1 1922, to Oct 19 1922
 that I last saw her alive on Oct 16 1922
 and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Flux of Kidney

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. H. Nelson M. D.

Malaga (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Malaga

DATE OF BURIAL

Oct 24 1922

20. UNDERTAKER

J. J. Johnson

ADDRESS

Malaga

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min. 7

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Oct 24 1922

Local Registrar

RECEIVED

NOV 18 1922 CERTIFICATE OF DEATH

Registration District No.

Registration District No.

(No.

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 1 1922, to Oct 21 1922

that I last saw her alive on Oct 16 1922

and that death occurred on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed)

M. D.

10-23-1922

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH
in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Idaho Registration District No. 26
City of Malad Primary Registration District No. 2069 St.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

WILHELMINA Warner

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 39932Registered No. 36

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Widowed

6. DATE OF BIRTH

June 17 1888
(Month) (Day) (Year)

7. AGE

84 Yrs. 4 Mos. 3 ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Pennsylvania

10. NAME OF FATHER

Ernest Van Relt

11. BIRTHPLACE OF FATHER

(State or Country)

Pennsylvania

12. MAIDEN NAME OF MOTHER

Not Known

13. BIRTHPLACE OF MOTHER

(State or Country)

Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ernest Warner

(Address)

Malad, Idaho

15.

Filed

Nov 3 1922

R. M. Mauer M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 20 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 20, 1922 to Oct 20, 1922

that I last saw him alive on Oct 20, 1922

and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Dilatation of the heart

(Duration) Yrs. mos. 1 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

R. M. Mauer M.D.

Oct 20, 1922 (Address) Malad, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Jackson Mich.

DATE OF BURIAL

19

20. UNDERTAKER

D. E. Johnson

ADDRESS

Malad

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Oneida Registration District No. 26
 City of Malad Primary Registration District No. 2069
 (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ephriam Merfield Denning

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 39933
 Registered No. 37

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED Divorced
 (Write the word.)

6. DATE OF BIRTH

Jan. 9 1862
 (Month) (Day) (Year)

7. AGE

60 Yrs. 10 Mos. 13 ds.

IF LESS than 1 day
 how many _____ hrs.
 or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Farmer
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Logan Utah.

10. NAME OF FATHER

James Denning

11. BIRTHPLACE OF FATHER

(State or Country) England

12. MAIDEN NAME OF MOTHER

Sarah Merfield

13. BIRTHPLACE OF MOTHER

(State or Country) England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Martha Kent
 (Address) Malad Idaho.

15.

Filed Nov 3 1922 RD Mauer M.D.
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct. 22 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Oct 22 1922 to Oct 22 1922
 that I last saw him alive on Oct 22 1922
 and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows

acute Dilatation of the heart

(Duration) _____ Yrs. _____ mos. 1 ds.

Contributory
 (Secondary)

(Duration) _____ yrs. _____ mos. + ds.

(Signed)

Oct 22 1922 (Address) RD Mauer Malad Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

St. John

DATE OF BURIAL

Oct 26 1922

20. UNDERTAKER

D.E. JOHNSON

ADDRESS

Malad

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Oreida Registration District No. 26
City of Malad Primary Registration District No. 2069
St. Idaho

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Charles James LowryFile No. 39934Registered No. 38

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Child
(Write the word.)

6. DATE OF BIRTH

Sept. 19 1922
(Month) (Day) (Year)

7. AGE

1 Yrs. 4 Mos. 4 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (for employer)

Child

9. BIRTHPLACE

(State or Country)

Malad Idaho

10. NAME OF FATHER

Charles J. Lowry

11. BIRTHPLACE OF FATHER

(State or Country)

Virginia

12. MAIDEN NAME OF MOTHER

Rosa Jones

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

C. J. Lowry

(Address)

15.

Filed

Oct 22 1922R. J. Mauer M. D.
Local Registrar

16. DATE OF DEATH

Oct 22 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 22 1922 to Oct 22 1922that I last saw him alive on Oct 22 1922and that death occurred on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:

Convulsions
(unknown origin)

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Oct 22 1922 (Address) Malad

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Malad

DATE OF BURIAL

Oct 24 1922

20. UNDERTAKER

J. G. Benson

ADDRESS

Malad

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
NOV 18 1922
CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon
City of Parma

Registration District No. 3Primary Registration District No. 1007

(No. _____ St.)

File No. 39936Registered No. 24

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

John E Kerrick

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

white5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDmarried
(Write the word.)

6. DATE OF BIRTH

Apr 16 1865
(Month) (Day) (Year)

7. AGE

57 yrs. 6 Mos. 18 ds.

IF LESS than 1 day
how many _____ hrs
or _____ min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.Real Estate Loan(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)T. Ins.

9. BIRTHPLACE

(State or Country) Illinois10. NAME OF
FATHERWalter Kerrick11. BIRTHPLACE
OF FATHER(State or Country) Va.12. MAIDEN NAME
OF MOTHERDo not know13. BIRTHPLACE
OF MOTHER(State or Country) Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Walter Kerrick(Address) Parma, Idaho

15.

Filed 11-5 1922 Lulu Halder

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 3 22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 15 1920 to Nov. 3 1922that I last saw him alive on Nov. 2 1922

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis(Duration) 5 Yrs. mos. ds.Contributory
(Secondary)

(Duration) _____ yrs. mos. ds.

(Signed) W. H. Mitchell M. D.11-5 1922 (Address) Parma, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death _____ yrs. mos. days. In the _____ State _____ yrs. mos. days.

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Parma Cemetery

DATE OF BURIAL

Nov 8 1922

20. UNDERTAKER

Reckham Fur Co

ADDRESS

Parma

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Caribou*City of *Soda Springs*Registration District No. *82*Primary Registration District No. *2159*

(No. _____)

(St. _____)

File No. *39937*Registered No. *16*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Agnes E. Havercort

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Female

4. COLOR OR RACE

*White*5. SINGLE, MARRIED, WID-
OWED OR DIVORCED(Write the word.) *m*

6. DATE OF BIRTH

January 28 1894
(Month) (Day) (Year)

7. AGE

28 Yrs. *10* Mos. _____ ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)*House wife*

9. BIRTHPLACE

(State or Country)

Clemens Iowa

10. NAME OF FATHER

Samuel Davis

11. BIRTHPLACE OF FATHER

(State or Country)

Iowa

12. MAIDEN NAME OF MOTHER

Minnie B Mills

13. BIRTHPLACE OF MOTHER

(State or Country)

Mineola Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wm J. Sullivan

(Address)

Soda Springs Idaho

15.

Filed *Nov 25*, 19*22**E. K. Kaeley*
Local Registrar

16. DATE OF DEATH

Nov 24 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov. 1st 1922 to *Nov. 24 1922*that I last saw him alive on *Nov 24 1922*,and that death occurred on the date stated above, at *7.0* M.

The CAUSE OF DEATH* was as follows:

Right Fetal Pregnancy(Duration) Yrs. *4* mos. _____ ds.Contributory (Secondary) *None*

(Duration) yrs. _____ mos. _____ ds.

(Signed) *E. K. Kaeley* M. D.19 (Address) *Soda Springs Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. _____ mos. _____ days. In the State yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Clemens Iowa

DATE OF BURIAL

Nov 24 1922

20. UNDERTAKER

Wm. W. Hall

ADDRESS

Bozelle

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

39938

State of Idaho
BOARD OF HEALTH

Bureau of Vital Statistics

File No. 630

Registered No. _____
If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

1. PLACE OF DEATH

County of Cassia
City of Burley

Registration District No. 117

Primary Registration District No. 2196

(No. _____ St.)

If death occurs away from
usual residence, give facts
called for under special
information.

2. FULL NAME

Margaret Sullivan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

Married

6. DATE OF BIRTH.

May 15 1876
(Month) (Day) (Year)

7. AGE

46

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of in-
dustry, business, or estab-
lishment in which em-
ployed (or employer)

Waitress

9. BIRTHPLACE

(State or Country)

Illinois

10. NAME OF
FATHER

J. J. Sullivan

11. BIRTHPLACE
OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME
OF MOTHER

Mary Powers

13. BIRTHPLACE
OF MOTHER

(State or Country)

Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Maud M. Gant

(Address)

Laramie Falls, Idaho

15.

Filed Nov. 6 1922

J. C. Patterson
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

79

16. DATE OF DEATH

Nov 6 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct. 9 1922 to Nov. 6 1922

that I last saw him alive on Nov. 5 1922

and that death occurred on the date stated above, at 1.2 M.

The CAUSE OF DEATH* was as follows:

Valvular Heart
Fibrille

duration Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

J. C. Patterson M. D.
11-6-1922 (Address) Burley, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days, State yrs. mos. days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Mt Pleasant Cem Salt Lake, Nov. 8. 1922

20. UNDERTAKER

W. G. Goodman Rupert

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Cassia
City of Burley

Registration District No.

Primary Registration District No.

(No. St.)

File No. 39939Registered No. 636

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ada Caroline Wilson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F. 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single (Write the word.)

6. DATE OF BIRTH

Oct. 27 - 1921
(Month) (Day) (Year)

7. AGE

1 Yrs. 27 Mos. 27 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

At Home

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Burley Ida.

10. NAME OF FATHER

Franklin S. Wilson

11. BIRTHPLACE OF FATHER

(State or Country)

Beaver Utah

12. MAIDEN NAME OF MOTHER

Jella Walters

13. BIRTHPLACE OF MOTHER

(State or Country)

Salt Lake City Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) F. S. Wilson(Address) R. F. S. Burley Idaho

15.

Filed Nov. 23 1922 Dr. J. C. Patterson

Local Registrar

MEDICAL CERTIFICATE OF DEATH

91

16. DATE OF DEATH

Nov. 23 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov. 18 1922, to Nov. 23 1922that I last saw him alive on Nov. 22 1922and that death occurred on the date stated above, at 5:10 P.M.

The CAUSE OF DEATH was as follows:

Branchio-Pneumonia(Duration) Yrs. mos. 7 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. C. Patterson M. D.Nov. 23 1922 (Address) Burley, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Salt Lake City Utah Nov. 26 1922

20. UNDERTAKER

ADDRESS

L. B. Gallagher Burley Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 39940
Registered No. 637
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Cassia Registration District No. 117
City of Burley Primary Registration District No. 2196
(No. 127, N. Normal St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Melvin Elmer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)
6. DATE OF BIRTH March 1 1888
(Month) (Day) (Year)

7. AGE 34 Yrs. 8 Mos. 2 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Payson Utah

10. NAME OF FATHER Henry Elmer

11. BIRTHPLACE OF FATHER
(State or Country) Illinois

12. MAIDEN NAME OF MOTHER Lena Jones

13. BIRTHPLACE OF MOTHER
(State or Country) Chesterfield England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. V. Elmer
(Address) Burley Ida. R. 3d. #1

15. Filled Nov. 5 1922 P. J. C. Patterson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 3 1922
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from Jan 1921 to Nov. 3 1922
that I last saw him alive on Nov. 3 1922
and that death occurred on the date stated above, at 10:30 A.
The CAUSE OF DEATH* was as follows:
Epilepsy

(Duration) 2 Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) J. C. Patterson M. D.
11-4-1922 (Address) Burley, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Burley Idaho DATE OF BURIAL 11/6/1922
20. UNDERTAKER L. B. Georgey ADDRESS Burley Ida.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39942**
Registered No. **639**

1. PLACE OF DEATH

County of Cassia
City of Burley

Registration District No. 117
Primary Registration District No. 2196
(No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Hanna Gordon Seeds

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single

(Write the word.)

6. DATE OF BIRTH

June 26 1922
(Month) (Day) (Year)

7. AGE

Yrs. 4 Mos. 18 ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Alonzo Howard Seeds

11. BIRTHPLACE OF FATHER

(State or Country)

Champaign Ill

12. MAIDEN NAME OF MOTHER

Violet Mae Kavis

13. BIRTHPLACE OF MOTHER

(State or Country)

S. Dakota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Copied from birth certificate of
Honathy Rich, M.O.
Burley

15.

Filed 11-14-22 19 Prof. C. Patton

Local Registrar

MEDICAL CERTIFICATE OF DEATH

108

16. DATE OF DEATH

Nov 13 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 11 1922, to Nov 13 1922

that I last saw him alive on Nov 13 1922 and that death occurred on the date stated above, at 6:30 P.M.

The CAUSE OF DEATH* was as follows:

Appendicitis
(Confirmed by Post mortem)

(Duration) Yrs. _____ mos. 4 ds.

Contributory (Secondary) Broncho-pneumonia

(Duration) yrs. _____ mos. 2 ds.

(Signed) Honathy Rich M. D.

11-14-1922 (Address) Burley

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Burley Ida.

11/16/1922

20. UNDERTAKER

ADDRESS

L.S. Geogary

Burley Ida.

CERTIFICATE OF DEATH

1. PLACE OF DEATH **RECEIVED**
 County of Cassia Registration District No. 117
 City of Burley Registration District No. 2196 (St.)
BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Burton Clifford Fuller

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 39943
 Registered No. 626

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
 (Write the word.)

6. DATE OF BIRTH

Aug. 31 1860
 (Month) (Day) (Year)

7. AGE

62 Yrs. 1 Mos. 3 ds.

IF LESS than 1 day
 how many..... hrs.
 or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

Real Estate Dealer

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

Orin P. Fuller

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Ameral Cooley

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. B. C. Fuller

(Address)

161 So. Albion Ave., Burley

15. Filed Oct. 6 1922

D. J. Patterson
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct. 3rd 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 15 1922 to Oct 3rd 1922
 that I last saw him alive on Oct. 3 1922
 and that death occurred on the date stated above, at 4:30 A.M.
 The CAUSE OF DEATH* was as follows:
Chronic alcoholism

(Duration) unk yrs. mos. ds.

Contributory
 (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. C. Patterson M. D.

Oct. 4 1922 (Address) Burley, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Burley Ida.

DATE OF BURIAL

Oct. 4 - 1922

20. UNDERTAKER

L. B. Gregory

ADDRESS

Burley Ida

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Cassia Registration District No. 117
 City of Burley Primary Registration District No. 2196
 (No. 117 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Harvey Elliott Wright

Dorothy Rich
 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 39914
 Registered No. 627

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male White Single Write the word.)

6. DATE OF BIRTH

May 7th 1922
 (Month) (Day) (Year)

7. AGE

Yrs. 5 Mos. 2 ds. IF LESS than 1 day
 how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country) Burley Idaho.

10. NAME OF FATHER

Lee A. Wright.

11. BIRTHPLACE OF FATHER

(State or Country) Kansas.

12. MAIDEN NAME OF MOTHER

Ethel Rathbone.

13. BIRTHPLACE OF MOTHER

(State or Country) Kansas.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lee A. Wright.
 (Address) Burley Idaho.

15. Nov 9 1922 H. J. C. Patterson
 Filed Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct. 9th 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 2 1922 to Oct 9 1922
 that I last saw him alive on Oct 8 1922
 and that death occurred on the date stated above, at 6:30 A.M.
 The CAUSE OF DEATH* was as follows:

Meningitis (Pneumococci)

(Duration) Yrs. mos. ds.

Contributory (Secondary) Bronchial Pneumonia

(Duration) Yrs. mos. ds.

(Signed) Dorothy Rich M. D.

19 (Address) Burley

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Burley Idaho. 10/10/1922.

20. UNDERTAKER

L. B. Guelogy. ADDRESS Burley Ida.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39945**
Registered No. **827**
If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

1. PLACE OF DEATH

County of **Cassia** Registration District No.
City of **Burley** Primary Registration District No.
(No. **251** So. St.)
If death occurs away from
usual residence, give facts
called for under special
information.

2. FULL NAME

Ellen Louise Casperson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

Female

White

Married

(Write the word.)

6. DATE OF BIRTH.

Oct. 29, 1853
(Month) (Day) (Year)

7. AGE

68 Yrs. **11** Mos. **27** ds.

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of in-
dustry, business, or estab-
lishment in which em-
ployed (or employer)

West Va.

Housewife

9. BIRTHPLACE

(State or Country)

West Va.

10. NAME OF
FATHER

Washington Martin

11. BIRTHPLACE
OF FATHER

(State or Country)

Va.

12. MAIDEN NAME
OF MOTHER

Matilda Cool

13. BIRTHPLACE
OF MOTHER

(State or Country)

Va.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Mrs. Opha Coleman**
(Address) **251 So. Normal Ave.**

15.

Filed **Oct. 24, 1922**

Burley Ida.

H. J. Patterson

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct. 25, 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct. 24, 1922 to **Oct. 25, 1922**

that I last saw him alive on **Oct. 25, 1922**

and that death occurred on the date stated above, at **11** A. M.

The CAUSE OF DEATH* was as follows:

Ruptured Gall Bladder

(Duration) Yrs. mos. **2** ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) **J. L. Patterson** M. D.

Oct. 26, 1922 (Address) **Burley, Ida.**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days, State ... yrs. ... mos. ... days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Manhato Kansas

DATE OF BURIAL

Oct. 30, 1922

20. UNDERTAKER

L. S. Galloway

ADDRESS

Burley Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 39946
Registered No. 629

1. PLACE OF DEATH
County of Cassia Registration District No. 117
City of Oakley Primary Registration District No. 2196
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William B. Vogelaar

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-OWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH Aug 9 1898
(Month) (Day) (Year)

7. AGE 24 Yrs. 8 Mos. 21 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Miner

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

Wm Vogelaar

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

"

13. BIRTHPLACE OF MOTHER

(State or Country)

"

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Susie Stevens
(Address) Oakley, Idaho

15. Filed Oct 31 1922 Hugh C. Patterson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 30 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

..... 19..... to 19.....
that I last saw h..... alive on 19.....
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Killed in Explosion in mine.

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) L. B. Galloway (Coroner) M. D.

10/31/22 (Address) Burley, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Montrose Colo.

DATE OF BURIAL

Nov 1 1922

20. UNDERTAKER

L. B. Galloway

ADDRESS

Burley, Ida.

CERTIFICATE OF DEATH

Patterson
State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 39947
Registered No. 631

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

Registration District No. _____

County of Cassia

Primary Registration District No. _____

City of BurleyNO. R. F. D. # 2 St.)

If death occurs away from usual residence, give facts called for under special information.

1922
Dr. J. C. Patterson
Dr. J. C. Patterson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male White Married (Write the word.)

6. DATE OF BIRTH

April 18 1896
(Month) (Day) (Year)

7. AGE

26 Yrs. 6 Mos. 9 ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Oakley Idaho.

10. NAME OF FATHER

Harrison R. Matthews

11. BIRTHPLACE OF FATHER

(State or Country) Grantsville Utah.

12. MAIDEN NAME OF MOTHER

Sarah Ann Williams

13. BIRTHPLACE OF MOTHER

(State or Country) Grantsville Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H. R. Matthews(Address) Oakley Idaho.

15.

Filed 9-28-22 19J. C. Patterson

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 27 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

08.20 1922 to 08.27 1922

that I last saw him alive on 08.27 1922and that death occurred on the date stated above, at 1:29 a.m.

The CAUSE OF DEATH* was as follows:

Sanguineous appendicitis
perforated, peritonitis

..... (Duration) Yrs. mos. 7 ds.Contributory
(Secondary)

..... (Duration) yrs. mos. ds.

(Signed)

J. C. Patterson M. D.
9-28-22 (Address) Burley, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Oakley Idaho.

DATE OF BURIAL

Oct 30-1922

20. UNDERTAKER

L. B. Gallagher

ADDRESS

Burley Ida.

CERTIFICATE OF DEATH

Butler.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Cassia Registration District No. 119
City of Burley Primary Registration District No. 2196
(No. 1192 St.)File No. 38948Registered No. 637

If death occurs away from usual residence, give facts called for under special information.

BUREAU OF VITAL STATISTICS

2. FULL NAME Mary Emma Rague

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Married (Use the word.)

6. DATE OF BIRTH

Dec. 29. 1
(Month) (Day) (Year)

7. AGE

47 Yrs. 9 Mos. 21 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Troutville Utah

10. NAME OF FATHER

Heber C. Rague

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Adraue McBride

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) L. J. Rague(Address) R. F. S. # 2, Burley Ida.

15.

Filed Nov. 9 19 22R. F. S. # 2, Burley Ida.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct. 20. 19 22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct. 11 19 22, to Oct 20 19 22
that I last saw him alive on Oct 11 19 22
and that death occurred on the date stated above, at 2:45 P.M.

The CAUSE OF DEATH* was as follows:

Valvular dilatation of heart(Duration) 3 Yrs. 1 mos. 1 ds.Contributory (Secondary) Arteriosclerosis(Duration) 1 Yrs. 1 mos. 1 ds.(Signed) L. J. Rague M. D.19 22 (Address) Burley Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 1 yrs. 1 mos. 1 days. In the State 1 yrs. 1 mos. 1 days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Oct. 22 - 1922DATE OF BURIAL
Oct. 22, 1922

20. UNDERTAKER

None

ADDRESS

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Cassia Registration District No. 117
 City of Burley Primary Registration District No. 2196
 (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Sarah Selsena Land Bowers

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 39949

Registered No. 633

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female White Widowed (Write the word.)

6. DATE OF BIRTH

Jan. 5 1960
 (Month) (Day) (Year)

7. AGE

62 Yrs. 9 Mos. 11 ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country) Texas

10. NAME OF FATHER

Samuel Leclie Land

11. BIRTHPLACE OF FATHER

(State or Country) Unknown

12. MAIDEN NAME OF MOTHER

Susan Ryan

13. BIRTHPLACE OF MOTHER

(State or Country) Louisiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. M. Power
 (Address) Burley Idaho

15.

Filed Nov 9 1977 P. J. Patterson
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 16 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept. 10 1922, to Oct. 16 1922
 that I last saw him alive on Oct. 16 1922
 and that death occurred on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:

Progressive Polymyositis

(Duration) 1 yrs. 0 mos. 0 ds.

Contributory
 (Secondary)

(Duration) 0 yrs. 0 mos. 0 ds.

(Signed)

J. C. Patterson M. D.

10-16-1922 (Address) Burley, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 0 yrs. 0 mos. 0 days. In the State 0 yrs. 0 mos. 0 days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Artesian City Idaho Oct. 19, 1922

20. UNDERTAKER

ADDRESS

L. B. Gallagher Burley Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of *Cassia*
City of *Burley*

RECEIVED

Registration District No. *117*Primary Registration District No. *2196*

File No.

39950

Registered No.

634

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Francis James Surgeon

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

*White*5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.*Married*
(Write the word.)

6. DATE OF BIRTH.

*Dec**27**1860*

(Month)

(Day)

(Year)

7. AGE

61

Yrs.

9

Mos.

24

ds.

IF LESS than 1 day
how many.....hrs. or
.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....*Housewife*

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

John William James

11. BIRTHPLACE OF FATHER

(State or Country)

Ida

12. MAIDEN NAME OF MOTHER

Sarah Frances Kent

13. BIRTHPLACE OF MOTHER

(State or Country)

Eng

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs J. Groves Rich

(Address)

Burley Ida

15.

Filed

*Nov. 9**1912**J. C. Patterson*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct

(Month)

21

(Day)

1912

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan. 10 1912 to *Oct. 21 1912*that I last saw him alive on *Oct. 21 1912*and that death occurred on the date stated above, at *4 A.* M.

The CAUSE OF DEATH* was as follows:

Cancer of stomach(Duration) *1* Yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *J. C. Patterson* M. D.*10.21.1912* (Address) *Burley, Ida.*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Pleasant Hill Cemetery

DATE OF BURIAL

Oct. 23, 1912

20. UNDERTAKER

R. H. Natto

ADDRESS

Burley Ida

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bassia
City of BureauRegistration District No. 2196 117

BUREAU OF VITAL STATISTICS

Primary Registration District No. 9196 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Verdes Marie Merrill

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH.

August 15 1920
(Month) (Day) (Year)

7. AGE

2 Yrs. 1 Mos. 20 ds.IF LESS than 1 day
how many hrs. or
..... min. 2]

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Levan A. Merrill

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Carrie Gray

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Levan A. Merrill

(Address)

Bureau Ida R 3d

15.

Filed

Nov. 91922R. J. C. Patterson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 6 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Oct. 1 1922 to Oct. 6 1922.that I last saw him alive on Oct. 6 1922.and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Thro. Cancer(Duration) Yrs. mos. 7 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) F. C. Patterson M. D.11-7 1922 (Address) Bureau, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Albion IdahoOct 8 1922

20. UNDERTAKER

R. H. Hatt

ADDRESS

Bureau Ida

1. PLACE OF DEATH

County of **Clearwater**City of **Orofino,**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **ELIZABETH FLUKE,**

CERTIFICATE OF DEATH

Registration District No. **90**Registration District No. **3/68**State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39952**Registered No. **57**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widow.

(Write the word.)

6. DATE OF BIRTH

About

(Month)

1847

(Day)

1

(Year)

7. AGE

Abt 75

Yrs.

Mos.

ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Formerly Housewife.

(b) General nature of industry, business or establishment in which employed (or employer)

General House Work,

9. BIRTHPLACE

(State or Country)

Canada,

10. NAME OF FATHER

Williamson,

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown,**Oct. 3rd, 19. 22,**

12. MAIDEN NAME OF MOTHER

Unknown,

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown,

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Orofino, Idaho.

15. Filed

Nov 9 1922**Jm Family**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

October Third, 1922. ##

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from **Oct. 8th 1917** to **Oct. 3rd 1922**that I last saw her alive on **Oct. 2nd, 1922,**and that death occurred on the date stated above at **M.**

The CAUSE OF DEATH* was as follows:

Parotitis**4:40 P. M.**(Duration) Yrs. mos. **14** ds.Contributory **Insanity.**

(Secondary)

Unknown,

(Duration) yrs. mos. ds.

(Signed)

John W. Sioren

M. D.

(Address) **Orofino, Idaho.**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death **4** yrs **11** mos **26** In the days. State **9** yrs mos. days

Where was disease contracted if not at place of death?

Former or usual residence

Orofino, Idaho.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Orofino, Ida**Oct 5 1922**

20. UNDERTAKER

ADDRESS

V-A Shum Orofino

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39953**Registered No. **52**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

Registration District No. **90**County of **Clearwater.**Primary Registration District No. **2168**City of **Orofino.**(No. **1922**) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **MARION JOHNSON.**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

MALE

4. COLOR OR RACE

WHITE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

MARRIED.

(Write the word.)

6. DATE OF BIRTH

1891

(Month)

(Day)

(Year)

7. AGE

31

Yrs.

Mos.

ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Cook,

(b) General nature of industry, business or establishment in which employed (or employer)

Cooking.

9. BIRTHPLACE

(State or Country)

Idaho,

10. NAME OF FATHER

Unknown,

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown,**Oct. 5th****22,**

12. MAIDEN NAME OF MOTHER

Unknown,

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown,

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Orofino, Idaho.

15.

Filed

Nov 1 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

October Fifth

(Month)

(Day)

19 **22.**
(Year)17. I HEREBY CERTIFY, That I attended deceased from **April 11th** 19 **17** to **Oct. 5th** 19 **22,**that I last saw him alive on **Oct. 5th** 19 **22,**

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

12 o'clock Noon,**Epilepsy**

(Duration) Yrs. mos. ds.

Contributory (Secondary)

Insanity,

(Duration) Yrs. mos. ds.

Unknown,

(Signed)

John W. Littleberry

M. D.

19

22,

(Address)

Orofino, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death **5** yrs. **5** mos. **25** days. In the **16** State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

Lewiston, Idaho.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Lawrence Cemetery**10/7 1922**

20. UNDERTAKER

ADDRESS

John W. Littleberry**Orofino, Idaho**

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39955**
Registered No. **54**

1. PLACE OF DEATH

Registration District No. **40**
County of **Clearwater**
Primary Registration District No. **2168**
City of **Orofino** (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

MATILDA WEISS

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Married,
(Write the word.)

6. DATE OF BIRTH

About**1884**

(Month)

(Day)

(Year)

7. AGE

About 38

Yrs.

Mos.

ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housewife.

(b) General nature of industry, business or establishment in which employed (or employer)

General House Work.

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

Unknown,

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown,

12. MAIDEN NAME OF MOTHER

Unkown,

13. BIRTHPLACE OF MOTHER

(State or Country)

Unkown,

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Orofino, Idaho.

15.

Filed

Nov 1 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

October Eighteenth**19 22**

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from **April 30th 1913** to **Oct. 18th 1922** that I last saw h. **or** alive on **Oct. 18th 1922** and that death occurred on the date stated above, at..... M. The CAUSE OF DEATH* was as follows: **11:50 A.M.**

Typhoid Fever.

(Duration)

Yrs.

mos. **28** ds.Contributory **Insanity.**

(Secondary)

(Duration)

Yrs.

mos. ds.

(Signed)

John W. Stevens

M. D.

Ad. 8 1922

(Address) **Orofino, Idaho.**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death **9** yrs **5** mos **19** days. In the **Over 10 years,** State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

P.O. Address, Garfield, Washington
(Residence Latah County)

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Northern Idaho Sanitar. **1920 1922**

20. UNDERTAKER

P. M. Johnson

ADDRESS

Orofino, Idaho

FORM V. S. No. 5-25 M. 1-16-12

CERTIFICATE OF DEATH.

1. PLACE OF DEATH Nov 18 1922
 County of Charlottesville Registration District No. 90
 City of Charlottesville Primary Registration District No. 2168
 (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Adelaide Ritter

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 39956Registered No. 55

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED. single
 (Write the word.)

6. DATE OF BIRTH.

Jan 20 1906
 (Month) (Day) (Year)

7. AGE

16 Yrs. 9 Mos. 3 ds.

IF LESS than 1 day
 how many hrs. or
 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
 (b) General nature of industry, business, or establishment in which employed (or employer).....

School Girl

9. BIRTHPLACE

(State or Country)

Ida

10. NAME OF FATHER

Theda Ritter

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Anna Ritter

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Margaret Ritter

(Address)

Charlottesville

15.

Filed

Nov 91922J. M. Fahey

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 23 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 13 1922 to Oct 23 1922
 that I last saw him alive on Oct 22 1922

and that death occurred on the date stated above, at 12:30 P. M.
 The CAUSE OF DEATH* was as follows:

Dysphoid Fever(Duration) Yrs. 11 mos. 11 ds.Contributory Chorea and Valv. Heart Disease
 (Secondary)(Duration) Yrs. 3 mos. 1 ds.(Signed) J. M. Fahey M. D.10231822 (Address) Charlottesville

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Charlottesville Ida Oct 25 1922

20. UNDERTAKER

ADDRESS

W. A. Spahr Charlottesville

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of **Clearwater**City of **Orofino**

If death occurs away from usual residence, give facts called for under special information.

Registration District No. **90**Primary Registration District No. **2168**

File No.

Registered No. **56**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME **PAUL HUFFMAN**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married

(Write the word.)

6. DATE OF BIRTH

About**1865**

(Month)

(Day)

(Year)

7. AGE

Abt 57

Yrs.

Mos.

ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Railroad Conductor,

(b) General nature of industry, business or establishment in which employed (or employer).

Train Service.

9. BIRTHPLACE

(State or Country)

Fairfield, Iowa.

10. NAME OF FATHER

Paul Huffman.

11. BIRTHPLACE OF FATHER

(State or Country)

Massachusetts

12. MAIDEN NAME OF MOTHER

Azuba Washburn.

13. BIRTHPLACE OF MOTHER

(State or Country)

Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Orofino, Idaho.

15.

Filed

Nov 9 1922

19

22

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

October twenty-fifth 1922.###

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from **June 17th 1922** to **October 25th 1922**.that I last saw him alive on **October 25th 1922**,and that death occurred on the date stated above, at **3:30 P. M.**

The CAUSE OF DEATH* was as follows:

General Paresis

(Duration)

Yrs.

mos.

ds.

Contributory (Secondary)

Insanity**Unknown**

(Duration)

Yrs.

mos.

ds.

(Signed)

Oct. 25, 1922

(Address)

Orofino, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

0 yrs.

4 mos.

9

In the

days.

State

15 yrs.

mos.

over

days

Where was disease contracted if not at place of death?

Former or usual residence

Ponderay, Idaho.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
 County of Custer Registration District No. 76
 City of Mackay Primary Registration District No. 2153
 (No. _____) (St.) _____

File No. 39958

Registered No. _____

If death occurs away from
 usual residence, give facts
 called for under special in-
 formation.

2. FULL NAME James Bennetts

If death occurred in a hos-
 pital, institution or camp,
 give its NAME instead of
 street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED Married
 (Write the word.)

6. DATE OF BIRTH July - 24 1883
 (Month) (Day) (Year)

7. AGE 58 Yrs. 11 Mos. 2 ds.
 IF LESS than 1 day
 how many _____ hrs.
 or _____ min.?

8. OCCUPATION

(a) Trade, profession or
 particular kind of work
 (b) General nature of in-
 dustry, business or estab-
 lishment in which employ-
 ed (or employer)

Painter.

9. BIRTHPLACE Condurrow
 (State or Country) Cornwall County - England

10. NAME OF FATHER James Bennetts

11. BIRTHPLACE OF FATHER Condurrow
 (State or Country) Cornwall Co. England

12. MAIDEN NAME OF MOTHER Grace Pettalack

13. BIRTHPLACE OF MOTHER Condurrow
 (State or Country) Cornwall Co. England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thomas C. Bennetts
 (Address) Mackay - Idaho

15. Filed 11/27 1922 Rae Nowalk
 Local Registrar

16. DATE OF DEATH

6 - 22 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
6-20-22 19____, to 6-22-22 19____

that I last saw him alive on 6-22-22 19____
 and that death occurred on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

chronic phthisis

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Carroll A. Jensen M. D.

11/28 1922 (Address) Mackay, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state
 (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted
 if not at place of death? _____

Former or
 usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Mackay, Idaho 19____

20. UNDERTAKER ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

1. PLACE OF DEATH *Keen*
 County of *Cassia* Registration District No. *76*
 City of *Maer* Primary Registration District No. *2153*
 (No. *1*) St.)

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. *39959*
 Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Inoch Arthur Lewis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *M* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
Married

(Write the word.)

6. DATE OF BIRTH.

6 *15* *1890*
 (Month) (Day) (Year)

7. AGE

32 Yrs. *3* Mos. *10* ds.

IF LESS than 1 day
 how many hrs. or
 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
 (b) General nature of industry, business, or establishment in which employed (or employer).....

Miner

9. BIRTHPLACE

(State or Country)

Maer

10. NAME OF FATHER

John Lewis

11. BIRTHPLACE OF FATHER

(State or Country)

Maer

12. MAIDEN NAME OF MOTHER

Jane Kennedy

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. E. G. Lewis

(Address)

Maer, Ida

15.

*11/28**1922**Rae Nowack*

Filed

Local Registrar

16. DATE OF DEATH

9 *25* *1922*
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *9/9/22* 191... to *9/25/22* 191...
 that I last saw him alive on *9/25/22* 191...
 and that death occurred on the date stated above, at *2:30* A.M.
 The CAUSE OF DEATH* was as follows:

Pneumonia - Lobar(Duration) Yrs. mos. *15* ds.Contributory (Secondary) *Pulmonary tuberculosis*(Duration) yrs. mos. *10* ds.(Signed) *J. P. Richards* M. D.*9/26/22* (Address) *Maer, Ida*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Maer, Ida**191*

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 76
County of Custer Primary Registration District No. 2153
City of Malta St.)

File No. 39960
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Thomas Ayers Bates
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH.

Uncertain 1874
(Month) (Day) (Year)

7. AGE

48 Yrs. Mos. ds.

IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...

Quartz Miner

9. BIRTHPLACE

(State or Country)

St. Just Cornwall-England

10. NAME OF FATHER

Richard Bates

11. BIRTHPLACE OF FATHER

(State or Country)

St. Just Cornwall-England

12. MAIDEN NAME OF MOTHER

Fanny Ayres

13. BIRTHPLACE OF MOTHER

(State or Country)

St. Just Cornwall-England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Thomas C. Pennells
Mackay, Idaho

15.

Filed 7/8 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

2 (Month) 24 (Day) 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

2/12/22 1922 to 2/24/22 1922
that I last saw him alive on 2/23/22 1922
and that death occurred on the date stated above, at 5 A M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration) Several Yrs. mos. ds.

Contributory (Secondary)

Chronic Nephritis

(Duration) Several Yrs. mos. ds.

(Signed)

7/6/22 1922 (Address) P. P. Richards M. D.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....Yrs.....mos.....days In the State.....Yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

Mackay, Idaho

WRITE PLAINLY, WITH UNFADEING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

DEC - CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 39961

1. PLACE OF DEATH.

Registration District No. 36'

County of Elmore

Primary Registration District No. 2021

City of Glenn's Ferry

(No. , St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Gladys Duncan

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

April 12 1914
(Month) (Day) (Year)

7. AGE

8 yrs. 7 mos. 14 ds.

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work At Home.
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) King Hill, Idaho.

10. NAME OF FATHER

William A. Duncan

11. BIRTHPLACE OF FATHER

(State or Country) Auchmagatt, Scotland

12. MAIDEN NAME OF MOTHER

Elizabeth Mullison

13. BIRTHPLACE OF MOTHER

(State or Country) Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. A. Duncan

(Address) Glenn's Ferry, Idaho.

15.

Filed 191

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov. 26 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov. 21 1922, to Nov. 26 1922

that I last saw her alive on Nov. 26 1922, and that death occurred on the date stated above, at 3:15 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) yrs. mos. 8 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. W. Davis M. D.

Nov. 27 1922 (Address) Glenn's Ferry Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death? Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

Glenn's Ferry

DATE OF BURIAL

11/27 1922

20. UNDERTAKER

J. W. Davis

ADDRESS

Glenn's Ferry

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH *Elmore* Registration District No. *34*
 County of *Elmore* Registration District No. *20 20*
 City of *Mt Home* (No. *20 20*) St.)

File No. *39964*
 Registered No. *27*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Robert J. Smith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M.* 4. COLOR OR RACE *W.* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *married.*
 (Write the word.)

6. DATE OF BIRTH *March 2 1874*
 (Month) (Day) (Year)

7. AGE *47* Yrs. *6* Mos. *12* ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

Farmer

9. BIRTHPLACE *Alpena, Mich*
 (State or Country)

10. NAME OF FATHER *W. H. Smith*

11. BIRTHPLACE OF FATHER *England.*
 (State or Country)

12. MAIDEN NAME OF MOTHER *A. Rupper*

13. BIRTHPLACE OF MOTHER *Canada.*
 (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) *Effie J. Smith*
 (Address) *Mt Home Ida.*

15. Filed *9-17-1922*

J. E. Evans
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *Sept 14 1922*
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *9-13-1922* to *9-14-1922*
 that I last saw him alive on *9-13-1922*
 and that death occurred on the date stated above, at *9 A.M.*
 The CAUSE OF DEATH* was as follows:

Accident fracture of fifth Cervical vertebra
 (Duration) Yrs. mos. ds.

Contributory
 (Secondary)

(Duration) yrs. mos. ds.
 (Signed) *J. E. Evans* M. D.
9-15-1922 (Address) *Mt Home Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death *15* yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *City Cem. Mt Home Ida* DATE OF BURIAL *9/17 1922*

20. UNDERTAKER *Wm O Valley* ADDRESS *Mt Home Ida.*

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Elmore Registration District No. 34
 City of Mt. Home Primary Registration District No. 2020 (St.)
 If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ida Payne

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 39965

Registered No. 28

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widow
 (Write the word.)

6. DATE OF BIRTH

12 - 16 - 1851
 (Month) (Day) (Year)

7. AGE

70 Yrs. 9 Mos. 3 ds.

IF LESS than 1 day
 how many..... hrs.
 or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Ky

10. NAME OF FATHER

Robert G. Cole

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Lucela Weir

13. BIRTHPLACE OF MOTHER

(State or Country)

Ky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wm McBratney
Boise, Idaho

(Address)

15.

Filed 9-22-1922

J. E. Evans
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

9 - 19 - 22
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9-8-1922 to 9-19-1922, that I last saw her alive on 9-19-1922, and that death occurred on the date stated above, at 8 P. M. The CAUSE OF DEATH* was as follows:

Dysentery

(Duration) Yrs. mos. 13 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

9/20/22 (Address) Mt Home, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Mt Home Cemetery

DATE OF BURIAL

9-27-22

20. UNDERTAKER

Wm McBratney

ADDRESS

Boise Idaho

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH

County of ElmoreCity of Butte

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No. 34Registration District No. 2020

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 39966Registered No. 29

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.4. COLOR OR RACE White5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single

(Write the word.)

6. DATE OF BIRTH

March 10

(Day)

1922

(Year)

7. AGE

Yrs. 7Mos. 21

ds.

* LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

None.

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

J. W. Woodruff

11. BIRTHPLACE OF FATHER

(State or Country) Missouri

12. MAIDEN NAME OF MOTHER

May Ellburg

13. BIRTHPLACE OF MOTHER

(State or Country) Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. W. Woodruff(Address) Butte, Idaho

15.

Filed 11-2-1922Local Registrar J. C. Evans

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct. 31 - 1922

(Month)

(Day)

19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct. 16 1922, to Oct. 31 1922that I last saw her alive on Oct. 31 1922and that death occurred on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Typhoid fever(Duration) Yrs. 15 ds.

Contributory (Secondary)

(Duration) yrs. 15 mos. 15 ds.(Signed) O. P. Hamilton M. D.11/1/22 (Address) Butte, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted, if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Butte, Idaho

DATE OF BURIAL

11/2/22

20. UNDERTAKER

McBride

ADDRESS

Butte, Idaho

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A-25 M. 1-19.

RECEIVED
NOV 18 1922
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of ChautauqueCity of Montpelier

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No. 3Registration District No. 2421(No. 1 (Berentz) St.)File No. 39967Registered No. 26

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female White

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Aug 7 (Month) 7 (Day) 1922 (Year)

7. AGE

7 Yrs. 4 Mos. 26 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)None

9. BIRTHPLACE

(State or Country)

Ada Co., Ida

10. NAME OF FATHER

H. Berentz

11. BIRTHPLACE OF FATHER

(State or Country)

Poland

12. MAIDEN NAME OF MOTHER

Marie Salmon

13. BIRTHPLACE OF MOTHER

(State or Country)

Poland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. Berentz

(Address)

3rd St. Montpelier

15.

Filed 9-5-1922J. E. Evans
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 5th (Month) 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19... to 19...
that I last saw him alive on 19...
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Accident with
fallen turtle near
left leg,
(Duration) yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) H. J. Lester
9/5/1922 (Address) Montpelier, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Boise Idaho

DATE OF BURIAL

19...

20. UNDERTAKER

W. McBratney

ADDRESS

Boise Idaho

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Franklin
City of Oneida StationRegistration District No. 27
Primary Registration District No. 2119
(No. _____, St. _____)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lyle JenksState of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 39968
Registered No. 45

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH

November 7 1922
(Month) (Day) (Year)

7. AGE

0 Yrs. 0 Mos. 0 ds.IF LESS than 1 day
how many 4 hrs.
or 50 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).None

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Wilford B. Jenks

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Hazel Verna Moore

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wilford B. Jenks

(Address)

Preston, Idaho

15.

Filed Nov. 27 1922Mrs. Ida Lippitt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov. 7 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
Nov. 7 1922 to Nov. 7 1922
that I last saw h.a.m. alive on Nov. 7 1922
and that death occurred on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

Premature birth — between 6 & 7 m.

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Curtis Bland M. D.11/7/22 (Address) Preston Idaho

State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ✓ yrs. ✓ mos. ✓ In the days. State yrs. mos. daysWhere was disease contracted if not at place of death? ✓Former or usual residence ✓

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Preston CemeteryNov. 8 1922

20. UNDERTAKER

W. C. Erickson

ADDRESS

Preston, Idaho

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Franklin
City of Preston

Registration District No. 27
Primary Registration District No. 2119
(No. 155 North State St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Elise Vilhelmine Jorgensen

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 39969
Registered No. 63

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Female White

Married (Write the word.)

6. DATE OF BIRTH

February 12, 1878
(Month) (Day) (Year)

7. AGE

44 Yrs. 9 Mos. 7 ds. 3

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

At Home

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Denmark

10. NAME OF FATHER

Carl Doormann

11. BIRTHPLACE OF FATHER

(State or Country) Germany

12. MAIDEN NAME OF MOTHER

Vitta Frandsen

13. BIRTHPLACE OF MOTHER

(State or Country) Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Peter Jorgensen

(Address) Preston, Idaho

15.

Filed Nov. 27 1922 Mrs. Ida Lippert
Local Registrar

16. DATE OF DEATH

November 19 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov. 11 1922, to Nov. 19 1922,
that I last saw her alive on Nov. 19 1922,
and that death occurred on the date stated above, at 3:10 p M.

THE CAUSE OF DEATH* was as follows:

uraemic poisoning following
nephritis complicating pregnancy
(Duration) Yrs. mos. ds.

Contributory
(Secondary)

Bright's Disease

(Duration) yrs. mos. ds.

(Signed)

G. W. States M. D.

19. (Address) Preston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 1 yrs. 6 mos. 1 days. In the State 1 yrs. 6 mos. 1 days

Where was disease contracted if not at place of death?

Former or usual residence

Denmark

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Preston Cemetery

Nov. 21, 1922

20. UNDERTAKER

ADDRESS

Wm. O. Erickson

Preston, Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 39970
Registered No. 107

1. PLACE OF DEATH
County of Franklin
City of Preston

Registration District No. 27
Primary Registration District No. 2119
(No. 155 N State St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lamar Edward Jorgensen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH
November 13, 1922
(Month) (Day) (Year)

7. AGE
0 Yrs. 0 Mos. 0 ds. & IF LESS than 1 day
how many 12 hrs.
or 10 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. None
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE
(State or Country) Preston, Idaho.

10. NAME OF FATHER
Peter Jorgensen,

11. BIRTHPLACE OF FATHER
Denmark.
(State or Country)

12. MAIDEN NAME OF MOTHER
Elise Doormann,

13. BIRTHPLACE OF MOTHER
Denmark.
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Peter Jorgensen
(Address) Preston, Idaho

15. Filed Nov. 27 1922 Mrs. M. L. Jorgensen
Local Registrar

16. DATE OF DEATH

November 14, 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 13, 1922, to Nov. 14, 1922
that I last saw him alive on Nov. 13, 1922
and that death occurred on the date stated above, at 12:30 AM.
The CAUSE OF DEATH* was as follows:

atelectasis

(Duration) ✓ Yrs. ✓ mos. 1/2 ds.
Contributory (Secondary) ✓

(Duration) ✓ yrs. ✓ mos. ✓ ds.
(Signed) G. W. Stahls M. D.

Nov. 14, 1922 (Address) Preston, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Life mos. ✓ days. In the State Life mos. ✓ days

Where was disease contracted if not at place of death?

Former or usual residence None

19. PLACE OF BURIAL OR REMOVAL Preston, Idaho. DATE OF BURIAL Nov. 15, 1922
20. UNDERTAKER M. O. Erickson, ADDRESS Preston, Idaho.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39971**
Registered No. **68**

1. PLACE OF DEATH **Franklin**
County of **Franklin**
City of **Preston**
Registration District No. **27**
Primary Registration District No. **2119**
(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lillian Wilcox

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX **F.** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **single**
(Write the word.)

6. DATE OF BIRTH

May 1 1922
(Month) (Day) (Year)

7. AGE

6 Yrs. **6** Mos. **6** ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Preston Idaho

10. NAME OF FATHER

Wm Harvey Wilcox

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Lora Mable Mickelson

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Wm H. Wilcox
Preston Idaho

15.

Filed **Nov 27 1922**

Mrs Ida Lippert
Local Registrar

16. DATE OF DEATH

Nov 1 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

10-31 1922 to 11-1 1922
that I last saw him alive on **11-1 1922**
and that death occurred on the date stated above, at **6 P.M.**

The CAUSE OF DEATH* was as follows:

Surgical shock following operation for intussusception

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory (Secondary)

Intussusception

(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed)

A. R. Cutler M. D.

19. (Address) **Preston Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Preston Idaho

Nov 3 1922

20. UNDERTAKER

ADDRESS

Wm O. Erickson

Preston

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Franklin
City of Preston

If death occurs away from usual residence, give facts called for under special information.

RECEIVED

DEC 8 1922

CERTIFICATE OF DEATH

Registration District No. 27BUREAU OF VITAL STATISTICS
Primary Registration District No. 219

STANDARD

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 39972Registered No. 49

2. FULL NAME

Norma Elizabeth Bright

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Sep 15 1912
(Month) (Day) (Year)

7. AGE

10 Yrs. 2 Mos. 13 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

at home

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Winder Idaho

10. NAME OF FATHER

Gilbert Bright

11. BIRTHPLACE OF FATHER

(State or Country)

Richmond Utah

12. MAIDEN NAME OF MOTHER

Ruth McAlbiston

13. BIRTHPLACE OF MOTHER

(State or Country)

Richmond Wt.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Gilbert Bright(Address) Preston R.F.D. #2

15.

Filed Dec 4 1922Mrs. Harriet
Local Registrar

MEDICAL CERTIFICATE OF DEATH

50

16. DATE OF DEATH

Nov 28 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 1 1922 to Nov 28 1922
that I last saw her alive on Nov 28 1922and that death occurred on the date stated above, at 11:30 PM.

The CAUSE OF DEATH* was as follows:

Diabetic Coma

(Duration) Yrs. mos. ds.

Contributory
(Secondary)Diabetic mellitus

(Duration) yrs. mos. ds.

(Signed)

G. R. Quinter M. D.12/4 1922 (Address) Preston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Winder Idaho

DATE OF BURIAL

Dec 1 1922

20. UNDERTAKER

W. A. Skidmore

ADDRESS

Preston

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39973**
Registered No. **70**

1. PLACE OF DEATH

County of **Franklin**City of **Weston**

If death occurs away from
usual residence, give facts
called for under special in-
formation.

Registration District No. **27**Primary Registration District No. **2119**

(No. _____) (St.)

2. FULL NAME **Andrea Nielsen**

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED **Widowed** (Write the word.)

6. DATE OF BIRTH

May 9, 1842. (Month) (Day) (Year)

7. AGE

80 Yrs. **6** Mos. **21** ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work **At home**
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country) **Denmark**

10. NAME OF FATHER

Jens R. Jensen,

11. BIRTHPLACE OF FATHER

(State or Country) **Denmark.**

12. MAIDEN NAME OF MOTHER

Elsie (Not Known.)

13. BIRTHPLACE OF MOTHER

(State or Country) **Denmark.**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **James Nielsen**(Address) **Weston, Idaho**

15.

Filed **Dec. 5** 19**22** **Mrs. Ida Lippert**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

November 30, 1922. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 8 19**22** to **Oct 8** 19**22**
that I last saw her alive on **Oct 8** 19**22**
and that death occurred on the date stated above, at **10:20 AM**

The CAUSE OF DEATH* was as follows:

respirator & general debility

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) **Thos. B. Holder**

M. D.

Dec. 2, 1922 (Address) **Weston, Idaho.**

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death **52** yrs. _____ mos. _____ days. In the State **52** yrs. _____ mos. _____ days

Where was disease contracted
if not at place of death?

Former or usual residence **Denmark.**

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Weston Cemetery**Dec. 4, 1922.**

20. UNDERTAKER

Wm. O. Erickson

ADDRESS

Weston, Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39974**
Registered No. **64**

1. PLACE OF DEATH

County of **Franklin**
City of **Weston**

Registration District No. **27**
Primary Registration District No. **2119**
(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Francis Mildred Francis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WID-OWED OR DIVORCED **married**
(Write the word.)

6. DATE OF BIRTH

Sept- 26 1896
(Month) (Day) (Year)

7. AGE

26 Yrs. 1 Mos. 7 ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

Thos B. Holder

11. BIRTHPLACE OF FATHER

(State or Country)

Missouri

12. MAIDEN NAME OF MOTHER

Mildred Holder

13. BIRTHPLACE OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Frank Francis

(Address)

Weston Idaho

15.

Filed **Nov. 27 1922** **Mrs. H. Lippold**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov. 6 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **August-10 1922** to **Nov. 6 1922**
that I last saw her alive on **Nov. 5 1922**
and that death occurred on the date stated above, at **4:30 P.M.**
The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) **2 Yrs. 1 mos. 7 ds.**

Contributory (Secondary)

Labor - Infection from pneumonia
(Duration) **7 yrs. 1 mos. 7 ds.**

(Signed)

G. W. States M. D.

Nov 6 1922 (Address) **Preston Ida**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death **0 yrs. 2 mos. 25 days** In the State **0 yrs. 2 mos. 25 days**

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Preston, Idaho

Nov. 8, 1922

20. UNDERTAKER

ADDRESS

Wm. O. Erickson

Preston, I

RECEIVED

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Franklin Registration District No. 27
 City of Heston Primary Registration District No. 2119
 (No. _____ St.)

File No. 39975
 Registered No. 44

If death occurs away from
usual residence, give facts
called for under special
information.

2. FULL NAME

James H. Refoed

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED. Married
 (Write the word.)

6. DATE OF BIRTH.

Sept 28 1848
 (Month) (Day) (Year)

7. AGE

74 Yrs. 1 Mos. 15 ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work...
 (b) General nature of in-
dustry, business, or estab-
lishment in which employ-
ed (or employer).....

Laborer

9. BIRTHPLACE

(State or Country)

Denmark

10. NAME OF FATHER

Hans Refoed

11. BIRTHPLACE OF FATHER

(State or Country)

Denmark

12. MAIDEN NAME OF MOTHER

Cecelia Monk

13. BIRTHPLACE OF MOTHER

(State or Country)

Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

John A. Refoed
Preston Idaho.

15.

Filed Nov. 27 1912

1912

Mrs. Ida Lippert
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

November 13th 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Nov 1 1922, to Nov 13 1922,
 that I last saw him alive on Nov 12 1922,
 and that death occurred on the date stated above, at 10:35 AM.

The CAUSE OF DEATH* was as follows:

Pertussis

(Duration) Yrs. 14 mos. 14 ds.

Contributory (Secondary) appendicitis

(Duration) yrs. 14 mos. 14 ds.

(Signed) Thos B. Holder M. D.

Nov 19 1922 (Address) Preston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Weston Ida.

Nov. 15 1922

20. UNDERTAKER

ADDRESS

W. A. Skidmore

Preston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39976**

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of **Yamhill**City of **Ashton**Registration District No. **102**Primary Registration District No. **6**

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Paul H. Strieder

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

January**22****1886**

(Month)

(Day)

(Year)

7. AGE

36

Yrs.

10

Mos.

1

ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

Hotel Proprietor

9. BIRTHPLACE

(State or Country)

Fort Wayne Indiana

10. NAME OF FATHER

Strieder

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

C. G. Strieder

13. BIRTHPLACE OF MOTHER

(State or Country)

Fort Wayne Ind.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Dorothy Strieder

(Address)

West Yellowstone Mont.

15.

Filed

11-28-1922**1922****C. H. Cochran**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

72

16. DATE OF DEATH

11

(Month)

23

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

11-14-1922 to 11-23-1922that I last saw him alive on **11-23-1922**and that death occurred on the date stated above, at **11:30 P.M.**

The CAUSE OF DEATH* was as follows:

Influenza

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)**OK**

(Duration)

Yrs.

mos.

ds.

(Signed)

Ch. J. M. Wolfe

M. D.

11-20-1922 (Address) **Yellowstone Park Wyo**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Fort Wayne Indiana**19**

20. UNDERTAKER

ADDRESS

Lewis Strieder Ashton Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH **RECEIVED**
 County of **FREMONT** **DEC 4 1922** Registration District No. **103**
 City of **ASHTON** **BUREAU OF VITAL STATISTICS** Primary Registration District No. **6** St.)
FILED (No. 3)

File No. **39977**
 Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME **THAN. VANNOY**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **MALE** 4. COLOR OR RACE **WHITE** 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED **SINGLE**
 (Write the word.)

6. DATE OF BIRTH **JANUARY 1922**
 (Month) (Day) (Year)

7. AGE **IF LESS than 1 day**
 how many hrs. or min.?
 Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE **ASHTON IDAHO**
 (State or Country)

10. NAME OF FATHER **JEDDIE VANNOY**

11. BIRTHPLACE OF FATHER **UTAH**
 (State or Country)

12. MAIDEN NAME OF MOTHER **BURTICE WILLIAMS**

13. BIRTHPLACE OF MOTHER **UTAH.**
 (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) **CLYDE WILLIAMS**
 (Address) **ASHTON IDAHO.**

15. Filed **Nov. 19, 1922** **C. C. Meacham**
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **Nov 18 1922**
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Nov 16 1922**, to **Nov 18 1922**
 that I last saw him alive on **Nov 18 1922**
 and that death occurred on the date stated above, at **9 A.M.**
 The CAUSE OF DEATH* was as follows:
Pneumonia.

(Duration) Yrs. mos. **10** ds.
 Contributory (Secondary)

(Duration) yrs. mos. ds.
 (Signed) **E. L. Haggerty** M. D.
Nov 18 1922 (Address) **Ashton, Idaho.**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **ASHTON IDAHO** DATE OF BURIAL **11/19/22**

20. UNDERTAKER **LEWIS KISER** ADDRESS **ASHTON IDAHO.**

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH
in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 39978
Registered No. 1

1. PLACE OF DEATH

County of Fremont

City of St. Anthony

If death occurs away from
usual residence, give facts
called for under special in-
formation.

Registration District No. 99

Primary Registration District No. 2177

(No. 1922 St.)

2. FULL NAME Martha Krug Bauer

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Married

(Write the word.)

6. DATE OF BIRTH

November Third 1899

(Month)

(Day)

(Year)

7. AGE

22 Yrs. 10 Mos. 25 ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work

Housewife

(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country) Russel, Kansas

10. NAME OF
FATHER

John Henry Krug

11. BIRTHPLACE
OF FATHER

(State or Country) Russia

12. MAIDEN NAME
OF MOTHER

Mary Elizabeth Bunker

13. BIRTHPLACE
OF MOTHER

(State or Country) Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Charles W. Bauer

(Address)

Sugar City, Idaho

15.

Filed Oct. 1st. 1922

W. M. Hansen
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept
(Month)

28
(Day)

1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 24

1922

to Sept 28

1922

that I last saw her alive on Sept 28 1922

and that death occurred on the date stated above, at 3 A. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) Yrs. mos. 10 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Frank Watkins

M. D.

Sept 28 1922

(Address)

St Anthony

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Wilford

DATE OF BURIAL

Oct. 1st. 1922

20. UNDERTAKER

W. M. Hansen

ADDRESS

St. Anthony, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 39979
Registered No. 2

1. PLACE OF DEATH
County of Fremont Registration District No. 99
City of St. Anthony Primary Registration District No. 2177
(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Rosenlof

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH August 31 1858
(Month) (Day) (Year)

7. AGE 64 Yrs. 30 Mos. — ds. IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Fanner
(b) General nature of industry, business or establishment in which employed (or employer) _____

9. BIRTHPLACE Sweden
(State or Country)

10. NAME OF FATHER Neil Rosenlof

11. BIRTHPLACE OF FATHER Sweden
(State or Country)

12. MAIDEN NAME OF MOTHER Annie Mary Rosenqvist

13. BIRTHPLACE OF MOTHER Sweden
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Sam Littlefield
(Address) St Anthony Hotel

15. Filed Sept. 29 1922 W M Hansen
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH September 29th 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 26 1922 to Sept. 26 1922 that I last saw him alive on Sept. 26 1922 and that death occurred on the date stated above, at 12:30 PM.
The CAUSE OF DEATH* was as follows:
Apoplexy

(Duration) 1 Yrs. 6 mos. — ds.
Contributory (Secondary) none
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) J. E. Melton M. D.
Sept. 19 1922 (Address) St Anthony Hotel

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days.
Where was disease contracted if not at place of death? _____
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Skilford DATE OF BURIAL Oct. 1 1922

20. UNDERTAKER W M Hansen ADDRESS St. Anthony Hotel

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39980**
Registered No. **3**

1. PLACE OF DEATH

County of **Fremont**
City of **St. Anthony**

Registration District No. **99**
Primary Registration District No. **2177**
(No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Hazel Barber

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Single**
(Write the word.)

6. DATE OF BIRTH

March 16 19**10**
(Month) (Day) (Year)

7. AGE

12 Yrs. **6** Mos. **22** ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

Child

9. BIRTHPLACE

(State or Country)

Garland Utah

10. NAME OF FATHER

Arthur J. Barber

11. BIRTHPLACE OF FATHER

(State or Country)

Centerville Utah.

12. MAIDEN NAME OF MOTHER

Phessa Rose

13. BIRTHPLACE OF MOTHER

(State or Country)

Farmington Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

H. Barber
St. Anthony

15.

Filed **Oct 9th** 19**22** **H M Hanson**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 7 19**22**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Oct 1** 19**22** to **Oct 7** 19**22**
that I last saw her..... alive on **Oct 7** 19**22**
and that death occurred on the date stated above, at **8 A.M.**
The CAUSE OF DEATH* was as follows:
Diphtheria

(Duration) Yrs. mos. **7** ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. Frank Harkness M. D.
19**22** (Address) **St. Anthony Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Father

DATE OF BURIAL

Oct 8th 19**22**

20. UNDERTAKER

H M Hanson

ADDRESS

St. Anthony Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 39981

Registered No. 4

1. PLACE OF DEATH

County of Fremont
City of St. Anthony

Registration District No. 99

Primary Registration District No. 2177

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Leonard Rud Anderson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-OWED OR DIVORCED

Male Caucasian Single
(Write the)

6. DATE OF BIRTH

May 14 1908
(Month) (Day) (Year)

7. AGE

14 Yrs. 5 Mos. 1 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Working on farm
and attending school

9. BIRTHPLACE

(State or Country)

Ada County, Idaho

10. NAME OF FATHER

John Rud

11. BIRTHPLACE OF FATHER

(State or Country)

Not known

12. MAIDEN NAME OF MOTHER

Camelia Rud

13. BIRTHPLACE OF MOTHER

(State or Country)

Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. D. Vincent, Supt.
St. Anthony, Ida

(Address)

Filed Oct 16th 1922

W. M. Hansen

Local Registrar

MEDICAL CERTIFICATE OF DEATH

169

16. DATE OF DEATH

Oct 15 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19
that I last saw h. alive on 19
and that death occurred on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. E. McElroy

M. D.

10-16-1922 (Address) St. Anthony, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Parker

DATE OF BURIAL

Oct 16th 1922

20. UNDERTAKER

W. M. Hansen

ADDRESS

St. Anthony, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39982**
Registered No. **3**

1. PLACE OF DEATH

County of **Greenough**
City of **St. Anthony**

Registration District No. **99**

Primary Registration District No. **2177**

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Birch

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

June 30th 1862
(Month) (Day) (Year)

7. AGE

60 Yrs. **3** Mos. **19** ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country) **Colville Utah**

10. NAME OF FATHER

Richard Birch

11. BIRTHPLACE OF FATHER

(State or Country) **England**

12. MAIDEN NAME OF MOTHER

Mary Ann Hale

13. BIRTHPLACE OF MOTHER

(State or Country) **England**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Daniel Birch**
(Address) **St Anthony Idaho**

15. Filed **Oct-18th 1922** **W.M. Hansen**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct. 18th 1922
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from **Oct. 1 - 1922** to **Oct. 10 - 1922**

that I last saw him alive on **10-10-1922**

and that death occurred on the date stated above, at **2 P.M.**

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory (Secondary) **Chronic Bronchitis**

(Duration) **1** yrs. _____ mos. _____ ds.

(Signed) **J E Mellen** M. D.

10-19-1922 (Address) **St Anthony**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

St. Anthony

DATE OF BURIAL

Oct. 21st 1922

20. UNDERTAKER

W M Hansen

ADDRESS

St. Anthony Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39983**
Registered No. **6**

1. PLACE OF DEATH **RECEIVED**
Registration District No. **99**
County of **Tremont** DEC 4 1922
Primary Registration District No. **2177**
City of **St. Anthony** (No. _____) St. _____
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Dorcas Winters**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **female** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **single**
(Write the word.)
6. DATE OF BIRTH **Oct 3 1921**
(Month) (Day) (Year)
7. AGE **1 Yrs. 6 Mos. 21 ds.**
IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work **none**
(b) General nature of industry, business or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country) **Ida.**

10. NAME OF FATHER

Arthur Winters

11. BIRTHPLACE OF FATHER

(State or Country) **Utah**

12. MAIDEN NAME OF MOTHER

Matilda Howard

13. BIRTHPLACE OF MOTHER

(State or Country) **Ida**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Arthur Winters**(Address) **Chesler Idaho**15. Filed **Oct. 22 1922**

W. M. Hansen
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 22 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Oct 16 1922** to **Oct 21 1922**
that I last saw him alive on **Oct 21 1922**
and that death occurred on the date stated above, at **6 A.** M.

The CAUSE OF DEATH* was as follows:

cholera infantum(Duration) _____ Yrs. _____ mos. **10** ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) **W. M. Hansen**

M. D.

10/22/22 (Address) **St. Anthony Ida.**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Chesler Ida

DATE OF BURIAL

Oct 23 1922

20. UNDERTAKER

W. M. Hansen

ADDRESS

St. Anthony Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Fremont
City of St. AnthonyRegistration District No. 99Primary Registration District No. 2177

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Daw Gray WalkerFile No. 39984Registered No. 7

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

married

(Write the word.)

6. DATE OF BIRTH

February 12 1843
(Month) (Day) (Year)

7. AGE

79 Yrs. 8 Mos. 17 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Farmer

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Illinois

10. NAME OF FATHER

William Walker

11. BIRTHPLACE OF FATHER

(State or Country) England

12. MAIDEN NAME OF MOTHER

Elizabeth Gray

13. BIRTHPLACE OF MOTHER

(State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Maple Walker(Address) St. Anthony, Idaho

15.

Filed Oct 31st 1922D. M. Hansen
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

10 - 29 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 1921 to 10 - 29 1922
that I last saw him alive on 10 - 28 1922
and that death occurred on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:

Myocarditis(Duration) _____ Yrs. _____ mos. 7 ds.Contributory (Secondary) Myocarditis(Duration) 2 yrs. _____ mos. _____ ds.(Signed) J. E. Mellon M. D.1030 1922 (Address) St. Anthony

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

St. Anthony

DATE OF BURIAL

Oct 31st 1922

20. UNDERTAKER

D. M. Hansen

ADDRESS

St. Anthony Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39985**
Registered No. _____

1. PLACE OF DEATH

County of *Idaho*City of *Emmett*

Registration District No. _____

Primary Registration District No. *6*

(No. _____) St. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

George D. Arney

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male white

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married

(Write the word.)

6. DATE OF BIRTH

Oct 15 1869
(Month) (Day) (Year)

7. AGE

53 Yrs. - *18* Mos. *18* ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Laborer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

Jesse Arney

11. BIRTHPLACE OF FATHER

(State or Country)

Not known

12. MAIDEN NAME OF MOTHER

Nancy Jane Kerrin

13. BIRTHPLACE OF MOTHER

(State or Country)

Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. G. D. Arney

(Address)

Emmett Idaho

15.

Filed

11/10

19

22

Local Registrar

MEDICAL CERTIFICATE OF DEATH

28

16. DATE OF DEATH

November 3 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from~~
once about two months ago

that I last saw him alive on *that date* 19

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

R. N. Cummings

(Address) *Emmett*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Emmett Idaho

DATE OF BURIAL

11/14 1922

20. UNDERTAKER

C. D. Buckner

ADDRESS

Emmett Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Idaho*City of *Emmett*

If death occurs away from usual residence, give facts called for under special information.

Registration District No. *6*Primary Registration District No. *6*(No. *6*)File No. *39986*Registered No. *79*

2. FULL NAME

Edwin Marshall Southwick

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3: SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

married

(Write the word.)

6. DATE OF BIRTH

Apr 5

(Day)

868

(Year)

7. AGE

54 Yrs. *6* Mos. *10* ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Farmer

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Wisconsin

10. NAME OF FATHER

Marshall Southwick

11. BIRTHPLACE OF FATHER

(State or Country)

New York

12. MAIDEN NAME OF MOTHER

Maria Betts

13. BIRTHPLACE OF MOTHER

(State or Country)

Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. E. Southwick

(Address)

Emmett Idaho

15.

Filed

11/10 *1922*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

*Oct**15**1922*

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19

to

*19*that I last saw him..... alive on..... *19*

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Heart failure
(I saw him only after death)

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

R. N. Cunningham

M. D.

11/10 *1922*

(Address)

Emmett

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

yrs.

mos.

In the

days.

State

yrs.

mos.

days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Emmett Idaho

DATE OF BURIAL

Oct 17 *1922*

20. UNDERTAKER

W. Bucknum

ADDRESS

Emmett Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Gem*
City of *Emmett*

Registration District No.

Primary Registration District No.

(No. St.)

File No. *39987*

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Martin L. Howard

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male white

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Child
(Write the word.)

6. DATE OF BIRTH

Oct 6 1918
(Month) (Day) (Year)

7. AGE

4 Yrs. *1* Mos. *2* ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

child

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Ben D. Howard

11. BIRTHPLACE OF FATHER

(State or Country)

North Dakota

12. MAIDEN NAME OF MOTHER

Oliver Morehouse

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mrs. Bess O. Howard*
(Address) *Emmett Ida*

15.

Filed *11/10* 19 *22*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 8 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *Nov 8 1922* to *Nov 8 1922*that I last saw him alive on *Nov 8 1922*and that death occurred on the date stated above, at *11 P* M.

The CAUSE OF DEATH* was as follows:

Ileo Colitis(Duration) Yrs. *5* mos. *6* ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *R. N. Cummings* M. D.*11/10 1922* (Address) *Emmett*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Emmett Ida

DATE OF BURIAL

11/10 1922

20. UNDERTAKER

O. Bucknum

ADDRESS

Emmett Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 399988

1. PLACE OF DEATH
County of *Ben*
City of *Emmett*

Registration District No.
Primary Registration District No. *6*
(No. St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Dorothy Belle Boren*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *female* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Infant*
(Write the word.)

6. DATE OF BIRTH *July 16 1921*
(Month) (Day) (Year)

7. AGE *1* Yrs. *3* Mos. *21* ds. IF LESS than 1 day how many.....hrs. or.....min.?

8. OCCUPATION *Infant*
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE *Idaho*
(State or Country)

10. NAME OF FATHER *Albert Boren*

11. BIRTHPLACE OF FATHER *Utah*
(State or Country)

12. MAIDEN NAME OF MOTHER *Veda Hughes*

13. BIRTHPLACE OF MOTHER *Idaho*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *Albert Boren*
(Address) *Emmett Ida*

15. Filed *11/9* 19*22* *J. L. Reynolds*
Local Registrar

16. DATE OF DEATH *Nov 7 1922*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 19..... to 19..... that I last saw h..... alive on 19..... and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:
No physician in attendance
Indications were that
pneumonia caused death

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) *W. M. Brown - Coroner*

19..... (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Emmett Ida* DATE OF BURIAL *11/9 1922*

20. UNDERTAKER *W. H. Dickinson* ADDRESS *Emmett Idaho*

1. PLACE OF DEATH

County of *Gooding*
City of *Gooding*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED CERTIFICATE OF DEATH

Registration District No. *24*
Primary Registration District No. _____
(No. _____) (St. _____)State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. *39989*
Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male *White* *Single* (Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year) *1852*

7. AGE

70 Yrs. _____ Mos. _____ ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

Miner

9. BIRTHPLACE

(State or Country)

Penn.

10. NAME OF FATHER

not known

11. BIRTHPLACE OF FATHER

(State or Country)

" "

12. MAIDEN NAME OF MOTHER

not known

13. BIRTHPLACE OF MOTHER

(State or Country)

" "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed *10-24-1922**F. J. Cairns, M.D.*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct + 22 19*22*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct. 15 19*22*, to *Oct. 22* 19*22*
that I last saw him alive on *Oct. 22* 19*22*
and that death occurred on the date stated above, at *1:30* AM.

The CAUSE OF DEATH* was as follows:

*Acute Diffuse Nephritis**not known patient in state of coma when brought in.*
(Duration) yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *T. A. Johnson, D. M.D.**Oct 24 1922* (Address) *Gooding, Id.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

South Hampton, Pa

DATE OF BURIAL

10/19/22

20. UNDERTAKER

A. E. Thompson

ADDRESS

Gooding

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No.

Primary Registration District No.

(No.)

(St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male

White

(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

(Year)

7. AGE

About 55 yrs.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

10-10-1922

J. T. Coymus

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

October 8

(Month)

(Day)

1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

October 6, 1922, to October 8, 1922

that I last saw him alive on Oct. 8, 1922

and that death occurred on the date stated above, at 12 A.M.

The CAUSE OF DEATH* was as follows:

Acidosis

(Duration)

Yrs.

mos.

4 ds.

Contributory
(Secondary)

nephritis

(Duration)

Yrs.

mos.

ds.

(Signed)

H. E. Lamb

M. D.

October 22

(Address) Gooding, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Indiana polis, Ind

DATE OF BURIAL

10-10-1922

20. UNDERTAKER

A. Thompson

ADDRESS

Gooding

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

RECEIVED CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. _____
County of Ida. _____
City of Boise _____
If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Jephtha McCampbell

File No. 39991

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Mar 4 1897
(Month) (Day) (Year)

7. AGE 25 yrs. 6 mos. 6 ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Washington State

10. NAME OF FATHER Q. Campbell

11. BIRTHPLACE OF FATHER (State or Country) North Carolina

12. MAIDEN NAME OF MOTHER Leona G. Watts

13. BIRTHPLACE OF MOTHER (State or Country) Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. B. Campbell
(Address) Joseph Id.

15. Filed Sept 6 1922 W. A. Forkett
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 4 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 10 1921 to Mar 4 1922
that I last saw her alive on June 26 1922
and that death occurred on the date stated above, at 7 P.M.
The CAUSE OF DEATH* was as follows:

Diabetes
2 years sick
(Duration) yrs. mos. ds.

Contributory (Secondary) _____
(Duration) yrs. mos. ds.
(Signed) W. A. Forkett M. D.
Sept 1922 (Address) White Bird

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Campfield DATE OF BURIAL Sept 6 1922
20. UNDERTAKER Naris ADDRESS Cottonwood

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Idaho Registration District No. DEC
 City of White Bird Primary Registration District No. STANLEY (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lanier J. Gallaway

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 39992
 Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widowed
 (Write the word.)

6. DATE OF BIRTH Dec 4 1929
 (Month) (Day) (Year)

7. AGE 92 Yrs. 3 Mos. 1 ds. IF LESS than 1 day
 how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country) Georgia U.S.A.

10. NAME OF FATHER

Thomas Billiland

11. BIRTHPLACE OF FATHER

(State or Country) Not Known

12. MAIDEN NAME OF MOTHER

Not Known

13. BIRTHPLACE OF MOTHER

(State or Country) Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thomas B. Gallaway
 (Address) _____

15. Filed 19

Local Registrar

MEDICAL CERTIFICATE OF DEATH 154

16. DATE OF DEATH

March 9 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 10 1922 to Mar 8 1922
 that I last saw her alive on Mar 8 1922
 and that death occurred on the date stated above, at 2:30 A.M.

The CAUSE OF DEATH* was as follows:

Old Age

(Duration) Yrs. mos. ds.

Contributory (Secondary)

Congestion of lung

(Duration) yrs. mos. ds.

(Signed)

W.A. Fookett

M. D.

Mar 10 1922 (Address) White Bird Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

White Bird

DATE OF BURIAL

Mar 10 1922

20. UNDERTAKER

Hancock

ADDRESS

Grangeville

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.
County of Idaho Primary Registration District No.
City of White Bird (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Virginia HaydonFile No. 39993
Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED widow
(Write the word.)

6. DATE OF BIRTH

April 7 1859
(Month) (Day) (Year)

7. AGE

65 Yrs. 1 Mos. 18 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Housewife

9. BIRTHPLACE

(State or Country)

Missisippi

10. NAME OF FATHER

George Galloway

11. BIRTHPLACE OF FATHER

(State or Country)

Alabama

12. MAIDEN NAME OF MOTHER

Louise Gillilano

13. BIRTHPLACE OF MOTHER

(State or Country)

Georgia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harriett T. Willman
(Address) White Bird

15.

Filed..... 19.....

W. A. Foskett
Local Registrar

MEDICAL CERTIFICATE OF DEATH

40

16. DATE OF DEATH

May 25 19 22
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Jan 1st 19 22 to May 19 22
that I last saw her alive on 11 24 19 22
and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Cancer of Liver(Duration) 1 Yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. A. Foskett

M. D.

19 22

(Address)

White Bird

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

White Bird

DATE OF BURIAL

May 27 19 22

20. UNDERTAKER

E. S. Hancock

ADDRESS

Grangerville
2da.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.
County of Ida Primary Registration District No.
City of White Bird (No.) St.)

If death occurs away from usual residence, give facts called for under special information.

File No. 39994
Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

James Baxter Berry

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widower
(Write the word.)

6. DATE OF BIRTH

Dec 26 1845
(Month) (Day) (Year)

7. AGE

76 3 29
Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Gardener

9. BIRTHPLACE

(State or Country)

Illinois

10. NAME OF FATHER

Preston Berry

11. BIRTHPLACE OF FATHER

(State or Country)

Tenn.

12. MAIDEN NAME OF MOTHER

Sarah Wilcox

13. BIRTHPLACE OF MOTHER

(State or Country)

Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Elva Berry

(Address)

White Bird - Ida

15.

Filed

19W.A. Fiskett
Local Registrar

MEDICAL CERTIFICATE OF DEATH

126

16. DATE OF DEATH

April 26 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from April 1, 1922 to April 23, 1922
that I last saw him alive on April 23, 1922
and that death occurred on the date stated above, at — M.

The CAUSE OF DEATH* was as follows:

Cancer of Prostate(Duration) Yrs. mos. ds.
Contributory (Secondary) metastasis to throat(Duration) yrs. mos. ds.
(Signed) W.A. Fiskett M. D.19 (Address) White Bird

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

White Bird

DATE OF BURIAL

April 27, 1922

20. UNDERTAKER

Magg

ADDRESS

Grangerille
Ida.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Idaho
City of Joseph - P.O.

Registration District No.

Primary Registration District No.

City of Idaho No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Samuel Harrison WrightState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 39995

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH

Aug 3 1854
(Month) (Day) (Year)

7. AGE

67 Yrs. 8 Mos. 4 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Farmer

9. BIRTHPLACE

(State or Country)

Penn.

10. NAME OF FATHER

Andrew Jackson Wright

11. BIRTHPLACE OF FATHER

(State or Country)

Family don't know

12. MAIDEN NAME OF MOTHER

" " "

13. BIRTHPLACE OF MOTHER

(State or Country)

" " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs Ada M. Wright

(Address)

Boles - Idaho

15.

Filed

19.....

W.A. Foskett

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 7 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
..... 19..... to 19.....that I last saw him alive on Apr - 6 - 1922
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Influenza..... (Duration) Yrs. mos. 10 ds.Contributory
(Secondary)

..... (Duration) yrs. mos. ds.

(Signed)

W. A. Foskett

M. D.

19.....

(Address)

White Bird

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Joseph Idaho

DATE OF BURIAL

Apr 9, 1922

20. UNDERTAKER

Undertaker from

ADDRESS

CottonwoodIdaho

1. PLACE OF DEATH

County of 2da
City of Riggins

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John H. Killoran

CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

State of Idaho

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 39996
Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH

Nov. 8 1850
(Month) (Day) (Year)

7. AGE

72 Yrs. 9 Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Stockman

9. BIRTHPLACE

(State or Country)

New York

10. NAME OF FATHER

Mark Killoran

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Not Known

13. BIRTHPLACE OF MOTHER

(State or Country)

11

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. H. Lamont

(Address)

Pollock

15.

Filed

19W. A. Foskett
Local Registrar

MEDICAL CERTIFICATE OF DEATH

79

16. DATE OF DEATH

Sept 10 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from 19 to 19that I last saw him alive on Sept. 10, 1922
and that death occurred on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Heart Failure

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. A. Foskett M. D.19

(Address)

White Bird

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Riggins - 2da

DATE OF BURIAL

9/12 1922

20. UNDERTAKER

none

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **39997**
Registered No. _____

1. PLACE OF DEATH _____
Registration District No. _____
County of Idaho _____
Primary Registration District No. _____
City of Joseph, Idaho _____ (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Minnie Elizabeth Talbott

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Female | White | married
(Write the word.)

6. DATE OF BIRTH

Nov. 30 1880
(Month) (Day) (Year)

7. AGE

41 Yrs. 4 Mos. 17 ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

House wife

9. BIRTHPLACE

(State or Country)

Moscow Ida

10. NAME OF FATHER

John Thornburg

11. BIRTHPLACE OF FATHER

(State or Country)

Penna

12. MAIDEN NAME OF MOTHER

Anna Bahorcas

13. BIRTHPLACE OF MOTHER

(State or Country)

Cal.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Platte Talbott

(Address)

Joseph Ida

15.

Filed

19

W.A. Foshett
Local Registrar

MEDICAL CERTIFICATE OF DEATH

10

16. DATE OF DEATH

April 7 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 5 1922 to April 7 1922, that I last saw her alive on 4 1922 and that death occurred on the date stated above, at 11 M.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) _____ Yrs. _____ mos. 15 ds.

Contributory (Secondary)

Pneumonia

(Duration) _____ yrs. _____ mos. 3 ds.

(Signed)

W.A. Foshett

M. D.

1922

(Address)

White Bird Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Joseph Ida

April 7, 1922

20. UNDERTAKER

ADDRESS

Rev. Chase - Cottonwood Ida

CERTIFICATE OF DEATH

1. PLACE OF DEATH

Registration District No. _____
 County of Ida DEPT. _____
 City of White Bird (No. _____) (St.) _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

None

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 39998

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED _____
 (Write the word.)

6. DATE OF BIRTH

July 27 1922
 (Month) (Day) (Year)

7. AGE

Yrs. _____ Mos. One ds. _____

IF LESS than 1 day
 how many _____ hrs.
 or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work _____

(b) General nature of industry, business or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country) White Bird

10. NAME OF FATHER

Hugh Alvin Vignor

11. BIRTHPLACE OF FATHER

(State or Country) Joseph Oregon

12. MAIDEN NAME OF MOTHER

Gertrude Dawson

13. BIRTHPLACE OF MOTHER

(State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Gertrude Vignor

(Address) White Bird

15.

Filed _____ 19 _____

W. A. Foshett
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

158a

16. DATE OF DEATH

July 28 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____ 19 _____ to _____ 19 _____

that I last saw him _____ alive on _____ 19 _____

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Premature

_____ (Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
 (Secondary)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W. A. Foshett M. D.

_____ 19 _____ (Address) White Bird

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

White Bird

DATE OF BURIAL

July 29, 1922

20. UNDERTAKER

none

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **39999**

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of **Ida** Registration District No. _____
City of **White Bird** Primary Registration District No. _____
DE No. _____ St.) _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

None

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

male **white** (Write the word.)

6. DATE OF BIRTH

July 25 19**23**
(Month) (Day) (Year)

7. AGE

— Yrs. **—** Mos. **one** ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work _____
(b) General nature of industry, business or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country) **White Bird**

10. NAME OF FATHER

Hugh Alvin Vignor

11. BIRTHPLACE OF FATHER

(State or Country) **Joseph Oregon**

12. MAIDEN NAME OF MOTHER

Gertrude Dawson

13. BIRTHPLACE OF MOTHER

(State or Country) **Iowa**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Gertrude Vignor**(Address) **White Bird**

15.

Filed _____ 19 _____

W. A. Fokett
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 28 19**23**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____ 19 _____, to _____ 19 _____
that I last saw h. _____ alive on _____ 19 _____
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Premature

_____ (Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) **W. A. Fokett** M. D.19 _____ (Address) **White Bird**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

White Bird

DATE OF BURIAL

July 29 19**23**

20. UNDERTAKER

none

ADDRESS _____

1. PLACE OF DEATH

Registration District No. 03County of IdahoPrimary Registration District No. 2181City of Ellettsville

(No. _____)

St.) _____

File No. 40001Registered No. 30

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ellsworth Green

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX M4. COLOR OR RACE W5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Single

(Write the word.)

6. DATE OF BIRTH _____

(Month) _____

(Day) _____

(Year) _____

7. AGE about 65

IF LESS than 1 day

how many _____ hrs.

or _____ min.?

8. OCCUPATION Miner

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE ?

(State or Country)

10. NAME OF FATHER ?11. BIRTHPLACE OF FATHER ?

(State or Country)

12. MAIDEN NAME OF MOTHER ?13. BIRTHPLACE OF MOTHER ?

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. J. Mangg(Address) Ellettsville15. See 1Filed 19 2219 2248 Ellettsville

Local Registrar

16. DATE OF DEATH Nov 5

(Month)

(Day)

19 22
(Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 19 _____, to _____ 19 _____

that I last saw him alive on _____ 19 _____

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows.

Gun shot wound self inflicted accidental

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) A. J. Mangg11/7/22(Address) Ellettsville

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL EllettsvilleDATE OF BURIAL Nov 8 19 2220. UNDERTAKER A. J. ManggADDRESS Ellettsville

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 103

County of Idaho

Primary Registration District No.

City of Grangeville (No. St.)

File No. 40002

Registered No. 29

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Harvey Douglas Johnson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widowed

(Write the word.)

6. DATE OF BIRTH.

June 30 1860

(Month)

(Day)

(Year)

7. AGE

61

Yrs.

Mos.

ds.

IF LESS than 1 day
how many.....hrs. or
.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

Retired Farmer.

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

G. J. Johnson

11. BIRTHPLACE OF FATHER

(State or Country)

Pennsylvania

12. MAIDEN NAME OF MOTHER

Mandy Bond

13. BIRTHPLACE OF MOTHER

(State or Country)

Tennessee

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Fred Johnson

(Address)

Grangeville

15.

Filed Dec 1 1922 G. S. Stockton

Local Registrar

MEDICAL CERTIFICATE OF DEATH

64

16. DATE OF DEATH

Nov 17 1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1 1922, to Nov 17 1922

that I last saw him alive on Nov 1 1922 and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) Yrs. mos. 17 ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed)

G. S. Stockton

M. D.

11/19/1922 (Address) Grangeville Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Denver

Nov. 19 1922

20. UNDERTAKER

ADDRESS

J. Mangg

Grangeville

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Idaho
City of GrangevilleRegistration District No. 103Primary Registration District No. 2181

(No.) (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Geo A YahrausState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 40003Registered No. 28

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

Feb 28 1871
(Month) (Day) (Year)

7. AGE

57 Yrs. 8 Mos. 9 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business or establishment in which employed (or employer).....Farmer

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

Fred A Yahraus

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

?

13. BIRTHPLACE OF MOTHER

(State or Country)

?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs Geo Yahraus

(Address)

Grangeville

15.

Filed

Dec 1 1922 382 Grangeville

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov. 6 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov. 4 1922 to Nov. 6 1922
that I last saw him alive on Nov. 4 1922
and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage(Duration) Yrs. mos. 14 ds.
Contributory (Secondary) Tuberculosis(Duration) 3 yrs. mos. ds.
(Signed) B Chipman M. D.12-4 1922 (Address) Grangeville Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Pravieview

DATE OF BURIAL

Nov. 9 1922

20. UNDERTAKER

A J Marney

ADDRESS

Grangeville

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

40005

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of IdahoCity of FerdinandRegistration District No. 100Primary Registration District No. 2183(No. 100)

St.)

File No. 22

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ervin Leslie King

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Oct 22 1922
(Month) (Day) (Year)

7. AGE

Yrs 12 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Walter King

11. BIRTHPLACE OF FATHER

(State or Country) Idaho

12. MAIDEN NAME OF MOTHER

Kathrine Arnsen

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Walter F. King(Address) Ferdinand Idaho

15.

Filed Nov - 30 19 22W. F. Orr
Local Registrar

16. DATE OF DEATH

Nov 4 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Nov 31 1922 to Nov 4 1922that I last saw him alive on Nov 31 1922,
and that death occurred on the date stated above, at 7.9 M.

The CAUSE OF DEATH* was as follows:

erypelas.(Duration) Yrs mos 3 ds.Contributory
(Secondary)(Duration) Yrs mos ds.(Signed) J. D. Shinnick M. D.Nov 4 19 22 (Address) Cottonwood Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs mos days In the State Yrs mos days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Ferdinand Id 11-4 19 22

20. UNDERTAKER

W. F. Orr Cottonwood Id

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

40006

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Idaho
City of Green CreekRegistration District No. 105
Primary Registration District No. 2183
(No. STATE St.)File No. 23
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Henry Jansen

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

64

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Widower
(Write the word.)

6. DATE OF BIRTH

May fourth 1848
(Month) (Day) (Year)

7. AGE

74 Yrs. 6 Mos. 9 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Farmer

9. BIRTHPLACE

(State or Country) Illinois, Co. Effingham

10. NAME OF FATHER

Anton Jansen

11. BIRTHPLACE OF FATHER

(State or Country) Oldenburg, Germany

12. MAIDEN NAME OF MOTHER

Elisabeth Brummer

13. BIRTHPLACE OF MOTHER

(State or Country) Hanover, Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Anton Jansen
(Address) Green Creek, Ida.15. Filed Nov 30 19 22W. F. Orr
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

16. DATE OF DEATH

Nov. 13 19 22
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Oct 31 1922, to Nov 13 1922, that I last saw him alive on Nov 7 1922 and that death occurred on the date stated above, at 2 P M. The CAUSE OF DEATH* was as follows:Cerebral Hemorrhage(Duration) Yrs. mos. 14 ds.
Contributory (Secondary) arteriosclerosis(Duration) yrs. mos. ds.
(Signed) J. J. Sheinick M. D.
Nov 19 1922 (Address) Cottonwood Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence Green Creek, Ida.19. PLACE OF BURIAL OR REMOVAL Green Creek, Ida. DATE OF BURIAL Nov 15, 192220. UNDERTAKER A. H. Nau ADDRESS Cottonwood Ida.

CERTIFICATE OF DEATH

40007 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Idaho DEC 1922
County of Idaho Registration District No. 105
City of Kenterville Primary Registration District No. 2183
(No. St.)File No. 24
Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

George L. Russell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED single
(Write the word.)6. DATE OF BIRTH Nov 23 1922
(Month) (Day) (Year)7. AGE Yrs. Mos. ds.
IF LESS than 1 day how many 5 hrs. or min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Laurance Russell

11. BIRTHPLACE OF FATHER

(State or Country) Idaho

12. MAIDEN NAME OF MOTHER

Mary Shea

13. BIRTHPLACE OF MOTHER

(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Laurence Russell
(Address) Kenterville, Ida.15. Filed Nov. 30 1922 W. F. Orr
Local Registrar

MEDICAL CERTIFICATE OF DEATH

151-a

16. DATE OF DEATH Nov 23 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from 19....., to 19.....
that I last saw him alive on Nov. 23 1922
and that death occurred on the date stated above, at 99 M.

The CAUSE OF DEATH* was as follows:

Fetal underdevelopment
Premature Birth, 7 months

..... (Duration) Yrs. mos. ds.

Contributory
(Secondary)

..... (Duration) yrs. mos. ds.

(Signed) Wesley F. Orr M. D.Nov. 23 1922 (Address) Cottonwood, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Kenterville, Idaho DATE OF BURIAL 11-23 192220. UNDERTAKER Father Martin, Kenterville, Idaho ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Idaho
City of KassiaRegistration District No. 106
Primary Registration District No. 2184
(No. 106 St.)File No. 40008
Registered No. 120

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Robert Russell Brauchton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH.

August 21 1922
(Month) (Day) (Year)

7. AGE

2 Yrs. 2 Mos. 2 ds.IF LESS than 1 day
how many hrs. or
min.

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....Infant

9. BIRTHPLACE

(State or Country)

Kassia - Idaho

10. NAME OF FATHER

William Brauchton

11. BIRTHPLACE OF FATHER

(State or Country)

Michigan

12. MAIDEN NAME OF MOTHER

Minnie Kiele

13. BIRTHPLACE OF MOTHER

(State or Country)

Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Minnie Kiele(Address) Kassia - Idaho

15.

Filed Oct-14 1922J. M. S. K. K. K.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct-12 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Oct-7 1912, to Oct-12 1912, that I last saw him alive on Oct-11 1922 and that death occurred on the date stated above, at 9:45 A.M.
The CAUSE OF DEATH* was as follows:Iles Colitis(Duration) Yrs. mos. ds.Contributory
(Secondary)(Duration) yrs. mos. ds.(Signed) J. M. S. K. K. K. M. D.Oct-12 1922 (Address) Kassia - Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Kassia - Idaho

DATE OF BURIAL

Oct-14 1922

20. UNDERTAKER

Family

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

1. PLACE OF DEATH *Idaho* Registration District No. *103*
 County of *Idaho* Primary Registration District No. *1001*
 City of *Brangerville* (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Pauline White

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. *40009*
 Registered No. *27*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *7* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED
married
 (Write the word.)

6. DATE OF BIRTH

June 18 1837
 (Month) (Day) (Year)

7. AGE

86 Yrs. *3* Mos. *20* ds.

IF LESS than 1 day
 how many _____ hrs.
 or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Housewife

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

New York City

10. NAME OF FATHER

John Stepler

11. BIRTHPLACE OF FATHER

(State or Country)

New York

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Fred White

(Address)

Brangerville Idaho

15.

Filed

Nov 1 1922

G S Stockton

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 10 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Sept 12 1922* to *Oct 10 1922* that I last saw her alive on *Sept 30 1922* and that death occurred on the date stated above, at *6 A* M. The CAUSE OF DEATH* was as follows:

acute attack of Enterocolitis

(Duration) _____ Yrs. _____ mos. *26* ds.

Contributory (Secondary)

Senile Decay

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

G S Stockton

M. D.

10/12/22 (Address) *Brangerville Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Prarie view

DATE OF BURIAL

Oct 12 1922

20. UNDERTAKER

E S Hancock

ADDRESS

Brangerville

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Idaho Registration District No. 103
 City of Grangeville Primary Registration District No. 1001
 (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary Ellen Eimers

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 40010
Registered No. 26

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

Jan 1 1903
(Month) (Day) (Year)

7. AGE

19 Yrs. 8 Mos. 0 ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

House wife

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Illinois

10. NAME OF FATHER

John Kimbrell

11. BIRTHPLACE OF FATHER

(State or Country)

Tennessee

12. MAIDEN NAME OF MOTHER

Mary Gray

13. BIRTHPLACE OF MOTHER

(State or Country)

Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Gil Eimers

(Address)

Grangeville

15.

Filed Nov 1 1922 G B Stockton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 1 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 1 1922 to Oct 1 1922

that I last saw him alive on Oct 1 1922

and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus

(Duration) about 10 yrs. 0 mos. 0 ds.

Contributory
(Secondary)

(Duration) 0 yrs. 0 mos. 0 ds.

(Signed)

G B Stockton

M. D.

10/1 1922 (Address) Grangeville Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. 0 mos. 0 days. In the State yrs. 0 mos. 0 days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Albion Illinois

DATE OF BURIAL

Oct 2 1922

20. UNDERTAKER

A J Maugy

ADDRESS

Grangeville

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 40011
Registered No. 69

1. PLACE OF DEATH
County of Jefferson
City of Kenfield
Registration District No. 98
Primary Registration District No. 12176
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME
Chas. E. Jenson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH
January 10 1865
(Month) (Day) (Year)

7. AGE 62 1/2
IF LESS than 1 day how many hrs. or min.?
Yrs. Mos. ds.

8. OCCUPATION
(a) Trade, profession or particular kind of work. Farming
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Denmark

10. NAME OF FATHER
Soren Jenson

11. BIRTHPLACE OF FATHER
(State or Country) Denmark

12. MAIDEN NAME OF MOTHER
? Meline
Caroline Madson

13. BIRTHPLACE OF MOTHER
(State or Country) Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ray Fisher
(Address) Riggins, Idaho

15. Filled 11-15-22 Ray Fisher
Local Registrar

16. DATE OF DEATH
Nov 12 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 6th 1922 to Nov. 12 1922 that I last saw him alive on Nov 6th 1922 and that death occurred on the date stated above, at 10:30 A.M.

The CAUSE OF DEATH* was as follows:
Angina Pectoris
Do not know ds.
(Duration) Yrs. mos.

Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) Ray Fisher M. D.
Nov 14 1922 (Address) Riggins, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL
Scout, Ida
DATE OF BURIAL 11-15-22

20. UNDERTAKER
E. E. Woodward
ADDRESS
Idaho Falls

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40014**
Registered No. **66**

1. PLACE OF DEATH

County of JeffersonCity of RayRegistration District No. 192Primary Registration District No. 192St. Idaho

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jake Ober Keller

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15. Filed

Nov 10 1922Ray H Fisher

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept

(Month)

12

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19..... to 19.....

that I last saw him..... alive on..... 19.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Phenitiazine and complications

(Duration)..... Yrs..... mos..... ds.

Contributory (Secondary)

(Duration)..... Yrs..... mos..... ds.

(Signed)

Sam F Price M.D.

19.....

(Address) Paris Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

RaySept 13 1922

20. UNDERTAKER

ADDRESS

Ed SalmonRay

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH

Registration District No. 98
County of Jefferson Primary Registration District No. 2176
City of Booth (No. 111) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Francis Eugene Campbell
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 40015
Registered No. 65

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH May 6
(Month) (Day) (Year)

7. AGE 78 Yrs. 4 Mos. 13 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Farmer
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Tenn.

10. NAME OF FATHER Daniel Campbell

11. BIRTHPLACE OF FATHER
(State or Country) Tenn.

12. MAIDEN NAME OF MOTHER Maria Katie

13. BIRTHPLACE OF MOTHER
(State or Country) Tenn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. G. Campbell
(Address)

15. Nov 10 1922 Ray H. Fiske
Filed Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 18 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 18 1922 to Sept 19 1922
that I last saw him alive on Sept 18 1922
and that death occurred on the date stated above, at _____ M.
The CAUSE OF DEATH* was as follows:

Angina Pectoris
(Duration) Yrs. mos. 2 ds.
Contributory (Secondary) Cardio-vascular chronic
(Duration) yrs. mos. ds.
(Signed) Ray H. Fiske M. D.
(Address) Booth, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Amis, County DATE OF BURIAL 9-21-1922

20. UNDERTAKER Ed Gillen ADDRESS Booth, Ida.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 40017
Registered No. 63

1. PLACE OF DEATH RECEIVED
County of Jefferson Registration District No. 98
City of Rigby Primary Registration District No. 2-176
STAT. REG. NO. 63 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Gilda Pearl Prophet

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH

March 14 1919
(Month) (Day) (Year)

7. AGE

3 Yrs. 5 Mos. 29 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Rigby, Jefferson Co, Idaho

10. NAME OF FATHER

David D. Prophet

11. BIRTHPLACE OF FATHER

(State or Country) Centerville, Utah

12. MAIDEN NAME OF MOTHER

Lillian M. Saxton

13. BIRTHPLACE OF MOTHER

(State or Country) Salt Lake City, Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Minnie L. Shanks
(Address) Route 3, Rigby, Idaho

15. Nov 10 1922 Ray H. Fisher
Filed Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 12 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 5 1922 to Sept 12 1922

that I last saw her alive on Sept 12 1922, and that death occurred on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:

Acute Enteritis

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) W. H. Hudson M. D.

19. (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Rigby Idaho 9/14 1922

20. UNDERTAKER

Ed. L. Linn Rigby

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
40018

1. PLACE OF DEATH
County of Jefferson
City of Heimer
Registration District No. 98
Primary Registration District No. 2176
(No. St.)

File No. 40018
Registered No. 62

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Julius Kremer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widowed
(Write the word.)

6. DATE OF BIRTH Dec 4 1845
(Month) (Day) (Year)

7. AGE 76 Yrs. 12 Mos. 12 ds. 1 hr. 45 min.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION Retired
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE Germany
(State or Country)

10. NAME OF FATHER Jacob Kremer

11. BIRTHPLACE OF FATHER Germany
(State or Country)

12. MAIDEN NAME OF MOTHER Catherine

13. BIRTHPLACE OF MOTHER Germany
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Kremer
(Address) Heimer Ida

15. Filed Oct 10 1922
Local Registrar W. Fisher

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 3 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1st to Oct 3 1922
that I last saw him alive on Sept 28 1922
and that death occurred on the date stated above, at 1 P. M.
The CAUSE OF DEATH* was as follows:
Hemiplegia

(Duration) Yrs. mos. ds.
Contributory (Secondary) Age; Semblity
(Duration) yrs. mos. ds.
(Signed) Ray Fisher M. D.
10/4/22 (Address) Regley, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Idaho Falls DATE OF BURIAL 10/5 1922

20. UNDERTAKER Edwin Woodley ADDRESS Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40019**
Registered No. **61**

1. PLACE OF DEATH
County of **Jefferson** Registration District No. **98**
City of **Reynolds** Primary Registration District No. **2176**
(No. St.)
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME **Anna Petersen**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
6. DATE OF BIRTH **10 24 1922**
(Month) (Day) (Year)
7. AGE _____ Yrs. _____ Mos. _____ ds. IF LESS than 1 day how many **13** hrs. or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) **Lewisville Ida**

10. NAME OF FATHER

Steve Petersen

11. BIRTHPLACE OF FATHER

(State or Country) **Utah**

12. MAIDEN NAME OF MOTHER

Julia Casper

13. BIRTHPLACE OF MOTHER

(State or Country) **Lewisville Ida**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Steve Petersen**

(Address) **Lewisville**

15. **Nov 10 1922** **Ray Fisher**
Filed Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **Oct 24 1922**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Oct 24 1922** to **1922** that I last saw her alive on **Oct 24 1922** and that death occurred on the date stated above, at **7 P. M.**
The CAUSE OF DEATH* was as follows:

**Coronary defects;
necrosis of heart valves**

(Duration) _____ Yrs. _____ mos. **one** ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) **J. H. Anderson** M. D.

19. (Address) _____

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL **Lewisville** DATE OF BURIAL **10/25 1922**

20. UNDERTAKER **Ed. Hallin** ADDRESS **Reidy**

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Jefferson*City of *Highway #3*

If death occurs away from usual residence, give facts called for under special information.

Registration District No. *98*Primary Registration District No. *2176*

(No. _____ St.)

File No. *40020*Registered No. *60*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Clara Bernice Mattson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female. White

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

July 1 1921
(Month) (Day) (Year)

7. AGE

1 Yrs. *2* Mos. *8* ds. *8* days
IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) *Highway #3*

10. NAME OF FATHER

Clarence Mattson

11. BIRTHPLACE OF FATHER

(State or Country) *Ogden Utah*

12. MAIDEN NAME OF MOTHER

Emilia Mattson

13. BIRTHPLACE OF MOTHER

(State or Country) *Salt Lake Utah*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Clarence Mattson*
(Address) *Highway #3*

15.

Filed *Nov 10 1922* *Ray H. Fisher*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct. 8 1922
(Month) (Day) (Year)HEREBY CERTIFY, That I attended deceased from *Oct 7 1922* to *Oct 8 1922*
that I last saw her alive on *Oct 8 1922*

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Dysentery with emaciation(Duration) _____ Yrs. _____ mos. *7* ds.

Contributory (Secondary) _____

(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed) *Sam Thrice* M. D._____ 19 _____ (Address) *Revere Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Archer

20. UNDERTAKE

Ed. Helmer

DATE OF BURIAL

10-10-1922

ADDRESS

Revere

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH *Jefferson* Registration District No. *98*
 County of *Jefferson* Primary Registration District No. *2176*
 City of *Ray* (No. _____ St.)

File No. _____
 Registered No. *59*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Anna Brown Robbins

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *F* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED
 (Write the word.)

6. DATE OF BIRTH

*July 9**1899*

7. AGE

83 Yrs. *3* Mos. *5* ds.

IF LESS than 1 day
 how many _____ hrs.
 or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

House wife

9. BIRTHPLACE

(State or Country)

Hawthorn Norfolk Co. England

10. NAME OF FATHER

Charles Brown

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Mrs. Arviss

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs Edith Orosen

(Address)

Ray

15.

Filed

Nov 10 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

*October 14**1922*

17. I HEREBY CERTIFY, That I attended deceased from *Aug 1st* *1922* to *Oct 14* *1922*

that I last saw him alive on *Oct 13th* *1922*,
 and that death occurred on the date stated above, at *4 P* M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

F. G. Anderson

M. D.

19

(Address)

Ray

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

*Edw. Gilman**Ray*

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Jefferson
City of RichfieldRegistration District No. 98
Primary Registration District No. 2176
(No. Emergency Hosp St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Christopher WalzState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 40022
Registered No. 58

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Never married
(Write the word.)

6. DATE OF BIRTH

D.K. July 2 1851
(Month) (Day) (Year)

7. AGE

about 70
Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Former

(b) General nature of industry, business or establishment in which employed (or employer)

✓

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

D.K.

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

D.K.

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

L.C. Walz

(Address)

Richfield, Id.

15.

Filed

Nov 10 1922 Ray H. Fisher
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 23 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 23 1922 to Feb 23 1922that I last saw him alive on Feb 23 1922and that death occurred on the date stated above, at 5:41 P.M.

The CAUSE OF DEATH* was as follows:

Sebor Pneumonia

(Duration) Yrs. mos. ds.

Contributory (Secondary)

Flu

(Duration) yrs. mos. ds.

(Signed)

Eug. Jones

M. D.

19

(Address)

Richfield, Id.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. days

Where was disease contracted if not at place of death? on ranch

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Rose Hill

DATE OF BURIAL

Nov 21 1922

20. UNDERTAKER

W. H. Hayne

ADDRESS

Idaho Falls

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of *Jefferson* Registration District No. *98*
City of *Butte* Primary Registration District No. *2176*
(No. St.)

File No. *40023*
Registered No. *57*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Richard Curtin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WID-
OWER OR DIVORCED *married*
(Write the word.)

16. DATE OF DEATH *May 20* 19*22*
(Month) (Day) (Year)

6. DATE OF BIRTH *July 2* 19*91*
(Month) (Day) (Year)

7. AGE *21* Yrs. Mos. ds. IF LESS than 1 day
how many hrs. or min.?

17. I HEREBY CERTIFY, That I attended deceased from *19* to *19*
that I last saw h. alive on *19*
and that death occurred on the date stated above, at *M.*
The CAUSE OF DEATH* was as follows:

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

miner

accident run over by freight train.
(Duration) Yrs. mos. ds.

9. BIRTHPLACE

(State or Country)

Montana (Butte)

10. NAME OF FATHER

Simon Curtin

Contributory (Secondary)

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

(Duration) yrs. mos. ds.

(Signed) *J. H. Balmer*

19 (Address)

12. MAIDEN NAME OF MOTHER

May, Mary

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Thos. Mary*
(Address) *Butte*

19. PLACE OF BURIAL OR REMOVAL

Butte Mont

DATE OF BURIAL

May 23 1922

15. Filed *Nov 10 1922* *Ray H. Fisher*
Local Registrar

20. UNDERTAKER

Chaffey Hayes

ADDRESS

Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40024**
Registered No. **36**

1. PLACE OF DEATH. *Jefferson* Registration District No. *98*
County of *Jefferson* Primary Registration District No. *2176*
City of *Roberts* (Mol.) *Roberts* St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Lucinda Gibson*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *F* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. *Widowed*
(Write the word.)

6. DATE OF BIRTH *Dec 28 1834*
(Month) (Day) (Year)

7. AGE *88* yrs. mos. ds.
IF LESS than 1 day how many hrs. or mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work *None*
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE *Pennsylvania*
(State or Country)

10. NAME OF FATHER *Sparks*

11. BIRTHPLACE OF FATHER *Penn.*
(State or Country)

12. MAIDEN NAME OF MOTHER *Wheffield*

13. BIRTHPLACE OF MOTHER *Penn.*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *W. Gibson*
(Address) *Roberts*

15. Filed *Nov 10 1922* *Kay Fisher*
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH *Dec 17 1922*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *191* to *191*,
that I last saw h. *alive* on *191*,
and that death occurred on the date stated above, at *10* M.
The CAUSE OF DEATH* was as follows:

Smelly
(Duration) yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) *Earl D. Jones* M. D.
10/21 1922 (Address) *Roberts*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.
Where was disease contracted if not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL *Memorial* DATE OF BURIAL *10/20 1922*

20. UNDERTAKER *E. C. Hayes* ADDRESS *Idaho Falls*

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 98

County of Jefferson

Primary Registration District No. 2176

City of Butte

(No. Roberts Ida)

St.)

File No. 40025

Registered No. 55

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME J. C. Roark

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

male

white

Single
(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

1 (Year)

7. AGE

about 67

Yrs.

Mos.

ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Rancher.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Texas.

10. NAME OF FATHER

Don't know

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John Baker

(Address)

Butte

15.

Filed

Nov 10 1922

Ray H. Fisher
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 19

(Month)

(Day)

1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19

that I last saw him alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Influenza Coronary
Artery

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

E. J. Jones

M. D.

19 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Rough

DATE OF BURIAL

Oct 13 1922

20. UNDERTAKER

C. J. Hays

ADDRESS

Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40026**
Registered No. **54**

1. PLACE OF DEATH **Jefferson** Registration District No. **98**
County of **Jefferson** Primary Registration District No. **2176**
City of **Roberts** (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Joseph M. Irving**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Married**
(Write the word.)

6. DATE OF BIRTH **Aug. 27 1875**
(Month) (Day) (Year)

AGE **47** yrs. _____ mos. _____ ds. IF LESS than 1 day how many _____ hrs. or _____ mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work **Rancher**
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE **Scotland, S.**
(State or Country)

10. NAME OF FATHER **John Irving**

11. BIRTHPLACE OF FATHER **Scotland, S.**
(State or Country)

12. MAIDEN NAME OF MOTHER **Thomaria Maxwell**

13. BIRTHPLACE OF MOTHER **Scotland, S.**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Mrs. Margaret Irving**
(Address) **Dillon Mont**

15. Filed **Nov 10 1922** **Ray Fisher**
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH **October 13th 1922**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **10/18/22** 191, to **10/18/22** 191, that I last saw him alive on **10/18/22** 191, and that death occurred on the date stated above, **2:30 P. M.**

The CAUSE OF DEATH* was as follows:
Perforating Gastric Ulcer

Do not know (Duration) yrs. _____ mos. _____ ds.
Contributory (Secondary) **Do not know**
(Duration) yrs. _____ mos. _____ ds.
(Signed) **E. J. Jones** M. D.
10/19 1922 (Address) **Roberts, Ida.**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. **1** days. In the State _____ yrs. _____ mos. _____ days.
Where was disease contracted if not at place of death? **Do not know**

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL **Dillon Mont** DATE OF BURIAL _____ 191

20. UNDERTAKER **Piffet Hays** ADDRESS **Idaho Falls, Ida.**

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

Registration District No.

Primary Registration District No.

City of

St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of area and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Signature)

Oct 13 1922

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 126

40028

County of KootenaiPrimary Registration District No. 2204File No. 3City of Rose Lake(No. 1)

St.)

Registered No. 11

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Thomas Jefferson Johnson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

malewhitemarried

(Write the word.)

6. DATE OF BIRTH.

Feb

(Month)

(Day)

1853

(Year)

7. AGE

67

Yrs.

9

Mos.

11

ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or unemployed).Farmer

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Batts

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Alonzo Evan Johnson

(Address)

Rose Lake, Idaho

15.

Filed 12-11922J. W. Timm
Local Registrar

16. DATE OF DEATH

Nov

(Month)

21

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I ~~attended~~ deceased from did not attend him
191..... to 191.....that I last saw him..... alive on 191.....
and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

No previous illness.
Found dead in bed.

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) L. J. Stauffer M. D.
Nov 21 1922 (Address) Rose Lake, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Spotkanie ParkNov 25 1922

20. UNDERTAKER

ADDRESS

McShanekinKeelys J. J. J.WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH

County of *Boonewat*
City of *Harrison*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

May Connell

CERTIFICATE OF DEATH

Registration District No. *30*Registration District No. *1067*

BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *40029*Registered No. *1160*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F.

4. COLOR OR RACE

*W.*5. SINGLE, MARRIED, WIDOWED OR DIVORCED
married
(Write the word.)

6. DATE OF BIRTH

5 - 21 - 1868
(Month) (Day) (Year)

7. AGE

54 Yrs. *6* Mos. *9* ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)*Housewife*

9. BIRTHPLACE

(State or Country)

Minn.

10. NAME OF FATHER

Geo. Cogswell

11. BIRTHPLACE OF FATHER

(State or Country)

N. H.

12. MAIDEN NAME OF MOTHER

Clark

13. BIRTHPLACE OF MOTHER

(State or Country)

Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. E. Arnold
Harrison, Ida.

15.

Filed *Dec 4 1922* *W. Drennan*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

11 (Month) *30* (Day) *1922* (Year)17. I HEREBY CERTIFY, That I attended deceased from *Aug 8th 1922*, to *Nov 30th 1922* that I last saw her alive on *Nov 29th 1922*, and that death occurred on the date stated above, at *8 p.* M.
The CAUSE OF DEATH* was as follows:*Mitral Insufficiency*(Duration) *18* Yrs. *5* mos. *5* ds.

Contributory (Secondary)

Dropsy(Duration) *5* Yrs. *5* mos. *5* ds.

(Signed)

Lewis H. Mead M. D.*142* (Address) *Coastal Ave. Id.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Harrison Ida

DATE OF BURIAL

11-2-1922

20. UNDERTAKER

E. Carney

ADDRESS

Coastal Ave.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 30
County of Kootenai
City of Coeur d'Alene, Idaho, Montana St.)
Primary Registration District No. 1057

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mabel Irene Foster

File No. 40030
Registered No. 1107

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F.

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

single.
(Write the word.)

6. DATE OF BIRTH

7 - 28 - 1913
(Month) (Day) (Year)

7. AGE

9 Yrs. 4 Mos. 2 ds.
IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

School girl

9. BIRTHPLACE

(State or Country)

Iri.

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

Floyd Foster

Iowa

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Annie Baxter

Kan.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Floyd Foster
111st & Montana

15. Filed

Sept 4 1922
D. D. Drennan
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov. 30 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 23 1922 to Nov 29 1922

that I last saw h. alive on Nov 29 1922

and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows: probably

Traumatic mesenteric thrombosis

causing peritonitis

(Postmortem refused)

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) H. H. Haeberle M. D.

130 1922 (Address) Coeur d'Alene, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and, (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Lakereween Cem.

DATE OF BURIAL

12-1 1922

20. UNDERTAKER

C. Carstedt

ADDRESS

Coraline

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40032**
Registered No. **1167**

1. PLACE OF DEATH
County of **Kootenai**
City of **Coeur d'Alene**
Registration District No. **30**
Primary Registration District No. **1057**
(No. **4th** St.)
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME **David B. Buttb**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX **M.** 4. COLOR OR RACE **W.** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **widowed**
(Write the word.)

16. DATE OF DEATH

Nov. 26 19**22**
(Month) (Day) (Year)

6. DATE OF BIRTH **March 26** 18**45**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Nov. 22** 19**22**, to **Nov. 26** 19**22** that I last saw him alive on **Nov. 25** 19**22** and that death occurred on the date stated above, at **3 A.M.**
The CAUSE OF DEATH* was as follows:

7. AGE **77** Yrs. **0** Mos. **0** ds.
IF LESS than 1 day how many hrs. or min.?

Apoplexy
(Duration) Yrs. mos. ds.
Contributory (Secondary) **Arteriosclerosis**
(Duration) yrs. mos. ds.
(Signed) **J. D. Wynn** M. D.
Nov. 27 19**22** (Address) **Coeur d'Alene Idaho**

8. OCCUPATION **Retired**
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

9. BIRTHPLACE **Penn.**
(State or Country)

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

10. NAME OF FATHER **Frederic Buttb**

At place of death yrs. mos. days. In the State yrs. mos. days.

11. BIRTHPLACE OF FATHER **Penn.**
(State or Country)

Where was disease contracted if not at place of death?

12. MAIDEN NAME OF MOTHER **Sarah Wilson**

Former or usual residence

13. BIRTHPLACE OF MOTHER **Penn.**
(State or Country)

19. PLACE OF BURIAL OR REMOVAL **Forest Cem. C. D. A** DATE OF BURIAL **11-28** 19**22**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) **J. D. Wynn**
(Address) **Coeur d'Alene**

20. UNDERTAKER **W. Cassady** ADDRESS **Coeur d'Alene**

15. Filled **Dec. 4** 19**22** **D. D. Brennan**
Local Registrar

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40033**

1. PLACE OF DEATH

RECEIVED
DEC 8 1922
BUREAU
STATE

Registration District No. 30
County of Kootenai Primary Registration District No. 1051
City of Rathdrum (No. _____) St. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Charles R Bailey

Registered No. 1135

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH May 13 1884
(Month) (Day) (Year)

7. AGE 68 Yrs. 4 Mos. 6 ds. IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Henry Bailey

11. BIRTHPLACE OF FATHER

(State or Country)

New York

12. MAIDEN NAME OF MOTHER

Emmie Rathdrum

13. BIRTHPLACE OF MOTHER

(State or Country)

New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm E. R. Bailey

(Address) Rathdrum Idaho

15.

Filed Dec 2 19 22 Ed Drennan

Local Registrar

MEDICAL CERTIFICATE OF DEATH

92

16. DATE OF DEATH

October 19 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 13 19 22 to Oct. 19 19 22
that I last saw him alive on Oct. 19 19 22
and that death occurred on the date stated above, at 11:59 M.
The CAUSE OF DEATH* was as follows:
Acute lobar pneumonia

(Duration) _____ Yrs. _____ mos. 8 ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Frank W. W. M. D.

10/21/1922 (Address) Rathdrum, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Rathdrum Idaho

DATE OF BURIAL

10/22 19 22

20. UNDERTAKER

E. L. Casey

ADDRESS

Rathdrum Idaho

FORM V. S. No. 5-25 M. 1-19.

DEC 8 1922

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH **BUREAU OF VITAL STATISTICS**
 Registration District No. 30
 County of Kootenai Primary Registration District No. 1051
 City of Rathdrum (No. _____ St.)

File No. _____
 Registered No. 1136

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Thron Olsen

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
 (Write the word.)

16. DATE OF DEATH

10/22 19 22
 (Month) (Day) (Year)

6. DATE OF BIRTH

1872
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

7. AGE

50 Yrs. _____ Mos. _____ ds.

IF LESS than 1 day
 how many _____ hrs.
 or _____ min.?

_____ 19 _____, to _____ 19 _____

that I last saw h. _____ alive on _____ 19 _____

and that death occurred on the date stated above, at _____ M.

8. OCCUPATION

(a) Trade, profession or particular kind of work. P
 (b) General nature of industry, business or establishment in which employed (or employer).

The CAUSE OF DEATH* was as follows: Chronic interstitial Nephritis with dropsy & affection of heart & sudden death. I interviewed the body & made inquiries.

(Duration) 2 Yrs. _____ mos. _____ ds.

Contributory
 (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Frank Olsen M. D.

10/23/22 (Address) Rathdrum, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Spokane, Wn. DATE OF BURIAL 10/23 1922

20. UNDERTAKER C. L. Cassidy ADDRESS Rathdrum

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Nettie M. Beglar

(Address) Spokane

15. Filed Dec 3 1922 S. D. Brennan

Local Registrar

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40035**
Registered No. **1137**

1. PLACE OF DEATH

County of **Kootenai**
City of **Camden**

Registration District No. **30**
Primary Registration District No. **1951**
(No. **Camden Idaho** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Tobey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

male **white** **single**
(Write the word.)

6. DATE OF BIRTH

Nov 6 1922
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Frank L Tobey

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Ester Mercer

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

F. L. Tobey

(Address)

Camden Idaho

15.

Filed **Dec 3 1922** **Ada Arenas**
Local Registrar

16. DATE OF DEATH

Nov 6 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19
that I last saw him alive on **Nov 6 1922**
and that death occurred on the date stated above, at **11** M.
The CAUSE OF DEATH* was as follows:

Premature birth

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Nov 8 1922

(Address) **Camden Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Fourth Cemetery

11/7 1922

20. UNDERTAKER

ADDRESS

R B Mooney Camden Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40037**
Registered No. **1139**

1. PLACE OF DEATH
County of **Idaho** Registration District No. **30**
City of **Post, Ida** Primary Registration District No. **1051**
(No. **Post, Ida** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **William Ashby**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Married**
(Write the word.)

6. DATE OF BIRTH **May 7 1847**
(Month) (Day) (Year)

7. AGE **74** Yrs. **6** Mos. **0** ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. **Farmer**
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) **England**

10. NAME OF FATHER **John Ashby**

11. BIRTHPLACE OF FATHER
(State or Country) **England**

12. MAIDEN NAME OF MOTHER **Eliza Taylor**

13. BIRTHPLACE OF MOTHER
(State or Country) **England**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) **Fred Ashby**
(Address) **Post, Ida**

15. Filed **Dec 3 1922** **L. L. Brennan**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **Nov 7 1922**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Nov 3 1922** to **Nov 7 1922** that I last saw him alive on **Nov 7 1922** and that death occurred on the date stated above, at **4:30 PM**.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (apoplexy)
(Duration) Yrs. **1** mos. **4** ds.

Contributory (Secondary)
(Duration) yrs. **1** mos. **4** ds.

(Signed) **J. L. McCauley, M. D.**
Nov 9 1922 (Address) **Post Falls, Ida**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. **1** mos. **4** days. In the State yrs. **1** mos. **4** days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **Forest Cemetery** DATE OF BURIAL **11/9 1922**

20. UNDERTAKER **Robertson** ADDRESS **Post Falls, Ida**

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Postville*City of *Athol*Registration District No. *30*Primary Registration District No. *1051*

(No.)

(St.)

File No. *40038*Registered No. *1140*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *James Bradley*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male*4. COLOR OR RACE *White*5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*6. DATE OF BIRTH *Unknown*(Month) *Unknown*(Day) *Unknown*(Year) *Unknown*7. AGE *80*Yrs. *60*

Mos.

ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION *Laborer*

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer) *Northern Pacific R.R.*9. BIRTHPLACE *Ireland*

(State or Country)

10. NAME OF FATHER *Frank Williams*11. BIRTHPLACE OF FATHER *Unknown*

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Frank Williams*(Address) *Athol, Ida.*15. Filed *Dec. 3 1922*19 *22*

Local Registrar

MEDICAL CERTIFICATE OF DEATH *12*16. DATE OF DEATH *Nov 8 1922*

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19.....

19.....

that I last saw him..... alive on..... 19.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

*Found dead.
Neck Broken from fall
in cellar (Accidental)*

(Duration)

Yrs.

mos.

ds.

Contributory

(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed) *R. B. Morney*

M. D.

19.....

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Forest Cemetery*DATE OF BURIAL *Nov 9 1922*20. UNDERTAKER *R. B. Morney*ADDRESS *Forest Cemetery*

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 30

County of

Primary Registration District No. 1057

City of

(No. 1644)

City of

File No. 40039

Registered No. 1111

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Emmie F. Hammond

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

F.

W.

widowed

(Write the word.)

6. DATE OF BIRTH

Jan

26

1843

(Month)

(Day)

(Year)

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

78

Yrs.

9

Mos.

15

ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

N. H.

10. NAME OF FATHER

Rufus Seery

11. BIRTHPLACE OF FATHER

(State or Country)

N. Y.

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

N. H.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

H. H. Hammond

(Address)

Corner of Alene Id.

15.

Filed

Dec 3

1922

D. D. Drennan

Local Registrar

16. DATE OF DEATH

Nov.

11

1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov. 11 1922, to Nov. 11 1922

that I last saw her alive on Nov. 11 1922

and that death occurred on the date stated above, at 11:30 M.

The CAUSE OF DEATH* was as follows:

apoplexy

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

D. D. Drennan M. D.

Nov. 13 1922, (Address) Corner of Alene Id.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Forest Cemetery Nov. 11 - 1922

20. UNDERTAKER

ADDRESS

C. Cassidy C. Id.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics1. PLACE OF DEATH Rootenai
County of Boone Registration District No. 30
City of Boone Primary Registration District No. 1051
(No. 926-677 St.)File No. 40041
Registered No. 1143

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ruth Mary Larson

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH

May 13 1918
(Month) (Day) (Year)

7. AGE

4 Yrs. 6 Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. —
(b) General nature of industry, business or establishment in which employed (or employer). —

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

L M Larson

11. BIRTHPLACE OF FATHER

(State or Country) Idaho

12. MAIDEN NAME OF MOTHER

Mary Ruddy

13. BIRTHPLACE OF MOTHER

(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) L M Larson(Address) Boone & Alameda

15.

Filed Dec 3 1922 S D Brennan

Local Registrar

16. DATE OF DEATH

Nov 13 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 9 1922, to Nov 13 1922
that I last saw him alive on Nov 12 1922,
and that death occurred on the date stated above, at 10 AM.

The CAUSE OF DEATH* was as follows:

Diphtheria(Duration) Yrs. 1 mos. 1 ds.Contributory
(Secondary)(Duration) Yrs. — mos. — ds.(Signed) Alexander Barclay

M. D.

11-14 1922 (Address) Boone & Alameda Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. — mos. — days. In the State 4 yrs. — mos. — days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St Thomas CemeteryNov 14 1922

20. UNDERTAKER

ADDRESS

R B MooneyCDH

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 40042
Registered No. 1144

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene
Registration District No. 30
Primary Registration District No. 1051
(No. 709 Government Way St.)
If death occurs away from usual residence, give facts for under special information.
2. FULL NAME Mary Webster Gaylord

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX F
4. COLOR OR RACE W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)
6. DATE OF BIRTH July 4 1854
(Month) (Day) (Year)
7. AGE 68 Yrs. 4 Mos. 9 ds.
IF LESS than 1 day how many hrs. or min.?
8. OCCUPATION Housewife
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).
9. BIRTHPLACE Chicopee, Massachusetts
(State or Country)
10. NAME OF FATHER Charles H. Webster
11. BIRTHPLACE OF FATHER Massachusetts
(State or Country)
12. MAIDEN NAME OF MOTHER Mary Buckminster
13. BIRTHPLACE OF MOTHER Massachusetts
(State or Country)
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. W. Cook
(Address)

16. DATE OF DEATH Nov 13 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 8 1922 to Nov 13 1922 that I last saw him alive on Nov 13 1922 and that death occurred on the date stated above, at 12:15 P.M.

The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage followed by paralysis

(Duration) Yrs. mos. ds.
Contributory (Secondary) Arterial Sclerosis
(Duration) yrs. mos. ds.
(Signed) J. H. Koedee M. D.
11/13 1922 (Address) Coeur d'Alene, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Forest Cemetery
DATE OF BURIAL 11-14 1922
20. UNDERTAKER C. Casady
ADDRESS Coeur d'Alene

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Portland*
City of *Portland*Registration District No. *30*Primary Registration District No. *1057*(No. *1221* This *Office* St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Harold James Nilson*State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *40043*Registered No. *1145*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Nov 16 1922
(Month) (Day) (Year)

7. AGE

— Yrs. *—* Mos. *1* ds.

IF LESS than 1 day

how many _____ hrs.

or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) *Idaho*

10. NAME OF FATHER

A. C. Nilson

11. BIRTHPLACE OF FATHER

(State or Country) *Mo*

12. MAIDEN NAME OF MOTHER

Bessie Battelston

13. BIRTHPLACE OF MOTHER

(State or Country) *Mo*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *A. C. Nilson*(Address) *Portland 2nd*

15.

Filed *Dec 3 1922* *Address*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 17 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

.....19..... to19.....

that I last saw him alive on19.....

and that death occurred on the date stated above, atM.

The CAUSE OF DEATH* was as follows:

.....(Duration)Yrs.mos.ds.

Contributory
(Secondary)

.....(Duration)Yrs.mos.ds.

(Signed)M. D.

.....19..... (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....Yrs.mos.days. In the State.....Yrs.mos.days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Forest Cemetery

DATE OF BURIAL

Nov 18 1922

20. UNDERTAKER

P. J. Mooney

ADDRESS

Portland

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 40044
Registered No. 11416

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PLACE OF DEATH

County of Kootenai
City of Coeur d'AleneRegistration District No. 30
Primary Registration District No. 1051
No. 310 Foster St.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Joseph McCullough

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED single
(Write the word.)6. DATE OF BIRTH April 16
(Month) (Day) (Year)7. AGE not sure but think about 72 yrs IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Retired

9. BIRTHPLACE

(State or Country)

N. B. Canada

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Marjorie Cope

(Address)

15.

Filed

Dec 3 19 22D. D. Brennan
Local Registrar

16. DATE OF DEATH

Nov. 19 19 22
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Nov. 19 19 22 to Nov. 19 19 22
that I last saw him alive on Nov. 19 19 22
and that death occurred on the date stated above, at 10:30 M.
The CAUSE OF DEATH* was as follows:Lobar Pneumonia(Duration) Yrs. mos. 7 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Nov. 22 19 22

(Address)

John M. D.
Coeur d'Alene, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

St. Thomas Cem. Coeur d'Alene

DATE OF BURIAL

11-22 19 22

20. UNDERTAKER

C. Cassidy

ADDRESS

C. Cassidy

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 40045

Registered No. 1152

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

Registration District No. 30
County of Tootenue
Primary Registration District No. 1051
City of Coeur d'Alene (No. 1119) Fourth St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Marquita B Leach

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH

Jan 3 1922
(Month) (Day) (Year)

7. AGE

Yrs. 16 Mos. 24 ds.

IF LESS than 1 day
how many.....hrs.
or.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Ida

10. NAME OF FATHER

R R Leach

11. BIRTHPLACE OF FATHER

(State or Country) Neb

12. MAIDEN NAME OF MOTHER

Matter Sudden

13. BIRTHPLACE OF MOTHER

(State or Country) Neb

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

R R Leach
Coeur d'Alene

15.

Filed

11/22/22

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 26 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 25 1922 to Nov 26 1922

that I last saw her alive on Nov 26 1922

and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Double Pneumonia

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) D N Drennon M. D.

11/28/22 (Address) Coeur d'Alene, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. 10 mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Forest Cemetery

DATE OF BURIAL

11/27/22

20. UNDERTAKER

ADDRESS

R B Doney Coeur d'Alene

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40046**
Registered No. **1153**

1. PLACE OF DEATH
County of **Proctor** Registration District No. **30**
City of **Walt Lodge** Primary Registration District No. **1057**
(No. **Walt Lodge** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary Jane Pearson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **F** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Single**
(Write the word.)

6. DATE OF BIRTH **Dec 25 1854**
(Month) (Day) (Year)

7. AGE **67** Yrs. **11** Mos. **6** ds.
IF LESS than 1 day how many... hrs. or... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. **Housekeeper**
(b) General nature of industry, business or establishment in which employed (or employer). **for Brother**

9. BIRTHPLACE
(State or Country) **Canada**

10. NAME OF FATHER **Dennis B Pearson**

11. BIRTHPLACE OF FATHER
(State or Country) **Canada**

12. MAIDEN NAME OF MOTHER **Ellen Daily**

13. BIRTHPLACE OF MOTHER
(State or Country) **Canada**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) **M B Pearson**
(Address) **Corn & Olive St**

15. Filed **Dec 30** 19 **22**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **Nov. 24** 19 **22**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Nov. 21** 19 **22** to **Nov 24** 19 **22**, that I last saw him alive on **Nov. 23** 19 **22**, and that death occurred on the date stated above, at **1 P.** M.
The CAUSE OF DEATH* was as follows:

Solar Pneumonia

(Duration) Yrs. mos. **2** ds.
Contributory (Secondary)
(Duration) Yrs. mos. ds.
(Signed) **J O Dwan** M. D.
Nov 24 1922 (Address) **Corn & Olive St**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **Forest Cemetery** DATE OF BURIAL **11/25 1922**

20. UNDERTAKER **P B Mooney** ADDRESS **Panama**

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 40047

Registered No. 122

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

Registration District No. 3

County of Kootenai

Primary Registration District No. 121

City of Coeur d'Alene (No. 121 Coeur d'Alene St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jas. Earl Smith

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

M.

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

single

(Write the word.)

6. DATE OF BIRTH

Oct.

9

1922

(Month)

(Day)

(Year)

7. AGE

0 Yrs. 1 Mos. 15 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Jas. Smith

11. BIRTHPLACE OF FATHER

(State or Country)

Wis

12. MAIDEN NAME OF MOTHER

Beulah Tyree

13. BIRTHPLACE OF MOTHER

(State or Country)

Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Beulah Smith

(Address)

15.

Filed

Dec 5 1922 D.D. Drennan

Local Registrar

16. DATE OF DEATH

Nov

24

1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov. 24 1922 to Nov 24 1922

that I last saw him alive on Nov 24 1922

and that death occurred on the date stated above, at 89 M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

D.D. Drennan

M. D.

11/24/1922 (Address) Coeur d'Alene

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Forest Cem. Coeur d'Alene

19

20. UNDERTAKER

ADDRESS

J.O. Cassidy

Coeur d'Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 30County of BoolePrimary Registration District No. 1951City of Coeur d'Alene(No. 711 Lincoln Way St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Walter StoneFile No. 40048Registered No. 1155

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

single

(Write the word.)

6. DATE OF BIRTH

February

(Month)

3

(Day)

1922

(Year)

7. AGE

17 Yrs. 9 Mos. 22 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Laborer

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Wis

10. NAME OF FATHER

Sam Stone

11. BIRTHPLACE OF FATHER

(State or Country)

Wis

12. MAIDEN NAME OF MOTHER

Amelia Brisse

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Laura Stone

(Address)

15.

Filed

Dec. 5 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov.

(Month)

25

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov. 41922

to

Nov. 251922that I last saw him alive on Nov. 25 1922and that death occurred on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:

Solar pneumonia(Duration) Yrs. mos. 21 ds.Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

Nov. 25 1922

(Address)

W. C. Stone
Coeur d'Alene, Ida

M. D.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Forest Cem. Coeur d'Alene11-26 1922

20. UNDERTAKER

ADDRESS

Cassidy22

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 40049
Registered No. 156

1. PLACE OF DEATH

County of

City of

Registration District No. 30

Primary Registration District No. 1001

(Not)

St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John H Cryderman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WID-

OWED OR DIVORCED

Married

(Write the word.)

6. DATE OF BIRTH

Nov 11 1857

(Month)

(Day)

(Year)

7. AGE

65 Yrs 8 Mos 15 ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

Station agent
Spokane Eastern

9. BIRTHPLACE

(State or Country)

Canada

10. NAME OF FATHER

Chas R Cryderman

11. BIRTHPLACE OF FATHER

(State or Country)

Canada

12. MAIDEN NAME OF MOTHER

Emma Piller

13. BIRTHPLACE OF MOTHER

(State or Country)

Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. Cryderman

(Address)

Post Falls, Ida

15.

Filed

Dec 5 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 26 1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 15 1922 to Nov 26 1922

that I last saw him alive on Nov 26 1922

and that death occurred on the date stated above, at 2:50 AM.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
(apoplexy)

(Duration) yrs. mos. ds.

Contributory

(Secondary)

arteriosclerosis

(Duration) yrs. mos. ds.

(Signed)

Nov 26 1922 (Address) Post Falls, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State 19 yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Spokane, Ida

DATE OF BURIAL

11/28 1922

20. UNDERTAKER

E. J. Dwyer

ADDRESS

Bundschuh

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Idaho*City of *Moscow*

If death occurs away from usual residence, give facts called for under special information.

Registration District No. *61*Primary Registration District No. *1011*

(No.)

St.)

File No. *40021*Registered No. *324*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Vesta May Lowmyer

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

F

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

Oct 9 1922
(Month) (Day) (Year)

7. AGE

*Yrs. 1 Mos. 6 ds.*IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address) *Moscow, Ida*

15.

Filed *11/15 1922**M. Barithers*
Local Registrar

16. DATE OF DEATH

Nov 15 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 20 1922 to Jan 15 1922
that I last saw *her* alive on *Oct 20 1922*
and that death occurred on the date stated above, at *530*
The CAUSE OF DEATH* was as follows:*Institution*(Duration) Yrs. *1* mos. ds.Contributory (Secondary) *Permativity*(Duration) Yrs. *1* mos. ds.(Signed) *Thompson* M. D.*11/15 1922* (Address) *Moscow, Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Moscow

DATE OF BURIAL

11/15 1922

20. UNDERTAKER

Blue Hill

ADDRESS

Moscow

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 61

County of Latah

Primary Registration District No. 1011

City of Moscow

(No. St.)

File No. 40051

Registered No. 36

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Willard D Morgareidge

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

M

W

Widowed

(Write the word.)

6. DATE OF BIRTH

Nov 20 1878
(Month) (Day) (Year)

7. AGE

74 Yrs. 4 Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Real Estate Dealer

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

James D. Morgareidge

11. BIRTHPLACE OF FATHER

(State or Country)

Maine

12. MAIDEN NAME OF MOTHER

Hannah E. Levee

13. BIRTHPLACE OF MOTHER

(State or Country)

Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wm. Morgareidge

(Address)

Moscow Idaho

15.

Filed

11/25 1922 W. Harithers

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 24 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 14 1922 to Nov 24 1922
that I last saw him alive on Nov 24 - 1922
and that death occurred on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:

Myocarditis Acute

(Duration) Yrs. mos. 10 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. H. Clarke

M. D.

(Address)

Moscow

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Moscow

DATE OF BURIAL

11/26 1922

20. UNDERTAKER

Lan Gice

ADDRESS

Moscow

If death occurs away from usual residence, give facts called for under special information.

(No. _____, _____ St.

2. FULL NAME COOKSTON, Washington Venable

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

(Address) 1 Moscow

20	PURCHASE	ADDRESS
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WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40053**
Registered No. **37**

1. PLACE OF DEATH

County **Latah**
City of **Moscow**

Registration District No. **61**
Primary Registration District No. **2141**
(No. **Rural** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Sarah Ann Lockard

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX **F** 4. COLOR OR RACE **W** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Widowed**
(Write the word.)

6. DATE OF BIRTH **April 9th 1845**
(Month) (Day) (Year)

7. AGE **77** Yrs. **7** Mos. **20** ds. IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work **House wife**
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE **England**
(State or Country)

10. NAME OF FATHER **William Day**

11. BIRTHPLACE OF FATHER **England**
(State or Country)

12. MAIDEN NAME OF MOTHER **Ann Stout**

13. BIRTHPLACE OF MOTHER **England**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) **Oliver Lockard**
(Address) **Moscow**

15. Filed **11/30** 19**22** **M. H. Richards**
Local Registrar

16. DATE OF DEATH **Nov 29 1922**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Sept 1 1922** to **Nov 29 1922**
that I last saw him alive on **Nov 28 1922**
and that death occurred on the date stated above, at **4:30** M.

The CAUSE OF DEATH* was as follows:
Myocarditis chronic

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) **J. H. Clarke** M. D.
11/30 1922 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **Moscow** DATE OF BURIAL **12/1 1922**
20. UNDERTAKER **Blau Gice** ADDRESS **Moscow**

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Latah*City of *Moscow*

If death occurs away from usual residence, give facts called for under special information.

Registration District No. *61*Primary Registration District No. *2141*(No. *Rural*)

St.)

File No. *40054*Registered No. *38*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Alfred Oleg Narum.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

48

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male white married

(Write the word.)

6. DATE OF BIRTH

March 26th 1892

(Month)

(Day)

(Year)

7. AGE

30 8 4

Yrs.

Mos.

ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Minn.

10. NAME OF FATHER

Matthew Narum

11. BIRTHPLACE OF FATHER

(State or Country)

Norway

12. MAIDEN NAME OF MOTHER

Olivia Hanson

13. BIRTHPLACE OF MOTHER

(State or Country)

Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. A. O. Narum

(Address)

Moscow

15.

Filed *11/30**1922**M. H. Arithers*

Local Registrar

16. DATE OF DEATH

Nov 30 1922

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from *Nov 26 1922* to *Nov 30 1922*that I last saw him alive on *Nov 26 1922*and that death occurred on the date stated above, at *2 P.* M.

The CAUSE OF DEATH* was as follows:

General Rheumatism (Septic)

(Duration)

Yrs.

mos.

ds.

Contributory (Secondary)

Endocarditis & Myocarditis

(Duration)

Yrs.

mos.

ds.

(Signed)

A. Nagel M. D.*11/30 1922* (Address) *Moscow*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Moscow

DATE OF BURIAL

12/2 1922

20. UNDERTAKER

Ellen Grace Moscow

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 40055

Registered No.

1. PLACE OF DEATH *Lathe* Registration District No. *64*
 County of *Latah* Primary Registration District No. *2144*
 City of *Troy* State No. *Idaho* St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William A Struble

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male *White* *Married* (Write the word.)

6. DATE OF BIRTH

April *22* *1860*
 (Month) (Day) (Year)

7. AGE

62 Yrs. *7* Mos. *7* ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Penn

10. NAME OF FATHER

Daniel Struble

11. BIRTHPLACE OF FATHER

(State or Country)

Penn

12. MAIDEN NAME OF MOTHER

Kate Adamson

13. BIRTHPLACE OF MOTHER

(State or Country)

Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mrs Will Struble*(Address) *Troy Ida*

15.

Filed *Nov 30* *1922* *Lucy J. Pickard*
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

November 29 *1922*
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

..... 19....., to 19.....

that I last saw him alive on 19.....

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Dead when first seen by me from statement of family appears to be Haemorrhage of Brain

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) *R. Nelson* M. D.

10/1 *1922* (Address) *Troy, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Buchanan Cem. *Dec 2, 1922*

20. UNDERTAKER

ADDRESS

John J. Pickard *Troy Ida*

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40056**
Registered No. _____

1. PLACE OF DEATH

County of **Latah**City of **Troy**

If death occurs away from usual residence, give facts called for under special information.

RECEIVED

Registration District No. **64**Primary Registration District No. **2144**

(No. _____)

(St. _____)

2. FULL NAME

Inga Lena Sandell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widowed
(Write the word.)

6. DATE OF BIRTH

Feb.**27****1898**

(Month)

(Day)

(Year)

7. AGE

64

Yrs.

8

Mos.

11

ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

House wife

9. BIRTHPLACE

(State or Country)

Sweden

10. NAME OF FATHER

John Olson

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME OF MOTHER

Anna Britta Mattson

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. A. Sandell

(Address)

Troy, Ida

15.

Filed

Nov 30

19

22**Lucy M. Pickard**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov

(Month)

7

(Day)

22

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19

to

19

that I last saw her alive on **Nov 5** 19and that death occurred on the date stated above, at **8:45 PM**

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)**Unknown**

(Duration)

Yrs.

mos.

ds.

(Signed)

Olson

M. D.

Nov 22

(Address)

Troy, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Burnt-Ridge**Nov 16 1922**

20. UNDERTAKER

ADDRESS

John J. Pickard

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **40057**

Registered No. _____

1. PLACE OF DEATH

RECEIVED

Registration District No. **64**County of **Latah**

DEC

Primary Registration District No. **2144**City of **Troy**

BUREAU

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William David Stinson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married

6. DATE OF BIRTH

October 10 1865
(Month) (Day) (Year)

7. AGE

57 Yrs. 1 Mos. 12 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)**Farmer**

9. BIRTHPLACE

(State or Country)

Canada

10. NAME OF FATHER

William Stinson

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Liza Prophy

13. BIRTHPLACE OF MOTHER

(State or Country)

Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs W.D. Stinson

(Address)

Troy Ida

15.

Filed Nov - 30 1922 Lucy M. Pickard
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

November 22 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 _____ to 19 _____
that I last saw him alive on 19 _____
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Probably Cerebral Haemorrhage

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

W.D. Stinson M. D.**11/22 1922** (Address) **Troy, Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Nov. 25 1922

20. UNDERTAKER

ADDRESS

John J. Pickard **Troy Ida**

1. PLACE OF DEATH. **Harvard** Registration District No. **65**
 County of **Latah** Primary Registration District No. **2145**
 City of **Harvard** STATE (No. _____) St.)

File No. **40058**
 Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Gladys**May Hamburg**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **female** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED. **Single**
 (Write the word.)

6. DATE OF BIRTH.

Nov **2** **1918**
 (Month) (Day) (Year)

7. AGE

3 Yrs. **11** Mos. **27** ds.

IF LESS than 1 day
 how many hrs. or
 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
 (b) General nature of industry, business, or establishment in which employed (or employer).....

None

9. BIRTHPLACE

(State or Country)

Harvard Ida

10. NAME OF FATHER

Albert F. Hamburg

11. BIRTHPLACE OF FATHER

(State or Country)

Reedsburg Wisconsin

12. MAIDEN NAME OF MOTHER

Emma J. Messer

13. BIRTHPLACE OF MOTHER

(State or Country)

St. Paul, Minnesota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Albert F. Hamburg

(Address)

Harvard Idaho

15.

Filed

Oct 31

1922.

D. J. W. Thompson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct **29** **1922**
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July **1922**, to **Oct** **28** **1922**,
 that I last saw her alive on **Oct** **28** **1922**,
 and that death occurred on the date stated above, at **8 A.M.**

The CAUSE OF DEATH* was as follows:

Lobular - pneumonia(Duration) **1** Yrs. **1** mos. **ds.**Contributory (Secondary) **Congenital megacolon**(Duration) **3** yrs. **mos.** **ds.**(Signed) **D. J. W. Thompson** M. D.**Oct 28 1922** (Address) **Pothutch**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Woodfell Cemetery**Oct 31 1922**

20. UNDERTAKER

ADDRESS

(Name) Parents**Harvard**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40059**
Registered No.

1. PLACE OF DEATH. Registration District No. **65**
County of **Latah** Primary Registration District No. **2145**
City of **Potlatch** (Vital) (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Bruce Hording Howell**

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Single**
(Write the word.)

6. DATE OF BIRTH **July 11 1921**
(Month) (Day) (Year)

7. AGE **13 yrs. 13 mos. 28 ds.** IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. **Infant.**
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) **Idaho.**10. NAME OF FATHER **Chas Howell**

11. BIRTHPLACE OF FATHER **Oregon.**
(State or Country)

12. MAIDEN NAME OF MOTHER **Mary Boller**

13. BIRTHPLACE OF MOTHER **Ohio**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Edith Boller**
(Address) **Potlatch Idaho**

15.

Filed **Oct. 11 - 1922** **D. J. Thompson**
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct. 9 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Oct 9th 1922**, to **Oct 9th 1922** that I last saw him alive on **Oct 9th 1922** and that death occurred on the date stated above, at **5:20 P.M.**

The CAUSE OF DEATH* was as follows:

Fracto-pneumonia

(Duration) yrs. mos. **4** ds.

Contributory (Secondary) **Asthenia**

(Duration) yrs. mos. ds.

(Signed) **D. J. Thompson** M. D.
10/11/1922 (Address) **Potlatch**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Frederick Cemetery **10/11/1922**

20. UNDERTAKER ADDRESS

E. Irwin **Palouse Wash**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho

BOARD OF HEALTH
Bureau of Vital Statistics

File No. 40060

Registered No.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH. NOV Registration District No. 65
County of Latah BUREAU Primary Registration District No. 2145
City of Potlatch (No.) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Allen Southworth

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH Jan 17 1881
(Month) (Day) (Year)

7. AGE 41 yrs. 7 mos. 22 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work Farmer.
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Illino

10. NAME OF FATHER

Norman Southworth

11. BIRTHPLACE OF FATHER

(State or Country) N.Y.

12. MAIDEN NAME OF MOTHER

Almeta Hutch

13. BIRTHPLACE OF MOTHER

(State or Country) N.Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Bertha Southworth
(Address) Potlatch Wash.

15.

Filed Oct 9 1922 D. J. Thompson
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct 8 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 10 1922 to Oct 7 1922

that I last saw him alive on Oct 7 1922

and that death occurred on the date stated above, at 4 a.m.

The CAUSE OF DEATH* was as follows:

Acute large of stomach

(Duration) yrs. mos. ds.

Contributory Valvular Heart Disease & Dropsy.
(Secondary)

(Duration) yrs. mos. ds.

(Signed) E. K. Vogt M. D.

Oct 9 1922 (Address) Potlatch Wash.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,
If not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Potlatch Wash. Oct 10 1922

20. UNDERTAKER ADDRESS

A. M. Irwin Potlatch Wash.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho

BOARD OF HEALTH
Bureau of Vital Statistics

File No. 40061

Registered No. _____

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH. Registration District No. 65
County of Latah Primary Registration District No. 2145
City of Viola (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ivanita May Estes

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female white infant.
(Write the word.)

6. DATE OF BIRTH Nov 2 1922
(Month) (Day) (Year)

7. AGE IF LESS than 1 day
_____ yrs. _____ mos. _____ ds. how many 12 hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

infant

9. BIRTHPLACE

(State or Country)

Viola Idaho.

10. NAME OF FATHER

Willis Estes.

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho.

12. MAIDEN NAME OF MOTHER

Blanche Culton

13. BIRTHPLACE OF MOTHER

(State or Country)

Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Bernice Estes.
(Address) Viola Ida.

15.

Filed Nov 4 1922

J. M. Thompson
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov 2 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 2 1922, to Nov 2 1922

that I last saw her alive on Nov 2 1922 and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

underdevelopment & premature birth.

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) E. K. Stoll M. D.

Nov 4 1922 (Address) Calhoun, Mo.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Palmdale Cemetery Nov 5 1922

20. UNDERTAKER ADDRESS

Parents Viola, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho

BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 65
 County of Latah Primary Registration District No. 2145
 City of Harvard (No. 1 St.)

File No. 40063

Registered No. _____

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John J. Johnson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
 (Write the word.)

6. DATE OF BIRTH Sept 14 1881
 (Month) (Day) (Year)

7. AGE 41 yrs. 1 mos. 1 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work Farmer.
 (b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Sweden10. NAME OF FATHER John Nelson

11. BIRTHPLACE OF FATHER

(State or Country) Sweden12. MAIDEN NAME OF MOTHER Not known

13. BIRTHPLACE OF MOTHER

(State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jacob E. Johnson
 (Address) Harvard, Idaho

15.

Filed Oct-16-1922 Dr. J. W. Thompson
 Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Oct. 14 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1922, to September 1922 that I last saw him alive on September 25 1922 and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration) 10 yrs. 0 mos. 0 ds.

Contributory Senility
 (Secondary)

(Duration) 10 yrs. 0 mos. 0 ds.

(Signed) J. W. Thompson M. D.

Oct-16-1922 (Address) Pollock

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
 of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
 Where was disease contracted, _____
 If not at place of death? _____
 Former or _____
 usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Harvard Ida Oct 16 1922

20. UNDERTAKER ADDRESS

A. M. Lewis Pollock

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40064**
Registered No. _____

1. PLACE OF DEATH. **Idaho**
County of **Idaho**
City of **Pocatello**
Registration District No. **65**
Primary Registration District No. **2145**
(No. _____) (St. _____)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Kikue Handa**

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **Japanese** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH **Oct. 9th., 1922**
(Month) (Day) (Year)

7. AGE _____ yrs. _____ mos. **8** ds. IF LESS than 1 day
how many _____ hrs. or _____ min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work **None**
(b) General nature of industry business or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country) **Idaho U.S.A.**

10. NAME OF FATHER

Wickia Handa

11. BIRTHPLACE OF FATHER

(State or Country) **Japan**

12. MAIDEN NAME OF MOTHER

Satsuyo Yoshida

13. BIRTHPLACE OF MOTHER

(State or Country) **Japan**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Father**(Address) **Pocatello**

15.

Filed **Oct. 16th** **1922****J. W. Thompson**
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct., 16th., 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

9th. of Oct. 1922 to **Oct. 15, 1922**

that I last saw **her** alive on **Oct. 15, 1922**

and that death occurred on the date stated above, at **Pocatello**

The CAUSE OF DEATH* was as follows:

Malnutrition from birth

10 yrs (Duration) yrs. mos. ds.

Contributory (Secondary)

None known

(Duration) yrs. mos. ds.

(Signed)

Oct. 16, 1922 (Address) **Pocatello Idaho**
M. D.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Pocatello Cemetery**Oct 16th 1922**

20. UNDERTAKER

ADDRESS

Parents**Pocatello**

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

40065

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 66County of LatahPrimary Registration District No. 2146File No. 6City of Bovill(No. Bovill Hosp. St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Thomas Ellingston

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

MaleWhiteSingle
(Write the word.)

6. DATE OF BIRTH

Do not know

(Month)

(Day)

(Year)

7. AGE

about58 Yrs.

Mos.

ds.

IF LESS than 1 day

how many _____ hrs.

or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Farmer

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Succeeden

10. NAME OF FATHER

Do not know

11. BIRTHPLACE OF FATHER

(State or Country)

Do not know

12. MAIDEN NAME OF MOTHER

Do not know

13. BIRTHPLACE OF MOTHER

(State or Country)

Do not know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) P. J. Eager(Address) Park Idaho

15.

Filed 11/6/19221922Mrs F. C. Gibson

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

November
(Month)4
(Day)1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 4 - 1922, to Nov 4th 1922that I last saw him alive on Nov 4th 1922and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Coronal hemorrhage

(Duration)

Yrs. 1

mos.

ds.

Contributory
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed) F. C. Gibson

M. D.

11/4 1922(Address) Bovill Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death Nov

In the

days.

State

Yrs.

mos.

days

Where was disease contracted if not at place of death?

Former or usual residence Park Idaho

19. PLACE OF BURIAL OR REMOVAL

Park Idaho

DATE OF BURIAL

11/6/1922

20. UNDERTAKER

Glenn Price

ADDRESS

Idaho

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

40066

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH NOV 18 1922

County of Idaho BUREAU OF VITAL STATISTICS

City of _____

Registration District No. _____

Primary Registration District No. _____

(No. _____)

St.) _____

File No. _____

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

R. R. Gray

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDMWWidower
(Write the word.)

6. DATE OF BIRTH

January

(Month)

15

(Day)

1852

(Year)

7. AGE

22
3 Yrs. 8 Mos. 13 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Farming

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Salt Lake City Utah

10. NAME OF FATHER

John Gray

11. BIRTHPLACE OF FATHER

(State or Country)

Ardrare Scotland

12. MAIDEN NAME OF MOTHER

E. Elisabeth Russel

13. BIRTHPLACE OF MOTHER

(State or Country)

Glasgow Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

R. R. Gray

(Address)

Here

15.

Filed Nov. 21 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

September 28,

(Month)

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from
July 26, 1922, to Sept. 28, 1922.that I last saw him alive on Sept. 28, 1922.and that death occurred on the date stated above, at 2:15 PM.

The CAUSE OF DEATH* was as follows:

Gastric carcinomaOperation: Gastrectomy Sept. 20, 1922

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Chas. L. Gritman

M. D.

9/30 1922 (Address) Moscow, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. 10 days. In the State _____ yrs. _____ mos. _____ daysWhere was disease contracted if not at place of death? No.

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

J. L. LambertIdaho

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 41
County of Lemhi Primary Registration District No. 2116
City of Lemhi (No. 1 St.)

File No. 40067
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Andrew Catea

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE Roumanian 5. SINGLE, MARRIED, WIDOWED OR DIVORCED unknown
(Write the word.)

6. DATE OF BIRTH About 48 years -
(Month) (Day) (Year)

7. AGE _____ IF LESS than 1 day
how many _____ hrs.
Yrs. Mos. ds. or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Sheep Herder

9. BIRTHPLACE

(State or Country)

Roumanian

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Emma R. Garrison
(Address) Lemhi Ida.

15. Filed Nov. 10-1922 Chas Bellamy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 20 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 20 1922 to Oct 21 1922

that I last saw him alive on Oct 21 1922 and that death occurred on the date stated above, at 2309 M.

The CAUSE OF DEATH* was as follows:

Accidental

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Oct 21, 1922 (Address) 5 Elm

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sakum Cemetery

10-22-1922

20. UNDERTAKER

ADDRESS

H.C. Jacobs

Sakum Ida

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40068**
Registered No. _____

1. PLACE OF DEATH

County of **Benewah**City of **May**Registration District No. **41**Primary Registration District No. **2116**

St. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

George Henry Miller

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Nov. 10 - 1922

Local Registrar

16. DATE OF DEATH

Oct 13

(Month)

13

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 10 - 1922, to Oct 13 1922that I last saw him alive on **Oct 13 1922**and that death occurred on the date stated above, at **7:00 P.M.**

The CAUSE OF DEATH* was as follows:

Acute ascending Paralysis(Duration) Yrs. mos. **5** ds.Contributory **Chronic Alcoholism**

(Secondary)

(Duration) yrs. mos. ds.

(Signed) **C. E. Miller** M. D.**Oct 19 1922** (Address) **May Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

May Idaho**19**

20. UNDERTAKER

ADDRESS

May Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH *Lucas* Registration District No. *47*
 County of *Lucas* Primary Registration District No. *47*
 City of *Lucas* St. *Idaho*

File No. *40069*
 Registered No. *84*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Charles E. Gertz

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*
 (Write the word.)

6. DATE OF BIRTH *Nov. 18* 1899
 (Month) (Day) (Year)

7. AGE *23* Yrs. *0* Mos. *2* ds. IF LESS than 1 day
 how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

George Gertz

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Jessie Parker

13. BIRTHPLACE OF MOTHER

(State or Country)

Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

George Gertz
Lucas Idaho

(Address)

15.

Filed *11-26* 19 *22*

Local Registrar

16. DATE OF DEATH

November 16 19 *22*
 (Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from *Nov 8* 19 *22* to *Nov 16* 19 *22*

that I last saw him alive on *Nov. 15* 19 *22*,

and that death occurred on the date stated above, at *9 A.M.*

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease(Duration) *7* Yrs. *0* mos. *0* ds.

Contributory (Secondary)

Acute Catarrhal Jaundice(Duration) *10* Yrs. *10* mos. *10* ds.

(Signed)

J. M. Farley M. D.
11/16/22 (Address) *Orfino, Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Street Idaho *11-16-19-22*

20. UNDERTAKER

ADDRESS

Arthur Shaw *Orfino Idaho*

1. PLACE OF DEATH

County of Lewis Registration District No. 36
 City of Winchester Primary Registration District No. 217 St.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Lee Kelly

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 40070Registered No. 18

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

male white married
 (Write the word.)

6. DATE OF BIRTH December 16 1864
 (Month) (Day) (Year)

7. AGE 57 Yrs. 11 Mos. 11 ds.
 IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

Physician & Surgeon

9. BIRTHPLACE

(State or Country)

California

10. NAME OF FATHER

M. Alexander Kelly

11. BIRTHPLACE OF FATHER

(State or Country)

Kentucky

12. MAIDEN NAME OF MOTHER

Abigail Gordon

13. BIRTHPLACE OF MOTHER

(State or Country)

Maired
Don't know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Louis Sewell
Winchester, Idaho

(Address)

15. Filed 11/27 1922 R. D. Driven
 Local Registrar

CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

November, 25th 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, ~~that I attended deceased from~~
 1922, to 1922

that I last saw him alive on Nov. 23 1922
 and that death occurred on the date stated above, at 6:30 A.M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

John H. Langhlin M. D.
Nov. 26 1922 (Address) Winchester, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

State of Idaho Nov. 28 1922

20. UNDERTAKER

ADDRESS

W. H. Merchant Clarkston Wash

1. PLACE OF DEATH

County of *Lewis*
City of *Craigmont*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Caroline Helen Bodine

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

(Write the word.)

6. DATE OF BIRTH

March 24 1917
(Month) (Day) (Year)

7. AGE

*5 Yrs. 8 Mos. 5 ds.*IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Lewiston Idaho

10. NAME OF FATHER

David Bodine

11. BIRTHPLACE OF FATHER

(State or Country)

New Jersey

12. MAIDEN NAME OF MOTHER

Elizabeth J. Shearer

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

David Bodine
Craigmont Ida.

15.

Filed

*11/30**1922**R. D. Duclap*

Local Registrar

CERTIFICATE OF DEATH

RECEIVED
DEC 4 1922

BUREAU OF VITAL STATISTICS

Registration District No.

Registration District No.

*6**2129*

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

40071

Registered No.

19

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

91

16. DATE OF DEATH

Nov 29 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

*Nov 19 1922 to Nov 29 1922*that I last saw her alive on *Nov 29 1922*and that death occurred on the date stated above, at *9:00* M.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia(Duration) yrs. mos. *10* ds.Contributory (Secondary) *Varicella*(Duration) yrs. mos. *12* ds.

(Signed)

R. D. Duclap M. D.*11/30 1922* (Address) *Craigmont Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Lewiston Idaho

DATE OF BURIAL

12/1 1922

20. UNDERTAKER

St. John & Sons

ADDRESS

Craigmont

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12		BUREAU OF VITAL STATISTICS RECEIVED NOV 24 1922		CERTIFICATE OF DEATH		State of Idaho BOARD OF HEALTH Bureau of Vital Statistics	
1. PLACE OF DEATH		Registration District No. 47		County of Lewis		File No. 40072	
City of Pizzere		(No.) St.		Primary Registration District No.		Registered No. 56	
If death occurs away from usual residence, give facts called for under special information.				2. FULL NAME Theresa Mary Snyder		If death occurred in a hospital, institution or camp, give its NAME instead of street and number.	
PERSONAL AND STATISTICAL PARTICULARS				MEDICAL CERTIFICATE OF DEATH			
3. SEX female		4. COLOR OR RACE white		5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)		16. DATE OF DEATH 11-14 1922 (Month) (Day) (Year)	
6. DATE OF BIRTH Aug 3 1922 (Month) (Day) (Year)				17. I HEREBY CERTIFY, That I attended deceased from 11-2 1922 to 11-16 1922; that I last saw him alive on 11-13 1922; and that death occurred on the date stated above, at 9 A.M.			
7. AGE yrs. 3 mos. 12 ds.		IF LESS than 1 day how many hrs. or mins.?		The CAUSE OF DEATH* was as follows: Malnutrition			
8. OCCUPATION (a) Trade, profession or particular kind of work Child (b) General nature of industry business, or establishment in which employed (or employer)				(Duration) yrs. 3 mos. 22 ds.			
9. BIRTHPLACE (State or Country) Grainsville Idaho				Contributory (Secondary) none			
10. NAME OF FATHER James D. Snyder				(Duration) yrs. 3 mos. 12 ds.			
11. BIRTHPLACE OF FATHER Virgna Wisc.				(Signed) M. D.			
12. MAIDEN NAME OF MOTHER Etie Murphy				11-15-1922 (Address) Pizzere			
13. BIRTHPLACE OF MOTHER Longap Wisc.				*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.			
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Mrs. J. D. Snyder (Address) Pizzere Ida				18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) At place of death yrs. mos. days. In the State yrs. mos. days.			
15. Filed 11-21 1922 Albert Huff Local Registrar				Where was disease contracted if not at place of death? Former or usual residence.			
19. PLACE OF BURIAL OR REMOVAL Pizzere Cemetery				DATE OF BURIAL 11-15 1922			
20. UNDERTAKER Albert Huff				ADDRESS Pizzere Idaho			

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

NEEDLE CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. **40073** ..
 Registered No. **8** ..
 If death occurred in a hos-
 pital, institution or camp,
 give its NAME instead of
 street and number.

1. PLACE OF DEATH

County of **Lewis Co** Registration District No. **47** ..
 City of **Mohler** Primary Registration District No.
 If death occurs away from **Route 1** (No. St.)
 usual residence, give facts
 called for under special
 information.

2. FULL NAME **John E. Fite**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED.

Male **white** **Married**

6. DATE OF BIRTH.

April 25 1863
 (Month) (Day) (Year)

7. AGE

59 Yrs. **6** Mos. **2** ds.
 IF LESS than 1 day
 how many hrs. or
 min.?"

8. OCCUPATION

(a) Trade, profession or
 particular kind of work **Farmer** ..
 (b) General nature of in-
 dustry, business, or estab-
 lishment in which em-
 ployed (or employer)

9. BIRTHPLACE

(State or Country) **Tenn.**

10. NAME OF FATHER

X Isaac J Fite

11. BIRTHPLACE OF FATHER

(State or Country) **X Liberty Tenn.**

12. MAIDEN NAME OF MOTHER

X Medora M Bethell

13. BIRTHPLACE OF MOTHER

(State or Country) **X Tennessee**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **X J Raymond Fite** ..
 (Address) **Mohler Idaho** ..

15.

Filed **10-28 1912** **Albert Hoff**
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

10-27 **1912**
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Nov 1912 to **1912**

that I last saw h..... alive on **bead 10-27 1912**
 and that death occurred on the date stated above, at **7:34 A.M.**

The CAUSE OF DEATH* was as follows:

Mythitis

(Duration) **X** Yrs. **8** mos. **4** ds.

Contributory (Secondary) **None**

(Duration) Yrs. mos. ds.

(Signed) **E Taylor** M. D.

..... 19..... (Address) **Mohler Idaho** ..

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
 of death yrs. mos. days, State yrs. mos. days

Where was disease contracted
 if not at place of death?

Former or
 usual residence

19. PLACE OF BURIAL OR REMOVAL

Burton Idaho

DATE OF BURIAL

10-28 1912

20. UNDERTAKER

J Taylor

ADDRESS

Mohler Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH *RECORD*
Registration District No. *49*
County of *Lewis* NOV 10 1922
Primary Registration District No. *2428*
City of *Kamiah* (No. *STATISTICS*) St.)
If death occurs away from usual residence, give facts called for under special information.

File No. *40074*
Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Chloe G. Egelston

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *F* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH.

Sept 26 1844
(Month) (Day) (Year)

7. AGE

78 Yrs. *1* Mos. *10* ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

housewife

9. BIRTHPLACE

(State or Country)

Illinois

10. NAME OF FATHER

Allen Sheldon

11. BIRTHPLACE OF FATHER

(State or Country)

New York

12. MAIDEN NAME OF MOTHER

Anna Lansing

13. BIRTHPLACE OF MOTHER

(State or Country)

New Jersey

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Rosa J. Buckingham
Kamiah Idaho

(Address)

15.

Filed

11/5

191

22

C. J. Johnson

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 5 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *11/2* 1922, to *Chloe* 191, that I last saw her alive on *Chloe* 191, and that death occurred on the date stated above, at *9* A. M. The CAUSE OF DEATH* was as follows:

Cerebral

(Duration) Yrs. *3* mos. *5* ds.Contributor *Mitral* (Secondary)(Duration) Yrs. *2* mos. *7* ds.(Signed) *C. J. Johnson* M. D.

11/5/22 (Address) *Kamiah Idaho*
*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lewiston, Ida

11/6 1922

20. UNDERTAKER

ADDRESS

C. J. Johnson

Kamiah Idaho

RECEIVED
NOV 18 1922
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

1. PLACE OF DEATH
County of Lincoln Registration District No. 1876
City of Shoshone Primary Registration District No. 1876 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary M. Quillian

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 40076

Registered No. 17

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED. single
(Write the word.)

6. DATE OF BIRTH. Oct-28 1861
(Month) (Day) (Year)

7. AGE 60 Yrs. 3 Mos. 8 ds.
IF LESS than 1 day how many — hrs. or — min.

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Nurse
General work

9. BIRTHPLACE

(State or Country)

Ireland

10. NAME OF FATHER

Wm. M. Quillian

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Mary M. Kent

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Body A Kay
Shoshone

15.

Filed 9-30

1922

J. L. Fuller

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 29 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 26 1922 to Sept 29 1922, that I last saw him alive on Sept 29 1922 and that death occurred on the date stated above, at 5:30 P.M. The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(Duration) Yrs. 30 mos. 30 ds.

Contributory (Secondary)

Age & hard work

(Duration) Yrs. 1 mos. — ds.

(Signed)

Sept 30 1922 (Address) Shoshone Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted Shoshone
if not at place of death?

Former or usual residence Shoshone

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Ketchum Idaho

1922

20. UNDERTAKER

ADDRESS

O. J. Brumaw Shoshone

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Lincoln* Registration District No. *16*
City of *Shoshone* Primary Registration District No. *1016* St.)File No. *40078*
Registered No. *18*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Charles F. Pearce

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male White Widowed
(Write the word.)

6. DATE OF BIRTH

July 22 1948
(Month) (Day) (Year)

7. AGE

74 Yrs. *2* Mos. *13* ds.
IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)*Retired*

9. BIRTHPLACE

(State or Country)

New Jersey

10. NAME OF FATHER

unknown

11. BIRTHPLACE OF FATHER

(State or Country)

unknown

12. MAIDEN NAME OF MOTHER

unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mr. J. Byrnes*
(Address) *Shoshone Ida*15. *Oct 5*Filed *19 22* *J. L. Fuller*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 5 22
(Month) (Day) (Year)

17. I HEREBY CERTIFY That I attended deceased from

Oct 5 19 22 to *Oct 5 19 22*
that I last saw him alive on *Oct 5 19 22*
and that death occurred on the date stated above, at *9 A.M.*
The CAUSE OF DEATH* was as follows:*Coronary Apoplexy*
(Duration) *1* yrs. *1* mos. *1* ds.
Contributory (Secondary) *Age*
(Duration) *1* yrs. *1* mos. *1* ds.
(Signed) *J. L. Fuller* M. P.
(Address) *Shoshone Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death *1* yrs. *1* mos. *1* days. In the State *1* yrs. *1* mos. *1* days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Pocatello Ida Oct 7 19 22

20. UNDERTAKER ADDRESS

Schumacher & Co Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS PERMANENT RECORD
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

1. PLACE OF DEATH

County of *Lincoln*City of *Butte*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No. *16*Primary Registration District No. *105*(No. *105*)

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *40078*Registered No. *19*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

married
(Write the word.)

6. DATE OF BIRTH

Nov 8 1882

(Month)

(Day)

(Year)

7. AGE

70

Yrs.

Mos. *08*ds. *1*

IF LESS than 1 day

how many _____ hrs.

or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Housewife

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Iowa U S A

10. NAME OF FATHER

James Webb

11. BIRTHPLACE OF FATHER

(State or Country)

Penn a

12. MAIDEN NAME OF MOTHER

Susan Sloan

13. BIRTHPLACE OF MOTHER

(State or Country)

Penn a

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Adeline Glass

(Address)

Butte Idaho

15. Filed

*Nov 10 1922**1922**J. L. Furer*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 9 21 8 a m

(Month)

(Day)

19 22
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

mo M D 19____, to 19____

that I last saw him alive on 19____

and that death occurred on the date stated above, at ____ M.

The CAUSE OF DEATH* was as follows: *o**Sick 4 days of a cold and no M.D. in attendance*

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

O. J. Bruman

19____

(Address)

Shoshone Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Shoshone

DATE OF BURIAL

11/12 1922

20. UNDERTAKER

O. J. Bruman

ADDRESS

RECEIVED DEC 6 1922 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. **40080**
Registered No. **70**

1. PLACE OF DEATH

County of Madison
City of Rexburg

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fredrick William Willyerd

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Married
(Write the word.)

6. DATE OF BIRTH

July 14th 1894
(Month) (Day) (Year)

7. AGE

28 Yrs. 4 Mos. -- ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Farmer

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Joseph W; Willyerd

11. BIRTHPLACE OF FATHER

(State or Country) Texas

12. MAIDEN NAME OF MOTHER

Jeannette M. Higley

13. BIRTHPLACE OF MOTHER

(State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thomas Archibald

(Address) City

15.

Filed 11/15 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 14 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 12 1922, to Nov 14 1922.

that I last saw him alive on Nov 14 1922, and that death occurred on the date stated above, at 8:20 A.M.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction

(Duration) Yrs. mos. 3 ds.
Contributory (Secondary) Intestinal obstruction

(Duration) Yrs. mos. 3 ds.
(Signed) Lorine F. Rich M. D.
11/15 1922 (Address) Rexburg Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Rexburg, Ida DATE OF BURIAL 11-16 1922

20. UNDERTAKER David Young ADDRESS Rexburg

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

RECEIVED
DEC 11 1922
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 40081

Registered No. 69

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Madison
City of Rexburg
Registration District No. _____
Primary Registration District No. _____
St. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emma Dean Rich

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH Jan 11 1892
(Month) (Day) (Year)

7. AGE 30 yrs. 10 mos. 15 ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE Lahi Utah
(State or Country)

10. NAME OF FATHER James E. Ross

11. BIRTHPLACE OF FATHER Utah
(State or Country)

12. MAIDEN NAME OF MOTHER Rose A. Wing

13. BIRTHPLACE OF MOTHER Utah
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James E. Ross
(Address) Lahi Utah

15. Filed 11/1/22 191 11/1/22 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 29 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 21 1922, to Nov 29 1922, that I last saw him alive on Nov 27 1922, and that death occurred on the date stated above, at 10⁴⁰ P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 8 ds.
Contributory Pneumonia
(Secondary)

(Duration) yrs. mos. 5 ds.
(Signed) Wm. H. Rich, M.D.
29 1922 (Address) Rexburg Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Rexburg DATE OF BURIAL 11/2 1922

20. UNDERTAKER W. H. Wing ADDRESS Rexburg

Form V. S. No. 5 20M.1-16-12

RECEIVED DEC 6 1922 BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of MadisonCity of Sugar

Registration District No. _____

Precinct Registration District No. _____

(No. _____ St.)

File No. 40082Registered No. 18

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

James - Winmill

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Bachelor
(Write the word.)

6. DATE OF BIRTH

Nov281922

(Month)

(Day)

(Year)

7. AGE

 yrs. mos. ds.IF LESS than 1 day
how many hrs. or
 mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)Bachelor

9. BIRTHPLACE

(State or Country)

Sugar Idaho

10. NAME OF FATHER

Joseph S. Winmill

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Ethel M. Mathews

13. BIRTHPLACE OF MOTHER

(State or Country)

Wyoming

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J S WinmillSugar

15.

Filed

11/29

191

22 J W Young

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov281922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov. 28 1922, to Nov. 28 1922,that I last saw him alive on Nov 28 1922,and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Premature Birth
(7 mos.)

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) H. Cuthland M. D.11-29-1922 (Address) Bozeng

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bozeng Sugar11/29 191

20. UNDERTAKER

ADDRESS

W YoungBozeng

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of *Madison*

Primary Registration District No.

City of *Salmon*(No. *STATISTICAL*)

St.)

File No. *40083*Registered No. *67*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Christena M. Jensen*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *F*4. COLOR OR RACE *W*

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

*Oct.**13.**1961*

(Month)

(Day)

(Year)

7. AGE

61 yrs. *1* mos. *4* ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Denmark

10. NAME OF FATHER

Peter Mortensen

11. BIRTHPLACE OF FATHER

(State or Country)

Denmark

12. MAIDEN NAME OF MOTHER

Karen M. Larsen

13. BIRTHPLACE OF MOTHER

(State or Country)

Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

H. P. Jensen

(Address)

Box 112

15.

Filed *11/20*191*2**W. Young*

Local Registrar

MEDICAL CERTIFICATE OF DEATH. *50*

16. DATE OF DEATH

*Nov.**17.**1922*

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

*Nov. 15**1922*to *Nov. 17**1922*that I last saw her alive on *Nov. 16**1922*and that death occurred on the date stated above, at *4 P.M.*

The CAUSE OF DEATH* was as follows:

Diabetic Mellitus(Duration) *3* yrs. mos. ds.Contributory *Endocarditis*
(Secondary)(Duration) *?* yrs. mos. ds.(Signed) *M. Sutherland* M. D.*11-18-1922* (Address) *Peyling, Ida*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Peyling**11/21* 1922

20. UNDERTAKER

ADDRESS

*W. Young**Peyling*

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40084**
Registered No. **49**

1. PLACE OF DEATH

County of Shoshone
City of Rupert

Registration District No. 19
Primary Registration District No. 2015
(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Charles L. Noble

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

Oct 18 1922
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day
how many 18 hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Infant

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Joseph L. Noble

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Laura B Pleasant

13. BIRTHPLACE OF MOTHER

(State or Country)

Tennessee

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Joseph L. Noble

(Address)

Rupert Idaho

15.

Filed Dec. 7 1922

W. H. Elmer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 19 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 18 1922 to Oct 19 1922
that I last saw him alive on Oct 18 1922
and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage.
(Prenatal anomaly)

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed)

W. H. Elmer M. D.

127 1922 (Address) Rupert Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

L. H. S. Cemetery

DATE OF BURIAL

19

20. UNDERTAKER

W. H. Goodman

ADDRESS

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Minnehaha
City of Rupert

Registration District No. 19
Primary Registration District No. 2015
(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Carnest J. Sinclair

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 40085
Registered No. 42

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married

6. DATE OF BIRTH

29 Nov 12 1879
(Month) (Day) (Year)

7. AGE

4
IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Train Auditor

9. BIRTHPLACE

(State or Country) Missouri

10. NAME OF FATHER

Lyvester Sinclair

11. BIRTHPLACE OF FATHER

(State or Country) Missouri

12. MAIDEN NAME OF MOTHER

Powell

13. BIRTHPLACE OF MOTHER

(State or Country) Don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edna J. Sinclair
(Address) Rupert Idaho

15. Filed Dec. 7 1922 Edna J. Sinclair
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 1 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 20 1922 to Oct. 1 1922 that I last saw him alive on Oct. 1 1922 and that death occurred on the date stated above, at 3 P. M. The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(Duration) 5 Yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Edna J. Sinclair M. D.

19. (Address) Rupert, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rupert Cemetery Oct 3 1922

20. UNDERTAKER

ADDRESS

W. G. Friedman Rupert

CERTIFICATE OF DEATH

40086

Smith

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No.
Registered No. 43.....
If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

1. PLACE OF DEATH

County of Minidoka

Registration District No.

City of PaulPrimary Registration District No. 2013.....If death occurs away from
usual residence, give facts
called for under special
information.

2. FULL NAME

Earl P. Payne Robinson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.Single

(Write the word.)

6. DATE OF BIRTH.

Sept.31922

(Month)

(Day)

(Year)

7. AGE

24 Yrs. Mos. ds.IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of in-
dustry, business, or estab-
lishment in which em-
ployed (or employer)At Home

9. BIRTHPLACE

(State or Country)

Paul Idaho10. NAME OF
FATHERJohn Earl Robinson11. BIRTHPLACE
OF FATHER

(State or Country)

Kopper Utah12. MAIDEN NAME
OF MOTHERBettie Payne13. BIRTHPLACE
OF MOTHER

(State or Country)

Syracuse Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. L. Mabey

(Address)

Paul Idaho

15.

Filed Dec. 7 1912E. H. Elmore

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

9

16. DATE OF DEATH

Sept271922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from
Sept. 16 1922 to Sept. 27 1922
that I last saw him alive on Sept. 27 1922
and that death occurred on the date stated above, at 5: A. M.

The CAUSE OF DEATH* was as follows:

Mass-Pharyngeal Diphtheria

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

(Address)

G. J. Smith
Burley Idaho*State the Disease Causing Death; or in deaths from Violent
Causes, state (1) Means of Injury; and (2) whether Accidental,
Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)At place In the
of death yrs. mos. days, State yrs. mos. daysWhere was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Burley Ida.

DATE OF BURIAL

Sept. 28-1922

20. UNDERTAKER

L. B. George

ADDRESS

Burley Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Minidoka
 City of Keyburn

Registration District No. 19
 Primary Registration District No. 2015
 (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Heleen Jane Walton

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 40087
 Registered No. 44

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female White Married (the word.)

6. DATE OF BIRTH

Dec. 18 1868
 (Month) (Day) (Year)

7. AGE

67 Yrs. 10 Mos. 29 ds.

IF LESS than 1 day
 how many..... hrs.
 or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country) Lacine Kansas

10. NAME OF FATHER

Cornelius Rathbone

11. BIRTHPLACE OF FATHER

(State or Country) Illinois

12. MAIDEN NAME OF MOTHER

Abigail Fordyce

13. BIRTHPLACE OF MOTHER

(State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. G. Walton

(Address) Keyburn Idaho

15.

Filed Dec. 7 1922 Ed Elmore
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 17 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 10 1922 to Oct. 17 1922
 that I last saw him alive on Oct. 15 1922
 and that death occurred on the date stated above, at 2:30 P. M.

The CAUSE OF DEATH* was as follows:

Paralysis, left side

(Duration) Yrs. 7 mos. ds.

Contributory
 (Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. C. Patterson M. D.
Oct. 18 1922 (Address) Barley, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Keyburn Ida.

Oct. 20 1922

20. UNDERTAKER

ADDRESS

L. B. Feely

Barley Ida.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of FranklinCity of Rupert

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 19Primary Registration District No. 2015

(No. _____) (St. _____)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 40088Registered No. 43

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

John R. Schutte

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

(Write the word.)

6. DATE OF BIRTH

June

(Month)

13

(Day)

1907

(Year)

7. AGE

15

Yrs.

5

Mos.

22

ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Cleveland Idaho.

10. NAME OF FATHER

John Schutte

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Schlaesantoinet Hoops

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John Schutte

(Address)

15.

Filed

Dec. 71922Ed E. Elmore

Local Registrar

MEDICAL CERTIFICATE OF DEATH

120

16. DATE OF DEATH

Dec

(Month)

5

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 7 1922 to Dec 5 1922that I last saw him alive on Dec 4 1922and that death occurred on the date stated above, at 6:30 AM.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

R. J. Brown, M.D.
Rupert Idaho

12/7 1922 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Blaine*Registration District No. *19*City of *Rupert*Primary Registration District No. *2013*

(No.)

St.

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

*Mary M. Bell*File No. *40089*Registered No. *46*

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

*White*5. SINGLE, MARRIED, WID-
OWED OR DIVORCED*Married*

6. DATE OF BIRTH

Nov *11* *1884*
(Month) (Day) (Year)

7. AGE

38 Yrs. *2* Mos. *ds.*

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer).

House Wife

9. BIRTHPLACE

(State or Country)

*Neb*10. NAME OF
FATHER*James Edney*11. BIRTHPLACE
OF FATHER

(State or Country)

*Don't Know*12. MAIDEN NAME
OF MOTHER*"**"*13. BIRTHPLACE
OF MOTHER

(State or Country)

*"**"*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

James A. Bell

(Address)

Rupert Idaho

15.

Filed *Dec. 7* *1922**Ed E. Moore*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov *14* *1922*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 1 *1922* to *Nov 14* *1922*that I last saw him alive on *Nov 14* *1922*and that death occurred on the date stated above, at *3 P.M.*

The CAUSE OF DEATH* was as follows:

Consumption following
Plauts Pivis, Justice
(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. H. ... M. D.*11-15* *1922* (Address) *Rupert*

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Omaha Neb**19*

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH
in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Minidoka
 City of Pau

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 19
 Primary Registration District No. 2015
 (No. 19 St.)

2. FULL NAME

Mat Jungmans

Patterson
 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 40090
 Registered No. 47

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH 181

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married

6. DATE OF BIRTH

Aug 6 1882
 (Month) (Day) (Year)

7. AGE

40 Yrs. 22 Mos. ds.

IF LESS than 1 day
 how many..... hrs.
 or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Hungary

10. NAME OF FATHER

John Jungmans

11. BIRTHPLACE OF FATHER

(State or Country)

Hungary

12. MAIDEN NAME OF MOTHER

Marie Dullius

13. BIRTHPLACE OF MOTHER

(State or Country)

Hungary

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Lena Reib

(Address)

Burley Idaho

15.

Filed

Dec. 1

1922

E. B. Elmore

Local Registrar

16. DATE OF DEATH

Aug 28 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

..... 19....., to 19.....

that I last saw h..... alive on..... 19.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Electrocuted by contact
high tension wire.

(Duration) Yrs. mos. ds.

Contributory
 (Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. G. Goodman Coroner
M. D.

..... 19..... (Address).....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Catholic Cemetery by R. P. Aug 30 1922

20. UNDERTAKER

ADDRESS

W. G. Goodman Thurport

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40091**
Registered No. **48**

1. PLACE OF DEATH

County of **Mendocino**
City of **Rupert**

Registration District No. **19**
Primary Registration District No. **2015**
(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Edgar L. Tyler

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Married**
(Write the word.)

6. DATE OF BIRTH **Nov 2 1884**
(Month) (Day) (Year)

7. AGE **37** Yrs. **9** Mos. **6** ds.
IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION **Nursery**
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE **Utah**
(State or Country)

10. NAME OF FATHER **Joseph A. Tyler**

11. BIRTHPLACE OF FATHER **Utah**
(State or Country)

12. MAIDEN NAME OF MOTHER **Helyla Warner**

13. BIRTHPLACE OF MOTHER **Utah**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Joseph A. Tyler**
(Address) **Edgar**

15. Filed **Dec 7 1922** **Edgar** Local Registrar

MEDICAL CERTIFICATE OF DEATH

79

16. DATE OF DEATH **Aug 8 1922**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 19 _____, to _____ 19 _____, that I last saw him _____ alive on _____ 19 _____, and that death occurred on the date stated above, at _____ M. The CAUSE OF DEATH* was as follows:

Heart Failure
no physician called
(Duration) _____ Yrs. _____ mos. _____ ds.
Contributory (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) **W. A. Goodman** **Coroner** M. D.
_____ 19 _____ (Address) _____

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.
Where was disease contracted if not at place of death? _____
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL **Chiles Cemetery** DATE OF BURIAL **Aug 11 1922**

20. UNDERTAKER **E. E. Drake** ADDRESS **Edgar**

FORM V. S. No. 5-25 M. 1-19.

FEC
DEC

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Minidoka*
City of *Paul*Registration District No. *19*Primary Registration District No. *2015*

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Hugh Francis*State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *40092*Registered No. *50*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male White

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Dec 19 1876
(Month) (Day) (Year)

7. AGE

*46 Yrs. 8 Mos. 15 ds.*IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Teacher

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

Joseph Francisco

11. BIRTHPLACE OF FATHER

(State or Country)

Missouri

12. MAIDEN NAME OF MOTHER

Mary Martin

13. BIRTHPLACE OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Chas Francisco
240 N. Paridena Ave
Paridena Cal

15.

Filed

Dec. 7 1922
E. M. Eburne
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 4 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 4 1922 to Sept 4 1922
that I last saw him alive on *Sept 1 1922*
and that death occurred on the date stated above, at *6 P. M.*

The CAUSE OF DEATH* was as follows:

Suicide from Carbolic Acid Poisoning

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

12/7 1922 (Address) *Rupert*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Paul Cemetery *Sept 7 1922*

20. UNDERTAKER

ADDRESS

W. G. Goodman *Rupert Id*

FORM V. S. No. 5-25 M. 1-19

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **40093**
Registered No. **38**

1. PLACE OF DEATH

County of **Minidoka**City of **Rupert**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Anna Lou Dick**Registration District No. **19**Primary Registration District No. **2015**

(No. St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Aug 23
(Month)

(Day)

1922
(Year)

7. AGE

6 weeks 3
Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Rupert

10. NAME OF FATHER

Claud Dick

11. BIRTHPLACE OF FATHER

(State or Country)

Kentucky

12. MAIDEN NAME OF MOTHER

Kate Burris

13. BIRTHPLACE OF MOTHER

(State or Country)

Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Claud Dick

(Address)

Minidoka

15.

Filed **Nov. 8** 19**22****Ed E. Elmore**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct. 7
(Month)**1922**
(Day)**1922**
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 5 - 1922 to Oct 7 1922that I last saw him alive on **Oct 7 1922**and that death occurred on the date stated above, at **3 P.M.**

The CAUSE OF DEATH* was as follows:

Marasmus.**mal nutrition**
(Duration) Yrs. mos. ds.Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) **[Signature]** D.**10-9 1922** (Address) **Rupert Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Minidoka

DATE OF BURIAL

Oct 9 1922

20. UNDERTAKER

[Signature]

ADDRESS

Rupert Idaho

RECEIVED
NOV 15 1922

CERTIFICATE OF DEATH

1. PLACE OF DEATH

Registration District No. 19

County of Mundana

Primary Registration District No. 2015

City of Rupert

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John RollhiserState of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 40094
Registered No. 39

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

m.

4. COLOR OR RACE

white5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

Nov 11

(Month)

(Day)

1922
(Year)

7. AGE

Yrs. 11 Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Rupert

10. NAME OF FATHER

John Rollhiser

11. BIRTHPLACE OF FATHER

(State or Country)

Russia

12. MAIDEN NAME OF MOTHER

Barbara Steinbach

13. BIRTHPLACE OF MOTHER

(State or Country)

Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John Rollhiser

(Address)

Rupert

15. Filed

Oct 10 1922W. H. Elmore

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 9

(Month)

9

(Day)

1922
(Year)17. I HEREBY CERTIFY, That I attended deceased from Oct 9 1922 to Oct 9 1922that I last saw him alive on Oct 9 1922and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Phlebotomy

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) mos. ds.

(Signed)

W. H. Elmore10/10/22 (Address) Rupert Id.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Rupert Cemetery

DATE OF BURIAL

Oct 11 1922

20. UNDERTAKER

Wm. Keel

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40095**
Registered No. **40**

1. PLACE OF DEATH

County of **Minidoka**City of **Reupert**

If death occurs away from usual residence, give facts called for under special information.

Registration District No. **19**Primary Registration District No. **2013**St. **Idaho**

2. FULL NAME

Theodor Gustav Bond

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

(Write the word.)

6. DATE OF BIRTH

5 Aug.

(Month)

(Day)

1903

(Year)

7. AGE

19 Yrs. 2 Mos. 15 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Marion Bond

11. BIRTHPLACE OF FATHER

(State or Country)

Id

12. MAIDEN NAME OF MOTHER

Sarah Wilson

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Floyd George Bond

(Address).....

15.

Filed

Oct 21 1922**Edith E. E. E. E.**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct

(Month)

19

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 15 - 1922 to Oct 19 1922that I last saw him alive on **Oct 19 1922**

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(Duration)..... Yrs..... mos..... ds.

Contributory
(Secondary).....

(Duration)..... yrs..... mos..... ds.

(Signed).....

1020 19/22 (Address).....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 40096
Registered No. 3441

1. PLACE OF DEATH
County of Minidoka Registration District No. 19
City of Paul Primary Registration District No. 2013 St.

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
NOV 18 1922
BUREAU OF VITAL STATISTICS

2. FULL NAME Eileen Marie

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH
Nov 12 1903
(Month) (Day) (Year)

7. AGE
18 Yrs. 11 Mos. 8 ds.
IF LESS than 1 day how many..... hrs. or..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Utah

10. NAME OF FATHER
William Marie

11. BIRTHPLACE OF FATHER
(State or Country) Richmond Utah

12. MAIDEN NAME OF MOTHER
Leroy Carson

13. BIRTHPLACE OF MOTHER
(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John C. Merrell
(Address) Paul Idaho

15. Filed Oct 21 1922 E. D. Elmore
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Oct 20 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 20 1922 to Oct 20 1922
that I last saw her alive on Oct 20 1922
and that death occurred on the date stated above, at 8:30 am

The CAUSE OF DEATH was as follows:
Diabetes mellitus

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Jay V. Kenney M. D.

19. (Address) Rupert Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

20. UNDERTAKER Edwards Kelley ADDRESS Rupert Idaho

CERTIFICATE OF DEATH

1. PLACE OF DEATH

Registration District No. 96
 County of Myer DEC 11 1922 Primary Registration District No. 1009
 City of Rehoboth (No. 100 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Eligabert E. Elledge

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 40097
 Registered No. 204

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married

6. DATE OF BIRTH

July 4 1871
 (Month) (Day) (Year)

7. AGE

51 Yrs. 4 Mos. 12 ds.

If LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

At home

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Virginia

10. NAME OF FATHER

Hogan

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Thomas Elledge

(Address)

215-4th St

15.

Filed

12/7/ 1922

F. T. Harris, M.D.
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 16 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 16 1922 to Nov 16 1922

that I last saw her alive on Nov 15 1922

and that death occurred on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis of abdominal aorta

(Duration) 3 Yrs. mos. ds.

Contributory
 (Secondary)

(Duration) yrs. mos. ds.

(Signed) E. J. Braddock M. D.

Nov 17 1911 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Lewiston Idaho

DATE OF BURIAL

11/18 1922

20. UNDERTAKER

Vassar and Co.

ADDRESS

Lewiston Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 96

County of Keyser

Primary Registration District No. 1009

City of Camiston

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Thomas Hayden

File No. 40098

Registered No. 149

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male White

(Write the word.)

6. DATE OF BIRTH

Dec 1 1922
(Month) (Day) (Year)

7. AGE

24 Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Mo.

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

St Josephs Hospital

(Address)

Records City

15.

Filed 12/7/ 1922

F. T. Harris, M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 31 31 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 5 1922 to Oct 31 1922

that I last saw h. alive on Oct 30 1922

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

neuropathic

(Duration) 5 Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

John H. Kelley M. D.
19 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Camiston Idaho

DATE OF BURIAL

11-1 1922

20. UNDERTAKER

ADDRESS

Camiston Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY; PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Bradlock
State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40099**
Registered No. **195**
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH **RECEIVED**
Registration District No. **96**
County of **Idaho** DEC 11 1922
Primary Registration District No. **1009**
City of **Reisterstown** (No. **1009** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **David Wright**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **male** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WID-OWED OR DIVORCED **single**
(Write the word.)

6. DATE OF BIRTH **11 Sept 2** 19**22**
(Month) (Day) (Year)

7. AGE **72** Yrs. **2** Mos. **3** ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION **Clearwater Co charge.**

9. BIRTHPLACE **Ill.**
(State or Country)

10. NAME OF FATHER **Not Known**

11. BIRTHPLACE OF FATHER **Ill.**
(State or Country)

12. MAIDEN NAME OF MOTHER **Ill.**

13. BIRTHPLACE OF MOTHER **Ill.**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____
(Address) _____

15. Filed **12/7/** 19 **22** **F.T. Harris, M.D.**
Local Registrar

SYN-ROCK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **Nov 4** 19**22**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Oct 13** 19**22** to **Nov 4** 19**22**
that I last saw h. **W.** alive on **Nov 3** 19**22**
and that death occurred on the date stated above, at **1304**
The CAUSE OF DEATH* was as follows:

Uremia following supra pubic prostatic
(Duration) _____ Yrs. _____ mos. _____ ds.
Contributory (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) **Ely Bradlock** M. D.
19 _____ (Address) **203 Bradlock**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL **Reisterstown Idaho** DATE OF BURIAL **12-4-1922**

20. UNDERTAKER **Dassan Und. Co** ADDRESS **Reisterstown Idaho**

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of My Pence
City of LeavertonRegistration District No. 96
Primary Registration District No. 1009
(No. _____, _____ St.)State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 40100
Registered No. 196

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Still Born Thomas

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED single
(Write the word.)

6. DATE OF BIRTH

Nov 5 1922
(Month) (Day) (Year)

7. AGE

X Yrs. X Mos. X ds.IF LESS THAN 1 day
how many 7 hrs.
or 1 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. X

(b) General nature of industry, business or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Thelma Linn Thomas

11. BIRTHPLACE OF FATHER

(State or Country) Idaho

12. MAIDEN NAME OF MOTHER

Thelma Knighten

13. BIRTHPLACE OF MOTHER

(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) St. Josephs Hospital
(Address) Records

15.

Filed 12/7/ 1922 F.T. Harris, M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 5 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____ 19____, to _____ 19____
that I last saw h. _____ alive on _____ 19____
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Mother had Ruptured
appendical abscessStill born
(Duration) _____ Yrs. _____ mos. _____ ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) John N. Alley M. D.

_____ 19____ (Address) _____

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Leaverton Idaho

DATE OF BURIAL

11/6 1922

20. UNDERTAKER

Vassar Lumber Co.

ADDRESS

Leaverton

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Nez Perce Reg. District No. 96
 City of Lewiston Ida. (No. 1009 St.)
 If death occurs away from usual residence, give facts called for under special information.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lucy Flechinger

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 40101

Registered No. 197

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
 (Write the word.)

6. DATE OF BIRTH

Feb 3 1894
 (Month) (Day) (Year)

7. AGE

71 Yrs. 9 Mos. 2 ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

Michel Flechinger

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Mary Koch

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H. D. Flechinger

(Address) 401 - 6 Ave

15.

Filed 12/7/1922 F. T. Harris, M.D.
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 5 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 9th 1922, to Nov 5th 1922

that I last saw him alive on Nov 5th 1922

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was, as follows:

Exhaustion from diarrhoea

(Duration) Yrs. mos. ds.
 Contributory Diabetes & Acidosis
 (Secondary) Don't know

(Duration) Yrs. mos. ds.
 (Signed) H. D. Flechinger M. D.

19 (Address) Lewiston

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Lewiston Idaho 11-7-1922

20. UNDERTAKER

Vassar Ind. Co. Lewiston Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
40102
File No.
Registered No. 198

1. PLACE OF DEATH
County of Boyer
City of Lewiston
Registration District No. 96
Primary Registration District No. 1009
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Bertha Spracklin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH 135

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

16. DATE OF DEATH
November 6th 1922
(Month) (Day) (Year)

6. DATE OF BIRTH
Mar 6 1900
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 4 1922, to Nov 6 1922, that I last saw her alive on Nov 6 1922, and that death occurred on the date stated above, at 3:30 P.M.

7. AGE 22 Yrs. 8 Mos. ✓ ds. IF LESS than 1 day how many hrs. or min.?

The CAUSE OF DEATH* was as follows:
Post partum Haemorrhage.

8. OCCUPATION
(a) Trade, profession or particular kind of work. Housewife
(b) General nature of industry, business or establishment in which employed (or employer)

(Duration) 2 hours Yes ✓ mos. 0 ds. 0
Contributory Haemophilic ✓ attached
(Secondary) placenta (Duration) 2 yrs. 0 mos. 0 ds.
(Signed) Edgar L White M. D.
11/8 1922 (Address) Lewiston 2nd

9. BIRTHPLACE Montana
(State or Country)

10. NAME OF FATHER Wm E Euster

11. BIRTHPLACE OF FATHER New Jersey
(State or Country)

12. MAIDEN NAME OF MOTHER Bertha Tedrom

13. BIRTHPLACE OF MOTHER Germany
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo Spracklin
(Address) 1109-12 Ave
Lewiston Idaho

15. Filed 12/7/ 19 22 F.T. Harris, M.D.
Local Registrar

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 0 yrs. 0 mos. 0 days. In the State 0 yrs. 0 mos. 0 days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Portland, Oregon DATE OF BURIAL 11-18 1922

20. UNDERTAKER Vassar Und. Co ADDRESS Lewiston Idaho

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Neperce
 City of Lewiston

Registration District No. 96
 Primary Registration District No. 1009
 (No. _____ St.)

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 40103
 Registered No. 200

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Estell Jones

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

Negro

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
 (Write the word.)

6. DATE OF BIRTH

Dec 20 1896
 (Month) (Day) (Year)

7. AGE

21 Yrs. 10 Mos. 17 ds.

IF LESS than 1 day
 how many _____ hrs.
 or _____ min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

at home

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Kansas

10. NAME OF FATHER

Joseph H. Jones

11. BIRTHPLACE OF FATHER

(State or Country)

Maryland

12. MAIDEN NAME OF MOTHER

Francis Jones

13. BIRTHPLACE OF MOTHER

(State or Country)

Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Francis Jones

(Address)

7 St. N. City.

15.

Filled

12/7/ 1922

F. T. Harris, M.D.
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 7 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1 1922 to Nov 6 1922

that I last saw her alive on Nov 6 1922

and that death occurred on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
 (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

John H. Valley M. D.

19. (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Lewiston Idaho.

DATE OF BURIAL

Dec 10 1922

20. UNDERTAKER

Vassar Ward, Co. Lewiston, Idaho.

ADDRESS

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40104**
Registered No. **201**

1. PLACE OF DEATH

County of *Myers*City of *Leaverton*Registration District No. **96**Primary Registration District No. **1009**

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Rose Webb

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

*Indian*5. SINGLE, MARRIED, WID-
OWED OR DIVORCED*Single*

(Write the word.)

6. DATE OF BIRTH

(Month) _____ (Day) _____ (Year) _____

7. AGE

27

Yrs. _____ Mos. _____ ds. _____

IF LESS than 1 day
how many _____ hrs.
or _____ min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

At Home

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Edward Webb

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Olympia Halfmoon

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Chas S. Webb

(Address)

Webb, Idaho

15.

Filed *12/7/* 19 *22**F.T. Harris, M.D.*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 9th 19 *22*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 8th 19 *22* to *Nov 9th* 19 *22*that I last saw her alive on *Nov 8th* 19 *22*

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Dysentery(Duration) _____ Yrs. _____ mos. _____ ds.
Contributory (Secondary) *Stomach*(Duration) _____ Yrs. _____ mos. _____ ds.
(Signed) *R. Harris* M. D._____ 19 _____ (Address) *Leaverton Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Webb Idaho

DATE OF BURIAL

19 _____

20. UNDERTAKER

ADDRESS

11/9/22

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

White
State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40105**
Registered No. **202**

1. PLACE OF DEATH

County of BoiseCity of LewistonRegistration District No. 96Primary Registration District No. 1009

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Laura Jane Smith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

married
(Write the words)

6. DATE OF BIRTH

June (Month) 5 (Day) 1870 (Year)

7. AGE

52 Yrs. 5 Mos. 4 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

At Home

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Washi.

10. NAME OF FATHER

Geo. Kirk

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Frank

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. J. Matheny

(Address)

Lewiston, Idaho

15.

Filed

12/7/ 19 22F. T. Harris, M. D.

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

November 12 (Month) (Day) 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 8 1922 to Nov 12 1922that I last saw him alive on Nov 12 1922and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Fracture of Base of Skull

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed)

W. D. Clark M. D.Nov 13 1922 (Address) Lewiston, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Lewiston, Ida

DATE OF BURIAL

12/13/1922

20. UNDERTAKER

Vassar and O. Lewiston

ADDRESS

Lewiston

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Alley
State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
40106
File No.
Registered No. 203

1. PLACE OF DEATH

County of *Nez Perce*City of *Twin Falls*Registration District No. *96*Primary Registration District No. *1009*

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

James Murray

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

*White*5. SINGLE, MARRIED, WID-
OWED OR DIVORCED*Single*
(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

1 (Year)

7. AGE

59 Yrs. *✓* Mos. *✓* ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

County Charge

9. BIRTHPLACE

(State or Country)

New York

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Nez Perce County Home records*
(Address)

15.

Filed *12/7/* 19 *22**F.T. Harris, M.D.*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

15 19 *22* (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 1 19 *22* to *Nov 12* 19 *22*that I last saw *him* alive on *19* *22*and that death occurred on the date stated above, at *9 A.M.*

The CAUSE OF DEATH* was as follows:

Ischemic Heart Disease
aged
(Duration) Yrs. mos. ds.Contributory
(Secondary)

(Duration)

mos.

ds.

(Signed)

John Nalley M.D.
19 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Levenshire Hall**11/15* 19 *22*

20. UNDERTAKER

ADDRESS

*Hussar Und. Co.**Levenshire Hall*

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Nezperce
City of LeicesterRegistration District No. 96
Primary Registration District No. 1009
(No. _____ St.)

If death occurs away from usual residence, give facts for under special information.

2. FULL NAME

Charles SchwartzState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 40107
Registered No. 205

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)6. DATE OF BIRTH Jan 4 1863
(Month) (Day) (Year)7. AGE 54 Yrs. 10 Mos. 16 ds.
IF LESS than 1 day
how many _____ hrs.
or _____ min.?8. OCCUPATION Farmer
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)9. BIRTHPLACE St Genevieve Mo.
(State or Country)10. NAME OF FATHER Peter Schwartz11. BIRTHPLACE OF FATHER Penn.
(State or Country)12. MAIDEN NAME OF MOTHER Clara Follant13. BIRTHPLACE OF MOTHER Penn
(State or Country)14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. S. Schwartz
(Address) Leicester Wash15. Filed 12/7/1922 F.T. Harris, M.D.
Local Registrar16. DATE OF DEATH Nov 20 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Nov 5 1922 to Nov 20 1922
that I last saw him alive on Nov 20 1922
and that death occurred on the date stated above, at 7 A.M.
The CAUSE OF DEATH* was as follows:Basal Skull Fracture(Duration) _____ Yrs. _____ mos. 20 ds.Contributory (Secondary) Same

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Edgar F. White M. D.Nov 20 22 (Address) Leicester

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Leicester Ida DATE OF BURIAL 11/21/192220. UNDERTAKER H. R. Muehler ADDRESS Clarkston

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Boyer*City of *Newton*Registration District No. *96*Primary Registration District No. *1009*

(No.)

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Thelma Thomas*State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *40108*Registered No. *207*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female*4. COLOR OR RACE *white*5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*
(Write the word.)

6. DATE OF BIRTH

Jan.
(Month)*16*
(Day)*1922*
(Year)

7. AGE

20 Yrs. *10* Mos. *6* ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Wiley H. Hargarten

11. BIRTHPLACE OF FATHER

(State or Country)

Calif

12. MAIDEN NAME OF MOTHER

Mrs. B. B. Hargarten

13. BIRTHPLACE OF MOTHER

(State or Country)

Calif

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mrs. Wiley Hargarten*(Address) *Thompsonville Idaho*

15.

Filed *12/7/ 1922**12/7/ 1922**F. T. Harris, M.D.*
Local RegistrarMEDICAL CERTIFICATE OF DEATH *20*

16. DATE OF DEATH

Nov.
(Month)*22*
(Day)*1922*
(Year)17. I HEREBY CERTIFY, That I attended deceased from *bet 28* *1922* to *Nov 22* *1922*
that I last saw him alive on *Nov 22* *1922*
and that death occurred on the date stated above, at *4 P.* M.

The CAUSE OF DEATH* was as follows:

Septicemia

(Duration)

Yrs.

mos. *14* ds.

Contributory (Secondary)

Appendical abscess

(Duration)

yrs.

mos. *24* ds.

(Signed)

*John H. Ceeley, M. D.**19*

(Address)

Newton Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

yrs.

mos.

In the

days.

State

yrs.

mos.

days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Newton Idaho

DATE OF BURIAL

11-23 1922

20. UNDERTAKER

ADDRESS

Newton Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Payson*Registration District No. *96*City of *Leicester*Primary Registration District No. *1009*(No. *1009*)

St.)

File No. *40116*Registered No. *209*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Maldigan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

Dec 30 1853
(Month) (Day) (Year)

7. AGE

68 Yrs.

Mos.

ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Gardener

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Holland

10. NAME OF FATHER

Wm Maldigan

11. BIRTHPLACE OF FATHER

(State or Country)

Holland

12. MAIDEN NAME OF MOTHER

Smitha Maldigan

13. BIRTHPLACE OF MOTHER

(State or Country)

Holland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs John Maldigan

(Address)

Genesee Idaho

15.

Filed

*12/7/ 19 22**F.T.Harris, M.D.*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

November 28 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 25 1922, to *Nov 28 1922*that I last saw him alive on *Nov 28 1922*and that death occurred on the date stated above, at *12 M.*

The CAUSE OF DEATH* was as follows:

*Perforating gastric Ulcer
causing general Peritonitis*

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

W.D. Clark

M.D.

Nov 28 1922 (Address) *Leicester Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Genesee Idaho

DATE OF BURIAL

12/29 1922

20. UNDERTAKER

Wasserman & Co

ADDRESS

Leicester

FORM V. S. No. 5-25 M. 1-19.

NOV 18 1922

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Nezperce
City of Leukston

Registration District No. 96
Primary Registration District No. 1009
(No., St.)

File No.
Registered No. 1170

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Sadie Cammoch

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDMarried
(Write the word.)

6. DATE OF BIRTH

Mar. 20 1922
(Month) (Day) (Year)

7. AGE

30 Yrs. 6 Mos. 10 ds.

IF LESS than 1 day
how many hrs.
or min. ?

8. OCCUPATION

(a) Trade, profession or
particular kind of work(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)Housewife

9. BIRTHPLACE

(State or Country)

Kansas10. NAME OF
FATHERW. J. James11. BIRTHPLACE
OF FATHER

(State or Country)

Leukston12. MAIDEN NAME
OF MOTHER13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Sadie Cammoch
Leukston, Idaho

15.

Filed

11/8/ 1922F. T. Harris, M.D.

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept. 30 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Sept 30 1922, to Sept 30 1922

that I last saw her alive on Sept 30 1922

and that death occurred on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH* was as follows:

Peritonitis
(Duration) Yrs. mos. 6 ds.

Contributory
(Secondary)Ruptured Gall Bladder

(Duration) yrs. mos. 2 ds.

(Signed)

O. B. Casperson M. D.

19..... (Address) Leukston, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Leukston, Idaho Oct 20 1922

20. UNDERTAKER

ADDRESS

Leukston, Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH **RECEIVED**
 Registration District No. 96
 County of Hyperion **NOV 18 1922**
 City of Truston Idaho **STATISTICS** Registration District No. 1009
 (State)

File No. 40112
 Registered No. 171

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Henry Helen Barnett

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
 (Write the word.)

6. DATE OF BIRTH Jan 1 1896
 (Month) (Day) (Year)

7. AGE 24 Yrs. 9 Mos. 1 ds.
 IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Retired
 (b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Ireland

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Neil Barnett
 (Address) Truston Idaho

15. Filed 11/8/ 19 22 F.T. Harris, M.D.
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 2 19 22
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1917 to Oct 2 19 22
 that I last saw him alive on Oct 2 19 22
 and that death occurred on the date stated above, at 7:20 A.M.

The CAUSE OF DEATH* was as follows:

Rheumatoid Arthritis

(Duration) 20 Yrs. mos. ds.
 Contributory (Secondary) Arterio Sclerosis

(Duration) 10 yrs. mos. ds.
 (Signed) C. W. Shaff M. D.
1922 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Truston Idaho Oct 4 19 22

20. UNDERTAKER

ADDRESS

Truston Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 40113

Registered No. 172

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH *RECEIVED*
 Registration District No. 96
 County of *IDAHO*
 Primary Registration District No. 1009
 City of *BOISE* (No.) (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Samuel Hall

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED *Single*
 (Write the word)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

70 Yrs. Mos. ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Canada

10. NAME OF FATHER

Hall

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Ward

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

P. H. Barber

(Address)

1513 B. St. City

15.

Filed *11/8/* 19 *22*

F. T. Harris, M.D.
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 3 19 *22*
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Sept 26* 19*22*, to *Oct 3* 19*22*
 that I last saw him alive on *Oct 3* 19*22*
 and that death occurred on the date stated above, at *11 P.* M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) Yrs. mos. ds.
 Contributory (Secondary) *Arteriosclerosis*

(Duration) yrs. mos. ds.
 (Signed) *John F. Alley, M.D.*
 19 (Address) *Boise, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Lewiston, Idaho* DATE OF BURIAL *10/6/1922*

20. UNDERTAKER

ADDRESS

Lewiston, Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40114**
Registered No. **774#173**

1. PLACE OF DEATH **Spalding**
County of **Spalding**
City of **Spalding**
Registration District No. **96**
Primary Registration District No. **1009**
(No. _____) (St. _____)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Russell Barton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Single**
(Write the word)
6. DATE OF BIRTH _____
(Month) (Day) (Year)
7. AGE **6** Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Schoolboy

9. BIRTHPLACE

(State or Country)

Oregon

10. NAME OF FATHER

Leo Barton

11. BIRTHPLACE OF FATHER

(State or Country)

Oregon

12. MAIDEN NAME OF MOTHER

Lee Haskins

13. BIRTHPLACE OF MOTHER

(State or Country)

Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

R. J. Haskins

(Address)

Spalding, Idaho.

15.

Filed **11/8/ 19 22** **F.T. Harris, M.D.**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 3 **19 22**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 3 **19 22** to **Oct 4** **19 22**
that I last saw him alive on **Oct 3** **19 22**,
and that death occurred on the date stated above, at **2 9** A.M.

The CAUSE OF DEATH* was as follows:

Diphtheria(Duration) Yrs. mos. ds. **2** ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

John H. Alley, M. D.

19.

(Address)

Spalding, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Spalding, Idaho

DATE OF BURIAL

10/6 19 22

20. UNDERTAKER

ADDRESS

Reverend**Spalding, Idaho**

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH **RECEIVED**
 County of **NOV 10 1922** Registration District No. **96**
 City of **BUREAU OF VITAL STATISTICS** Primary Registration District No. **1009** (City)
 State of **ID** (State)

File No. **40115**
 Registered No. **174**

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME **Daniel Hether**

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX **male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Married**
 (Write the word.)

16. DATE OF DEATH

6. DATE OF BIRTH

7. AGE

70

Yrs. Mos. ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

Miner
Prospector
Sweden

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

11/8/ 19 22**F. T. Harris, M.D.**

Local Registrar

17. I HEREBY CERTIFY, That I attended deceased from **Oct 4** 19**22**, to **Sept 2** 19**22**, that I last saw him alive on **Oct 2** 19**22**, and that death occurred on the date stated above, at **M.**

The CAUSE OF DEATH* was as follows:

Gastro enteritis

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

19 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Asotin**10/5 19 22**

20. UNDERTAKER

ADDRESS

Wasson and Co**Revison****Idaho**

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *My place*City of *Idaho*

If death occurs away from usual residence, give facts called for under special information.

Registration District No. *96*Primary Registration District No. *1009*(No. *1009*), St.File No. *40116*Registered No. *175*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Hannahetta Eutsler

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

*Female White**Widow*

(Write the word.)

6. DATE OF BIRTH

Sept 22 1844
(Month) (Day) (Year)

7. AGE

78 Yrs. *14* Mos. *14* ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

house wife

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Winnipeg, Minn.

10. NAME OF FATHER

James Brithoff

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Rebecca Nickles

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. L. B. Campbell

(Address)

Lewiston, Ida

15.

Filed *11/8/22* *1922* *F. T. Harris, M.D.*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 6 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *Oct. 3 1922* to *Oct 6 1922*that I last saw him alive on *Oct 6 1922* and that death occurred on the date stated above, at *9:30 P.M.*

The CAUSE OF DEATH* was as follows:

Paralysis(Duration) Yrs. mos. *3* ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. M. Lytle M. D.
10-7-22 (Address) *Lewiston*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Moscow, Ida**19*

20. UNDERTAKER

ADDRESS

ASSAR *Lewiston, Ida*

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Blaine
City of BlaineRegistration District No. 96Primary Registration District No. 1009File No. 40117
Registered No. 176

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary Jane Wager

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female White

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widowed
(Write the word.)

6. DATE OF BIRTH

May 30 1855
(Month) (Day) (Year)

7. AGE

67 Yrs. 4 Mos. 6 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

At Home

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Brantford Ont. Canada

10. NAME OF FATHER

John Brown

11. BIRTHPLACE OF FATHER

(State or Country) England

12. MAIDEN NAME OF MOTHER

Sarah Elisabeth Stewart
Mary Jane

13. BIRTHPLACE OF MOTHER

(State or Country) Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Morrice Palmer(Address) Genesee Ida.

15.

Filed 11/8/ 1922 F.T. Harris, M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 6 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 1 1922 to Oct 6 1922that I last saw her alive on Oct 5 1922and that death occurred on the date stated above, at 6:30 A.M.

The CAUSE OF DEATH* was as follows:

Apoplexy
Cerebral Haemorrhage(Duration) Yrs. 2 mos. ds.Contributory (Secondary) Arterio-sclerosis(Duration) 3 yrs. 2 mos. ds.(Signed) E.L. White M. D.10-6 1922 (Address) Lewiston Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Genesee Ida.

DATE OF BURIAL

10/8 1922

20. UNDERTAKER

Cassar and Co Lewiston
Ida.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Nurse
 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. **40118**
 Registered No. **177**

1. PLACE OF DEATH

County of *Blaine*City of *Blaine*Registration District No. **96**Primary Registration District No. **1009**(No. **1922**)

St.)

If death occurs away from usual residence, give facts called for under special information.

2. NAME

RECEIVED
NOV 18 1922*Mary Ann Tababas*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Tom Bronche*(Address) *Rapwar, Idaho*

15.

Filed

11/8/ 19 22**F. T. Harris, M.D.**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

*Oct**8*19 *22*

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from *Sept 29 1922* to *Oct 8th 1922*that I last saw her alive on *Oct 8th 1922*and that death occurred on the date stated above, at *2 P. M.*

The CAUSE OF DEATH* was as follows:

Typhoid fever complicated with pneumonia

(Duration) Yrs. mos. ds.

Contributory (Secondary) *Pneumonia*

(Duration) yrs. mos. ds.

(Signed) *J. H. Hays* M. D.19..... (Address) *Shawson*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Wible Idaho

DATE OF BURIAL

19.....

20. UNDERTAKER

VASSAR UNDERTAKING CO.

ADDRESS

Lewiston Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 96

County of

Primary Registration District No. 1009

City of

(Name) St.

File No. 40119

Registered No. 179

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

John Peter Harford

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

married
(Write the word.)

6. DATE OF BIRTH

Nov 8 1862
(Month) (Day) (Year)

7. AGE

59 Yrs. 11 Mos. 1 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Machinist

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

New York

10. NAME OF FATHER

Harford

11. BIRTHPLACE OF FATHER

(State or Country)

New York

12. MAIDEN NAME OF MOTHER

unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Alice P. Harford

(Address)

15.

Filed

11/8/ 1922

F.T. Harris, M.D.

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 9 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 8 1922, to Oct 9 1922

that I last saw him alive on Oct 9 1922
and that death occurred on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH* was as follows:

Apoplexy 2nd attack

(Duration) Yrs. mos. ds. 2

Contributory (Secondary) same 1 ds.

(Duration) yrs. mos. ds. 2

(Signed) E. H. White M. D.

Oct 10 1922 (Address) Lewiston, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Lewiston, Idaho

DATE OF BURIAL

10-11-1922

20. UNDERTAKER

ADDRESS

FARRAR UNDERTAKING CO. Lewiston, Idaho

CERTIFICATE OF DEATH

1. PLACE OF DEATH

Registration District No. 96
 County of Payson
 City of Lewiston Primary Registration District No. 1009 (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Robert Newell

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 40120
 Registered No. 179

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED single
 (Write the word.)

6. DATE OF BIRTH 1867
 (Month) (Day) (Year)

7. AGE 55 Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

Hotel Clerk

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Robert Newell

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Rebecca

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ed L. Wiggins
 (Address) Lewiston - Idaho

15. Filed 11/8/1922 F. T. Harris, M.D.
 Local Registrar

16. DATE OF DEATH

Oct 10 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 19 to 19
 that I last saw him alive on 19
 and that death occurred on the date stated above, at 12:30 AM.

The CAUSE OF DEATH* was as follows:

Acute Short Failure

(Duration) Yrs. mos. ds.

Contributory
 (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. B. Williamson, Coroner M. D.

Oct-11-1922 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Lewiston Idaho DATE OF BURIAL 10/11/1922

20. UNDERTAKER

ADDRESS Lewiston

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH *Reynolds* Registration District No. *96*
 County of *Reynolds* Primary Registration District No. *1009*
 City of *Reynolds* (No. _____) (St.) _____
 If death occurs away from usual residence, give facts called for under special information.

File No. *40121*
 Registered No. *181*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME *Ira Birum Cook*

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*
 (Write the word.)
 6. DATE OF BIRTH *May 28 1881*
 (Month) (Day) (Year)
 7. AGE *41* Yrs. *4* Mos. *6* ds. IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work *Fruit grower and*
 (b) General nature of industry, business or establishment in which employed (or employer) *Market gardening*

9. BIRTHPLACE *Flourville Ontario*
 (State or Country) *Canada*

10. NAME OF FATHER *C. H. Cook*

11. BIRTHPLACE OF FATHER *New Jersey*
 (State or Country)

12. MAIDEN NAME OF MOTHER *Mary Curry*

13. BIRTHPLACE OF MOTHER *Belfast*
 (State or Country) *Ireland*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) *Mrs I. B. Cook*
 (Address) *Clarkston Wash*

15. Filed *11/8/1922* F. T. Harris, M.D.
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 14 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Oct 7 1922* to *Oct 14 1922*
 that I last saw him alive on *Oct 14 1922*
 and that death occurred on the date stated above, at *3 A.M.*

The CAUSE OF DEATH* was as follows:

Appendicitis
acute

(Duration) Yrs. mos. _____
 Contributory (Secondary) *ruptured appendix*

(Duration) yrs. mos. _____
 (Signed) *J. M. Lyle* M.D.
 19. (Address) *Clarkston Wash*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? *Clarkston Wash*

Former or usual residence *Clarkston Wash*

19. PLACE OF BURIAL OR REMOVAL *Clarkston Wash* DATE OF BURIAL *10/16 1922*

20. UNDERTAKER *H. R. Merchant* ADDRESS *Clarkston*

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH **RECEIVED**
 County of **Boone** Registration District No. **96**
 City of **Leicester** Primary Registration District No. **1009**
 State **Idaho** (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Samuel T. Ellinger

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. **40122**

Registered No. **184**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Widower**
 (Write the word.)

6. DATE OF BIRTH

May 30 19**22**
 (Month) (Day) (Year)

7. AGE

4 - 15
75 Yrs. **10** Mos. **10** ds.
 IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

Retired

9. BIRTHPLACE

(State or Country)

NY

10. NAME OF FATHER

unknown

11. BIRTHPLACE OF FATHER

(State or Country)

NY

12. MAIDEN NAME OF MOTHER

unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Harold Gillette

(Address)

Leicester, Idaho

15.

Filed

11/8/1922

F.T. Harris, M.D.

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 5 19**22** to **Oct 15** 19**22**
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Oct 5** 19**22** to **Oct 15** 19**22**
 that I last saw him alive on **Oct 14** 19**22**

and that death occurred on the date stated above, at **1 P.M.**

The CAUSE OF DEATH* was as follows:

Chronic Intestinal

(Duration) Yrs. mos. ds.

Contributory
 (Secondary)

(Duration) Yrs. mos. ds.

(Signed)

W. O. Clark

M. D.

Oct 16 19**22** (Address) **Leicester, Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Leicester, Idaho

10-16 1922

20. UNDERTAKER

ADDRESS

Leicester, Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
 County of
 City of
 If death occurs away from usual residence, give facts called for under special information.

Registration District No. 96
 Primary Registration District No. 1009
 (No. St.)

File No. 40123
 Registered No. 185

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Richard T Smith

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male
 4. COLOR OR RACE white
 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
 (Write the word.)

6. DATE OF BIRTH

July 8 1881
 (Month) (Day) (Year)

7. AGE

71 Yrs. 3 Mos. 7 ds.

IF LESS than 1 day
 how many..... hrs.
 or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Wisconsin

10. NAME OF FATHER

Thomas B Smith

11. BIRTHPLACE OF FATHER

(State or Country)

Wales

12. MAIDEN NAME OF MOTHER

Margaret Morgan

13. BIRTHPLACE OF MOTHER

(State or Country)

Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Richard T Smith
 (Address) Lewiston, Idaho

15.

Filed 11/8/ 1922 F.T. Harris, M.D.
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 15 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 15 1922, to Oct 15 1922 that I last saw him alive on Oct 15 1922 and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Rupture of Pyloric end of stomach evidently from being struck by automobile

(Duration) Yrs. mos. 1 ds.

Contributory
 (Secondary)

(Duration) yrs. mos. ds.

(Signed) E. G. Braddock M. D.

Oct 16 1922 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Lewiston Idaho

DATE OF BURIAL

Oct 18 1922

20. UNDERTAKER

Vassar Undertaking Co

ADDRESS

Lewiston

CERTIFICATE OF DEATH

1. PLACE OF DEATH

Registration District No. 96
 County of Negre Primary Registration District No. 1009
 City of ... (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

J. W. Bluffield

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 40124
 Registered No. 186

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED
 (Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

27

Yrs. Mos. ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer)

County Charge

9. BIRTHPLACE

(State or Country)

Ill.

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) County Farm records
 (Address) Negre, Ill.

15.

Filed 11/8/ 1922 F.T. Harris, M.D.
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

10 17 22
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
19, to 19

that I last saw him alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

U. S. Marine Hospital
St. Louis, Mo.
 (Duration) Yrs. mos. ds.

Contributory
 (Secondary)

(Duration) yrs. mos. ds.

(Signed) John W. Bailey M. D.

19 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Tomb in Idaho 10-18 1922

20. UNDERTAKER

ADDRESS

Tomb in Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 96
County of Nez Perce Primary Registration District No. 1009
City of Lewiston St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Edward Lott WigginsFile No. 40125
Registered No. 187

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-OWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH

Feb 15 1871
(Month) (Day) (Year)

7. AGE

51 Yrs. 8 Mos. 3 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Merchant
Cigar

9. BIRTHPLACE

(State or Country)

Washington

10. NAME OF FATHER

Lott Wiggins

11. BIRTHPLACE OF FATHER

(State or Country)

Bottoms, Maine

12. MAIDEN NAME OF MOTHER

Mary J. Newell

13. BIRTHPLACE OF MOTHER

(State or Country)

Salem Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Edward Wiggins
Lewiston Idaho

15.

Filed

11/8/1922F.T. Harris, M.D.

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 15 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Oct 11th 1922 to Oct 18th 1922that I last saw him alive on Oct 16th 1922and that death occurred on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH was as follows:

Acute degeneration of heart

(Duration) Yrs. mos. ds.

Contributory Excessive use of tobacco
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Dr. H. H. H. H. H. M. D.19 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lewiston IdahoOct 20 1922

20. UNDERTAKER

ADDRESS

VASSAR UNDERTAKING CO. Lewiston Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
NOV 18 1922

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

40126

1. PLACE OF DEATH

County of Nez Perce Registration District No. 96
City of Lewiston Registration District No. 1009
(No. _____) (St.) _____

File No. _____
Registered No. 188

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Maurice Timothy Hartnett

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH

MO 4 1922
(Month) (Day) (Year)

7. AGE

74 Yrs. 11 Mos. 14 ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Retired
(b) General nature of industry, business or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country) Ireland

10. NAME OF FATHER

Timothy Hartnett

11. BIRTHPLACE OF FATHER

(State or Country) Ireland

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country) Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) T. Hartnett

(Address) _____

15.

Filed 11/8/1922 F.T. Harris, M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 18 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 19 _____ to _____ 19 _____

that I last saw h. _____ alive on _____ 19 _____
and that death occurred on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

Over dose Chloroform
Accidental

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W. B. Thompson Coroner M. D.

10-20 1922 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Lewiston Idaho Oct 20 1922

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

Lewiston
Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

40127

File No.

Registered No. 189

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

Registration District No. 96
County of Nez Perce Primary Registration District No. 1009
City of Lewiston (Vt.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Joseph Chambers

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED widower
(Write the word.)

6. DATE OF BIRTH

Unknown 1840
(Month) (Day) (Year)

7. AGE

82 Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

County charge

9. BIRTHPLACE

(State or Country)

Virginia

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) County Records
(Address) Nez Perce Co Idaho

15.

Filed 11/8/1922 F.T. Harris, M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 20 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 1 1922 to Oct 20 1922
that I last saw him alive on Sept 30 1922,
and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

arterial sclerosis(Duration) 5 Yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) John H. Alley M. D.

19 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Lewiston Idaho 10-20-1922

20. UNDERTAKER

ADDRESS

Lewiston Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Boz Perce Registration District No. 96
City of Boz Perce Primary Registration District No. 1009
(No. St.)File No. 40128
Registered No. 190

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ily May Mitchell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Single

6. DATE OF BIRTH

Aug 24 1922
(Month) (Day) (Year)

7. AGE

19 Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work waiter

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Robert Mitchell

11. BIRTHPLACE OF FATHER

(State or Country) Idaho

12. MAIDEN NAME OF MOTHER

Elizabeth

13. BIRTHPLACE OF MOTHER

(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Elizabeth Mitchell
(Address)

15.

Filed 11/8/ 1922 F. T. Harris, M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 20 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Oct 12 1922 to Oct 20 1922
that I last saw her alive on Oct 20 1922
and that death occurred on the date stated above, at 11 M.

The CAUSE OF DEATH* was as follows:

Drill wounds caused by criminal shooting
(Duration) Yrs. mos. ds.Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) John Valley

19 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Idaho

DATE OF BURIAL

10-23 1922

20. UNDERTAKER

ADDRESS

Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Myer Registration District No. 96
City of Idaho Falls Registration District No. 1009 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Wm E. Talbott

File No. 40129
Registered No. 191

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH

May 28 1844
(Month) (Day) (Year)

7. AGE

78 Yrs. 5 Mos. — ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

Farmer

Retired

9. BIRTHPLACE

(State or Country)

Indiana

10. NAME OF FATHER

Wm A. Talbott

11. BIRTHPLACE OF FATHER

(State or Country)

Ky.

12. MAIDEN NAME OF MOTHER

Harriet Pearson

13. BIRTHPLACE OF MOTHER

(State or Country)

Ky.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Jessie Spindler
(Address) Craigmont, Idaho

15.

Filled 11/8/1922 F. T. Harris, M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 22 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 22, 1922 to Oct 25, 1922 that I last saw him alive on Oct 24, 1922 and that death occurred on the date stated above, at Idaho Falls.

The CAUSE OF DEATH* was as follows:

apoplexy

(Duration) Yrs. 3 ds. Contributory (Secondary) arteriosclerosis

(Duration) yrs. — mos. — ds. (Signed) John W. Talbott M. D.

19 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho Falls 10-27-1922

20. UNDERTAKER

ADDRESS

O. J. Talbott

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 96
County of Boysen Primary Registration District No. 1009
City of Leoviston (No. 1009) St.

If death occurs away from usual residence, give facts called for under special information.

File No. 40130
Registered No. 193

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

John W. Stidwell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widowed
(Write the word.)

6. DATE OF BIRTH

May 20 1890
(Month) (Day) (Year)

7. AGE

82 Yrs. 5 Mos. 9 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. retired
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) England

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country) "

12. MAIDEN NAME OF MOTHER

"

13. BIRTHPLACE OF MOTHER

(State or Country) "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Evelyn Stidwell
(Address) Leoviston Idaho

15.

Filed 11/8/1922 F.T. Harris, M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 29 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from May 1922 to Oct 29 1922
that I last saw h. in alive on Oct 29 1922
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis(Duration) 3 Yrs. _____ mos. _____ ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) E. S. Braddock M. D.Oct 29 1922 (Address) Leoviston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence Leoviston

19. PLACE OF BURIAL OR REMOVAL

Leoviston Idaho

DATE OF BURIAL

10/28 1922

20. UNDERTAKER

Vassar Undert Co.

ADDRESS

Leoviston Idaho

RECEIVED

CERTIFICATE OF DEATH

40131 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

BUREAU OF VITAL STATISTICS

County of *Boyer*City of *Grand View*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*William G Corder*Registration District No. *14*

BUREAU OF VITAL STATISTICS

Registration District No. *2151*File No. *1*Registered No. *7*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

m.

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word)

6. DATE OF BIRTH

Dec 15 1870
(Month) (Day) (Year)

7. AGE

*52 Yrs. 10 Mos. 2 ds.*IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)*Stockman*

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

James O. Corder

11. BIRTHPLACE OF FATHER

(State or Country)

Illinois

12. MAIDEN NAME OF MOTHER

Anna Black

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Harry Streb

(Address)

Boise Ida.

15.

Filed *Dec 1 1922**W. G. Pakenburg*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 3 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 2 1922 to *1922*that I last saw him alive on *Nov 2-11 PM 1922*and that death occurred on the date stated above, at *3 A M.*

The CAUSE OF DEATH* was as follows:

Acute Pneumonia and other causes

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *L. C. Weiswanger* M. D.*Nov 2 1922* (Address) *Grand View*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Boise Idaho

DATE OF BURIAL

19

20. UNDERTAKER

Summers & Co.

ADDRESS

Boise Ida.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40133**

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of *Payette*City of *Payette*

Registration District No.

Primary Registration District No. *1008*

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

BUREAU OF VITAL STATISTICS

Milton Christian

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Nov 28 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 22 19*22*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 4 19*22* to *Nov 22* 19*22*

that I last saw him alive on *Nov 22* 19*22*

and that death occurred on the date stated above, at *2:30 P.M.*

The CAUSE OF DEATH* was as follows:

General Sepsis

(Duration) Yrs. mos. *20* ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) *H.W. Woodward* M. D.

11/24/22 (Address) *Payette Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

11-20-1922

20. UNDERTAKER

ADDRESS

W. C. Blair Payette Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-18

RECEIVED CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 40134

Registered No. 6

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Payette City of New Plymouth District No. 2009 St. Idaho

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

David Henry Jainer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH.

May 16 1848
(Month) (Day) (Year)

7. AGE

74 Yrs. 5 Mos. 3 ds.IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....Rancher

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

William P. Jainer
New Plymouth

15.

Filed

Oct 211922W. J. Drysdale

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 19 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from 191 to 191
Have seen him occasionally for several years
that I last saw him alive on May 4 1922
and that death occurred on the date stated above, at 3 P. M.
The CAUSE OF DEATH* was as follows:Arterio-sclerosis(Duration) Indeterminate yrs. mos. ds.

Contributory (Secondary)

Senility

(Duration) yrs. mos. ds.

(Signed) W. J. Drysdale M. D.10/20/1922 (Address) New Plymouth, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

New Plymouth10/20 1922

20. UNDERTAKER

ADDRESS

A. MeyerNew Plymouth

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED

NOV 18 1922

Registration District No.

BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 40135

Registered No. 7

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of *Payette*
City of *New Plymouth*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Armin**Schulze*

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

50

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH.

July 13 1913
(Month) (Day) (Year)

7. AGE

9 Yrs. *3* Mos. *8* ds.IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*School boy.*

9. BIRTHPLACE

(State or Country)

Manitoba

10. NAME OF FATHER

William

11. BIRTHPLACE OF FATHER

(State or Country)

Saxan Germany

12. MAIDEN NAME OF MOTHER

Christine Strack

13. BIRTHPLACE OF MOTHER

(State or Country)

Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

William Schulze

(Address)

New Plymouth

15.

Filed *10/25* 1922*Wm J. Drysdale*

Local Registrar

16. DATE OF DEATH

October 20 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *Oct. 14 1922* to *Oct. 20 1922*that I last saw him alive on *Oct. 16 1922*and that death occurred on the date stated above, at *4:00 A.M.*

The CAUSE OF DEATH* was as follows:

*Diabetes**unknown*

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *Wm J. Drysdale* M. D.*11/25 1922* (Address) *New Plymouth, Ida*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

New Plymouth, Ida

DATE OF BURIAL

Oct 23 1922

20. UNDERTAKER

A. Meyer

ADDRESS

New Plymouth

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

40136

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of **Power**City of **American Falls, Idaho**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **George Melton****Walker**Registration District No. **25**Primary Registration District No. **2071**File No. **4**Registered No. **178**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.**Single**

(Write the word.)

6. DATE OF BIRTH.

Sept

(Month)

27

(Day)

1922

(Year)

7. AGE

Yrs. **2** Mos. **3** ds.IF LESS than 1 day
how many.....hrs. or
.....min.2]

8. OCCUPATION

(a) Trade, profession or
particular kind of work...
(b) General nature of in-
dustry, business, or estab-
lishment in which employ-
ed (or employer).....**None**

9. BIRTHPLACE

(State or Country)

Power**Ida.**10. NAME OF
FATHER**Omer****Walker**11. BIRTHPLACE
OF FATHER

(State or Country)

Mo12. MAIDEN NAME
OF MOTHER**Irene Kelley**13. BIRTHPLACE
OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Omer Walker

(Address)

American Falls, Idaho

15.

Filed **12-4** **1922** **Mrs. R. J. Mott**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

December 1st **1922**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov. 29 **1922** to **Dec 1** **1922**that I last saw him alive on **Dec 1** **1922**and that death occurred on the date stated above, at **2 P.M.**

The CAUSE OF DEATH* was as follows:

Polio Contracting
Pneumonia(Duration) Yrs. mos. **2** ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) **V. J. Fogar** M. D.**19** (Address) **American Falls**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Rockland

DATE OF BURIAL

12/3 **1922**

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

40137

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Power District No. 25
City of American Falls Registration District No. 2072File No. 4
Registered No. 172

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Richard Ferdinand Roth

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male whiteMarried
(Write the word.)

6. DATE OF BIRTH.

May 27 1875
(Month) (Day) (Year)

7. AGE

43 Yrs. 6 Mos. 2 ds.IF LESS than 1 day
how many.....hrs. or
.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....Physician
Surgeon

9. BIRTHPLACE

(State or Country)

Wisconsin

10. NAME OF FATHER

Albert Roth

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Minnie Luedke

13. BIRTHPLACE OF MOTHER

(State or Country)

Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

McConaturnian
American Falls

15.

Filed

Dec 4 1912Mrs. R. F. Roth
Local Registrar

16. DATE OF DEATH

Oct 29 1912
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Dec 1912 to Oct 29 1912that I last saw him alive on Oct 28 1912
and that death occurred on the date stated above, at 1:30 M.

The CAUSE OF DEATH* was as follows:

Pericardial Anemia(Duration) 2 Yrs. - mos. - ds.Contributory
(Secondary)(Duration) - yrs. - mos. - ds.(Signed) McConaturnian M. D.(Address) American Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Falls View Cemetery Oct 31 1912
American Falls

20. UNDERTAKER

ADDRESS

Arthur Davis American Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

40142

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 25

County of Power

Primary Registration District No. 2072

City of American Falls, Idaho

St.)

File No. 4

Registered No. 171

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME August

Isaak

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widowed

(Write the word.)

6. DATE OF BIRTH.

August

20

1839

(Month)

(Day)

(Year)

7. AGE

83

Yrs. 2

Mos. 3

ds.

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...

None

9. BIRTHPLACE

(State or Country)

Russia

10. NAME OF FATHER

Not Known

11. BIRTHPLACE OF FATHER

(State or Country)

Russia

12. MAIDEN NAME OF MOTHER

Not Known

13. BIRTHPLACE OF MOTHER

(State or Country)

Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

American Falls, Idaho

15.

Filed

10-24

1922

R. J. Noth

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct

23

1912

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191

191

to

that I last saw him alive on 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Smile deficiency

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Oct 24, 1922

(Address) American Falls, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death... yrs... mos... days In the State... yrs... mos... days

Where was disease contracted if not at place of death?...

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

American Falls, Ida

191

20. UNDERTAKER

ADDRESS

A.W. Davis

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

40143

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 25

County of Power
City of Neeley, IdaPrimary Registration District No. 207A

(No. _____ St.)

File No. 4Registered No. 190

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Howard Thomas Thornton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-OWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH.

Oct 21 1922
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day
how many 12 hrs. or
..... min. >|

..... Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country) Power

10. NAME OF FATHER

George Dunn Thornton

11. BIRTHPLACE OF FATHER

(State or Country) Idaho

12. MAIDEN NAME OF MOTHER

Elva Thomas

13. BIRTHPLACE OF MOTHER

(State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George D. Thornton
(Address) American Falls, Idaho

15.

Filed 10-24 1922 R. J. Roth
Local Registrar

16. DATE OF DEATH

Oct 22 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Oct 21 1922, to Oct 21 1922, that I last saw him alive on Oct 21 1922, and that death occurred on the date stated above, at 6 A.M.
The CAUSE OF DEATH* was as follows:
Premature Birth.

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) V. E. Logan M. D.10/22 1922 (Address) American Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Oct 22 Neeley, Oct 22 1922

20. UNDERTAKER

ADDRESS

Amo Davis American Falls, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

40144

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Boyer
City of Amfall

Registration District No. 25-
Primary Registration District No. 2072
Bethany Deaconess Hospital

File No. 4
Registered No. 169

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Walter B. Jones Jr.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. single
(Write the word.)

6. DATE OF BIRTH Oct 28 1898
(Month) (Day) (Year)

7. AGE 3 Yrs. 11 Mos. 28 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION none
(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE Oregon
(State or Country)

10. NAME OF FATHER Walter B Jones

11. BIRTHPLACE OF FATHER Idaho
(State or Country)

12. MOTHER'S NAME Polley Wilburn

13. BIRTHPLACE OF MOTHER Idaho
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter B Jones
(Address) Rankland Ida.

15. Filed 10-24 1922 Richard M. O'Neil
Local Registrar

16. DATE OF DEATH Oct 20 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 15 1922 to Oct 20 1922
that I last saw him alive on Oct 20 1922
and that death occurred on the date stated above, at 5:30 A.M.

The CAUSE OF DEATH* was as follows:
Tooth Extraction

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) V. J. Logan M. D.
1922 (Address) Amfall Ida.

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Rankland Ida DATE OF BURIAL Oct 20 1922

20. UNDERTAKER Rankland Ida ADDRESS Rankland Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

40145 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 25

County of Power

Primary Registration District No. 2072

City of American Falls, Idaho

File No. 4

Registered No. 168

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Salvester Burnham Rowe

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

Married

(Write the word.)

6. DATE OF BIRTH.

March 7 1851

(Month)

(Day)

(Year)

7. AGE

71

Yrs.

7

Mos.

5

ds.

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
(b) General nature of in-
dustry, business, or estab-
lishment in which employ-
ed (or employer).....

Farmer

9. BIRTHPLACE

(State or Country)

Wis

10. NAME OF
FATHER

David Rowe

11. BIRTHPLACE
OF FATHER

(State or Country)

Not Known

12. MAIDEN NAME
OF MOTHER

Not Known

13. BIRTHPLACE
OF MOTHER

(State or Country)

Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

American Falls, Idaho

15.

Filed

191

Local Registrar

16. DATE OF DEATH

October 12 1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from
Oct 12 1922, to Oct 12 1922

that I last saw him alive on Oct 12 1922

and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) M. D.

10/12 1922 (Address) American Falls

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted
if not at place of death?.....Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Groton, S.D.

191

20. UNDERTAKER

A.W.Davis

ADDRESS

American Falls, I

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

40146

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 25

County of Power

Primary Registration District No. 2872

File No. 4

City of American Falls, Idaho

St.

Registered No. 167

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elsie Kristens

Johnoson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

Female

White

Widowed

(Write the word.)

6. DATE OF BIRTH.

Aug

2

1832

(Month)

(Day)

(Year)

7. AGE

90

1

3

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work...
(b) General nature of in-
dustry, business, or estab-
lishment in which employ-
ed (or employer).....

House wife

9. BIRTHPLACE

(State or Country)

Denmark

10. NAME OF
FATHER

Bartel Larsen

11. BIRTHPLACE
OF FATHER

(State or Country)

Denmark

12. MAIDEN NAME
OF MOTHER

Naren Larsen

13. BIRTHPLACE
OF MOTHER

(State or Country)

Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address) American Falls, Idaho

15.

Filed

10-24

1922

R. F. Roth

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 3

5

22

(Month)

(Day)

1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Sept 3 1922 to Sept 5 1922

that I last saw her alive on Sept 3 1922

and that death occurred on the date stated above, at 7 A. M.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(Duration) Yrs. mos. 5 ds.

Contributory
(Secondary)

Arterio - sclerosis

(Duration) Yrs. mos. ds.

(Signed)

C. F. Schults

M. D.

7/5 1922 (Address) American Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted
if not at place of death?.....Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

American Falls, Idaho

Sept 6 1922

20. UNDERTAKER

A.W. Davis

American Falls, Ida

ADDRESS

Falls, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

RECEIVED CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH Shoshone District No. 70
County of Shoshone Registration District No. 1011
City of Mullan (No. Shoshone) Idaho St.)

File No. 4011
Registered No. 621

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Louise Barry
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F. 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. single
(Write the word.)

6. DATE OF BIRTH Mar. 19 1922
(Month) (Day) (Year)

7. AGE 4 yrs. 4 mos. 12 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER William Barry

11. BIRTHPLACE OF FATHER (State or Country) Montana

12. MAIDEN NAME OF MOTHER Mary Corrigan

13. BIRTHPLACE OF MOTHER (State or Country) California

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm Barry
(Address) Mullan Idaho

15. Filed July 3 1922 J L Jumper
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 1 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1 1922, to July 2 1922
that I last saw her alive on June 29 1922
and that death occurred on the date stated above, at 12:00 PM
The CAUSE OF DEATH was as follows:

Indetermined. Possible
Natural heart disease
Four minutes
(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) W W Ralph M. D.

July 1 1922 (Address) Mullan Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence Mullan Idaho

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Mullan Idaho July 3 1922

20. UNDERTAKER ADDRESS

Ward Hud Co Mullan Idaho

FORM V. S. No. 7-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

Registration District No. 70

Primary Registration District No. 1101

(No. 1101)

File No.

Registered No. 63

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19

that I last saw him alive on 19

and that death occurred on the date stated above, at 11:40 A.M.

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Signed)

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

FORM V. S. No. 1-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

Registration District No. 70

Primary Registration District No.

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female

White

Single Sister
(Write the word.)

6. DATE OF BIRTH

April 18th

(Month)

(Day)

1878
(Year)

7. AGE

44 Yrs. 2 Mos. 20 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

Sister of Charity

9. BIRTHPLACE

(State or Country)

Lafayette
Canada

10. NAME OF FATHER

Joseph Mandemille

11. BIRTHPLACE OF FATHER

(State or Country)

Canada

12. MAIDEN NAME OF MOTHER

Mary Guilbault

13. BIRTHPLACE OF MOTHER

(State or Country)

Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Providence Hospital
Nallaes, Ida.

15.

Filed

19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jul

8

19

22

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar 21, to Jul 7, 1922

that I last saw him alive on Jul 7, 1922

and that death occurred on the date stated above, at 6th A.M.

The CAUSE OF DEATH* was as follows:

Subarachnoid Hemorrhage
& Pneumonia

(Duration) 12 hrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

1922 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Missoula Mont July 10, 1922

20. UNDERTAKER

ADDRESS

B. B. Worstell, Nallaes, Ida.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Shoshone Registration District No. 70
 City of Wallace Registration District No. 1011
Wallace Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Henry Hare Storjohann

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 40150

Registered No. 69

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
 (Write the word.)

6. DATE OF BIRTH

Aug 12 1875
 (Month) (Day) (Year)

7. AGE

48 Yrs. 11 Mos. — ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Chief Engineer
 (b) General nature of industry, business or establishment in which employed (or employer) morning mine

9. BIRTHPLACE

(State or Country) Germany

10. NAME OF FATHER

Johannes Storjohann

11. BIRTHPLACE OF FATHER

(State or Country) Germany

12. MAIDEN NAME OF MOTHER

Bertha Stoffers

13. BIRTHPLACE OF MOTHER

(State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Henry H. Storjohann
 (Address) Mullan 2da

Filed July 17 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 12 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 11 1922 to July 12 1922
 that I last saw him alive on July 12 1922
 and that death occurred on the date stated above, at 49 M.

The CAUSE OF DEATH* was as follows:

Fracture Base of Skull
multiple compound
fractures of Right + Tibia
 (Duration) Yrs. mos. ds.

Contributory
 (Secondary)

(Duration) yrs. mos. ds.

(Signed) Wm. D. Mullan M. D.

6/11 1922 (Address) Wallace 2da

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence Mullan 2da

19. PLACE OF BURIAL OR REMOVAL

Wallace 2da July 17 1922

20. UNDERTAKER

Ward and Co Wallace

RECEIVED

NOV 27 1922

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Shoshone*City of *Wallace*Registration District No. *70*Primary Registration District No. *104*(No. *Providence Hospital*)File No. *40151*Registered No. *66*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Emma Mary McHugh

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

married
(Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

21 Yrs. — Mos. — ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).*As House*

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Herman Pabst

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Lora Linnette

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Michael McHugh*(Address) *Mullan Ida*Filed *July 17 1922*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 13 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

*June 28 1922 to July 13 1922*that I last saw her alive on *July 13 1922*and that death occurred on the date stated above, at *10 P. M.*

The CAUSE OF DEATH* was as follows:—

Cerephaliolethargium

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *F. L. Lindsey* M. D.

19 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence *Mullan Ida*

19. PLACE OF BURIAL OR REMOVAL

Mullan Ida

DATE OF BURIAL

July 17 1922

20. UNDERTAKER

Mard Wood Co

ADDRESS

Wallace

N. B.—Every item of information should be carefully classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

If death occurs away from
usual residence, give facts
called for under special in-
formation.

Registration District No.

Primary Registration District No.

(No.)

File No.

Registered No.

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF
FATHER11. BIRTHPLACE
OF FATHER

(State or Country)

12. MAIDEN NAME
OF MOTHER13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on
and that death occurred on the date stated above, at 99 M.

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Signed)

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

40153

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

Shoshone
County of
City of Wallace

Registration District No.

Primary Registration District No.

Providence Hosp. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Annie Brezona

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

widowed
(Write the word.)

6. DATE OF BIRTH

Nov

(Month)

(Day)

(Year)

7. AGE

62

Yrs.

Mos.

ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

at home

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

Mr. Tenby

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Brey

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Richard Tenby

15. FILE

July 18 1922

1922

J. L. De Ge

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jul

(Month)

14

(Day)

1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19

19

that I last saw him alive on

19

and that death occurred on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:

Meningitis suppurative

(Duration)

Yrs.

Mos.

ds.

Contributor
(Secondary)

Erag. base skull & internal injuries

(Duration)

Yrs.

Mos.

ds.

(Signed)

J. L. De Ge

(Address)

71 Wallace, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Wallace, Idaho

DATE OF BURIAL

7-18 1922

20. UNDERTAKER

J. L. De Ge

ADDRESS

Wallace

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

Registration District No.

Primary Registration District No.

City of

(Name of City or Town) Beauty Super mary St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many hrs.

or min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Filed

1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Contributory (Secondary)

(Signed)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH *Shoshone*
County of *Shoshone* Registration District No. *70*
City of *Gen* Principal Registration District No. *1011*
STATIONER AS HOUR St.)

File No. *40155*
Registered No. *70*

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME *George Lemuel Huttell*

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *M* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *married*
(Write the word.)

16. DATE OF DEATH *July 19 22*
(Month) (Day) (Year)

6. DATE OF BIRTH
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 19..... to 19.....
that I last saw him alive on 19.....
and that death occurred on the date stated above, at *12:15 AM*.
The CAUSE OF DEATH* was as follows:

7. AGE *64* Yrs. - Mos. - ds. IF LESS than 1 day how many hrs. or min.?

pulmonary hemorrhage

8. OCCUPATION
(a) Trade, profession or particular kind of work. *Miner*
(b) General nature of industry, business or establishment in which employed (or employer)

(Duration) Yrs. mos. ds.
Contributory (Secondary) *pulmonary*
(Duration) yrs. mos. ds.
(Signed) *James R. Bran* M. D.
7/21 1922 (Address) *Wallace*

9. BIRTHPLACE
(State or Country) *Missouri*

10. NAME OF FATHER *Bloomfield Huttell*

11. BIRTHPLACE OF FATHER
(State or Country) *Kentucky*

12. MAIDEN NAME OF MOTHER *Emeline Harrison*

13. BIRTHPLACE OF MOTHER
(State or Country) *Kentucky*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *Mrs Geo. Huttell*
(Address) *Gene Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence *Gene Idaho*

15. *July 22 1922*
Filed *22* Local Registrar

19. PLACE OF BURIAL OR REMOVAL *Wallace Idaho* DATE OF BURIAL *July 22 1922*
20. UNDERTAKER *Ward and Co* ADDRESS *Wallace Idaho*

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Shoshone*City of *Wallace*Registration District No. *70*Primary Registration District No. *1011*(No. *Providence Hospital* St.)

File No.

Registered No. *71*

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Harley Swanson

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

F.

4. COLOR OR RACE

*white*5. SINGLE, MARRIED, WID-
OWED OR DIVORCED*single*
(Write the word.)

6. DATE OF BIRTH

July 26 19*22*
(Month) (Day) (Year)

7. AGE

Yrs. Mos. *1* ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).*none*

9. BIRTHPLACE

(State or Country)

Wallace Idaho

10. NAME OF FATHER

C. H. Swanson

11. BIRTHPLACE OF FATHER

(State or Country)

Providence

12. MAIDEN NAME OF MOTHER

Signa Nickstrom

13. BIRTHPLACE OF MOTHER

(State or Country)

Providence

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

C. H. Swanson

(Address)

Burke Idaho

15.

Filed

19

Local Registrar

16. DATE OF DEATH

July 21 19*22*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 20 19*22* to *July 21* 19*22*
that I last saw her alive on *July 21* 19*22*
and that death occurred on the date stated above, at *10:30* A.M.

The CAUSE OF DEATH* was as follows:

Atelectasis(Duration) Yrs. mos. *1* ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

James R. Bran M. D.(Address) *Wallace*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

none

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wallace Ida *July 22* 19*22*

20. UNDERTAKER

ADDRESS

Hard Hard Co *Wallace*
Ida

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 40157
Registered No. 401571. PLACE OF DEATH
County of Shoshone Registration District No. 20
City of Eagle (Not a City) Registration District No. 10 St.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joe James

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
(Write the word.)6. DATE OF BIRTH
(Month) (Day) (Year)7. AGE 61 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Carpenter

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

Not known

11. BIRTHPLACE OF FATHER

(State or Country)

✓ ✓

12. MAIDEN NAME OF MOTHER

✓ ✓

13. BIRTHPLACE OF MOTHER

(State or Country)

✓ ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Archie Smith
(Address) Eagle Idaho15. Joe 19 21

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Jul 22 21
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
19 19 to 19 19
that I last saw him alive on 19 19
and that death occurred on the date stated above, at 11 M.
The CAUSE OF DEATH* was as follows:Asphyxiation
Heart failure
(Duration) yrs. mos. ds.Contributory
(Secondary)(Duration) yrs. mos. ds.
(Signer) W. Mowery Coroner
12722 (Address) Wallace, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Murray Idaho DATE OF BURIAL July 24 19 21
20. UNDERTAKER B. G. Worstell ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 70

County of Shoshone

Primary Registration District No. 104

File No. 40158

City of Wallace

(No. 104)

Registered No. 72

If death occurs away from usual residence, give facts called for under special information.

STATISTICS

2. FULL NAME

Eugene Swanson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

single
(Write the word.)

6. DATE OF BIRTH

July 20th 1922
(Month) (Day) (Year)

7. AGE

Yrs. Mos. 3 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Wallace Idaho

10. NAME OF FATHER

C. H. Swanson

11. BIRTHPLACE OF FATHER

(State or Country)

Burden

12. MAIDEN NAME OF MOTHER

Signa Mickelson

13. BIRTHPLACE OF MOTHER

(State or Country)

Burden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

C. H. Swanson

(Address)

Burke Idaho

15
Filed July 22 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 22 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 20 1922 to July 23 1922
that I last saw him alive on July 22 1922
and that death occurred on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:

Atelectasis

(Duration) Yrs. mos. 3 ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

1/21 1922 James R. Dean M. D.
(Address) Wallace

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

none

19. PLACE OF BURIAL OR REMOVAL

Wallace Ida

DATE OF BURIAL

July 24 1922

20. UNDERTAKER

Hart and Co

ADDRESS

Wallace Idaho

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Shoshone
 City of Wallace

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 70Primary Registration District No. 1011CITY OF Providence Hospital (St.)

2. FULL NAME

Matt Hill

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 40159Registered No. 74

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

married

(Write the word.)

6. DATE OF BIRTH

June

(Month)

24

(Day)

1866

(Year)

7. AGE

56

Yrs.

1

Mos.

—

ds.

IF LESS than 1 day

how many _____ hrs.

or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Rancher

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Finland

10. NAME OF FATHER

Not known.

11. BIRTHPLACE OF FATHER

(State or Country)

Finland

12. MAIDEN NAME OF MOTHER

Rajamaki

13. BIRTHPLACE OF MOTHER

(State or Country)

Finland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mary Rantanen

(Address)

Kingston Ida

15.

Filed July 25 19 22

19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jul

(Month)

23

(Day)

22

(Year)

17. I HEREBY CERTIFY, That I attended deceased from Jul 10 19 22 to Jul 23 19 22that I last saw him alive on Jul 23 19 22and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Myocardial InfarctionMyocardial Infarction(Duration) several yrs. 1 mos. — ds.Contributors (Secondary) Tuberculosis Pulmonae(Duration) several yrs. 1 mos. — ds.(Signed) Dr. W. D. E. P.(Address) Wallace Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Kingston Ida

DATE OF BURIAL

7/25/1922

20. UNDERTAKER

(B.G.) Horstall

ADDRESS

Wallace

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Shoshone
City of Malheur

Registration District No. 10

Primary Registration District No. 10

(No. Providence Hospital)

File No. 40160

Registered No. 80

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Frank Overholt

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

single
(Write the word.)

6. DATE OF BIRTH

May 31 1872
(Month) (Day) (Year)

7. AGE

50 Yrs. 1 Mos. 24 ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

miner

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

Charles F. Overholt

11. BIRTHPLACE OF FATHER

(State or Country)

Penn.

12. MAIDEN NAME OF MOTHER

Florence Higgins

13. BIRTHPLACE OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. C. F. Overholt
Cripple Creek Col.

(Address)

15.

June 29 1922 F. L. Dineen

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jul 23 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jul 22 1922 to Jul 23 1922
that I last saw him alive on Jul 23 1922
and that death occurred on the date stated above, at 2:00 M.

The CAUSE OF DEATH* was as follows:

Coronary sclerosis
myocarditis

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed)

Dr. H. W. Walcott M.D.
24-22 (Address) Wallace, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

Malheur Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Malheur Ida July 29 1922

20. UNDERTAKER

ADDRESS

Ward and Co Malheur
Ida

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Shoshone
 City of Wallace

Registration District No. 70
 Primary Registration District No. County
 (No. Infirmery St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jack Edwards

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 40161
 Registered No. 76

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED Not known
 (Write the word.)

6. DATE OF BIRTH ✓ ✓ ✓
 (Month) (Day) (Year)

7. AGE 50 Yrs. ✓ Mos. ✓ ds.
 IF LESS than 1 day
 how many ✓ hrs.
 or ✓ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

Miner

9. BIRTHPLACE

(State or Country)

Wales

10. NAME OF FATHER

Not known

11. BIRTHPLACE OF FATHER

(State or Country)

Not known

12. MAIDEN NAME OF MOTHER

Not known

13. BIRTHPLACE OF MOTHER

(State or Country)

Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) County Infirmery
 (Address) Reeds

15. Qu 19 22

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 31 22
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 5 19 22 to July 31 19 22
 that I last saw h. M alive on July 29 19 22
 and that death occurred on the date stated above, at 10 am.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 3 Yrs. ✓ mos. ✓ ds.

Contributory
 (Secondary)

(Duration) ✓ Yrs. ✓ mos. ✓ ds.

(Signed) James R. Bran M. D.
7/31/22 (Address) Wallace

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ✓ yrs. ✓ mos. ✓ days. In the State ✓ yrs. ✓ mos. ✓ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Wallace DATE OF BURIAL 8/1/22

20. UNDERTAKER B. J. Horstall ADDRESS Wallace

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 40162
Registered No. 6

1. PLACE OF DEATH
County of Schoshone
City of Merriete

Registration District No. 20
Primary Registration District No. 1011
(No. 1011 State Idaho)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph J. Marsden

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)
6. DATE OF BIRTH Nov. 14 1879
(Month) (Day) (Year)
7. AGE 42 yrs. 8 mos. 20 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Lumberman
(b) General nature of industry, business or establishment in which employed (or employer) Cedar poles
9. BIRTHPLACE California
(State or Country)
10. NAME OF FATHER not known
11. BIRTHPLACE OF FATHER Switzerland
(State or Country)
12. MAIDEN NAME OF MOTHER not known
13. BIRTHPLACE OF MOTHER Switzerland
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Margretta M. Marsden
(Address) Merriete Ida.
15. Dec 7 1922 F. L. Zander
Filed Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 4th 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 4th 1922 to Aug 4th 1922
that I last saw him dead on Aug 4th 1922
and that death occurred on the date stated above, at 1:30 P.

The CAUSE OF DEATH* was as follows:
Bullet wound inflicted just one inch below the heart going thru body - death instantaneous from blood loss
(Duration) hrs. 1 mos. 1 ds.

Contributory (Secondary) none
(Duration) hrs. 1 mos. 1 ds.
(Signed) J. H. Wallace
1922 (Address) Wallace St.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death hrs. 1 mos. 1 days. In the State hrs. 1 mos. 1 days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Spokane, Wash DATE OF BURIAL 8-7 1922
20. UNDERTAKER Hagen & Jagers ADDRESS W. 3rd St.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Shoshone*

Registration District No.

City of *Wallace*

Primary Registration District No.

File No. *40163*

If death occurs away from usual residence, give facts called for under special information.

STATISTICS

2. FULL NAME

*Angus R. Mc Kay*Registered No. *29*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

married
(Write the word.)

6. DATE OF BIRTH

June 3 1867
(Month) (Day) (Year)

7. AGE

55 Yrs. *2* Mos. *3* ds.

IF LESS than 1 day

how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

night Watchman

(b) General nature of industry, business or establishment in which employed (or employer)

at Hoola Mine

9. BIRTHPLACE

(State or Country)

Nova Scotia Canada

10. NAME OF FATHER

no information

11. BIRTHPLACE OF FATHER

(State or Country)

" "

12. MAIDEN NAME OF MOTHER

no information

13. BIRTHPLACE OF MOTHER

(State or Country)

" "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Angus R. McKay

(Address)

Burke Idaho. B&R

15.

Filed

Aug 7 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 6 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY That I attended deceased from

Aug 10 1922 to *Aug 6 1922*that I last saw him alive on *Aug 6 1922*and that death occurred on the date stated above, at *11 P. M.*

The CAUSE OF DEATH was as follows:

*Coronary sclerosis
myocardial infarction*(Duration) Yrs. *2* mos. *1* ds.Contributory
(Secondary)(Duration) Yrs. *2* mos. *1* ds.

(Signed)

Dr. J. H. Mowbray M. D.(Address) *Wallace Idaho*

State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

Burke Idaho

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Wallace Idaho Aug 9 1922

20. UNDERTAKER

Hard Hard Co

ADDRESS

Wallace Idaho

CERTIFICATE OF DEATH

1. PLACE OF DEATH
 County of Shoshone Registration District No. 70
 City of Wallace Primary Registration District No. 104
 (No. River St. St.)
 File No. 40164
 Registered No. 0

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Fasthoff

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
 (Write the word.)

6. DATE OF BIRTH October 3, 1899
 (Month) (Day) (Year)

7. AGE 72
~~75~~ Yrs. 10 Mos. 11 ds.
 IF LESS than 1 day
 how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Gardener
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Quincy Ill

10. NAME OF FATHER

Henry Fasthoff

11. BIRTHPLACE OF FATHER

(State or Country) Germany

12. MAIDEN NAME OF MOTHER

Mary

13. BIRTHPLACE OF MOTHER

(State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. M. A. Fasthoff
 (Address)

15. Aug 15 1922 F. L. Jones
 Filed Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

August 14th 1922
 (Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from 1921 to Aug 14 1922
 that I last saw him alive on Aug 12 1922
 and that death occurred on the date stated above at 2 P.M.

The CAUSE OF DEATH* was as follows:

Myocardial Chorea
due to respiration
 (Duration) 1 day mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Dr. M. W. Jones M. D.
14 1922 (Address) Wallace Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wallace Ida 8/15 1922
 20. UNDERTAKER B. L. Worstell ADDRESS Wallace

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Shoshone
City of WallaceRegistration District No. 70Primary Registration District No. 1016(No. 5 miles west of Wallace)File No. 40165

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Charles S. Hawley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

married
(Write the word.)

6. DATE OF BIRTH

March 13 1845
(Month) (Day) (Year)

7. AGE

77 Yrs. 5 Mos. 5 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

farmer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

David S. Hawley

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

not known

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs C S Hawley

(Address)

Wallace Id

15. FILED

Aug 20 1922 F L Jones

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 18 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jul 20 1922 to Aug 18 1922that I last saw him alive on Aug 17 1922and that death occurred on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH was as follows:

Chronic Valvular disease of heart(Duration) several yrs. mos. ds.

Contributory (Secondary)

(Duration) several yrs. mos. ds.

(Signed)

D. M. M.(Address) Wallace Id

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Wallace Id

DATE OF BURIAL

8-20 1922

20. UNDERTAKER

B. G. Norstall

ADDRESS

Wallace

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 70

County of

Primary Registration District No. 10

City of

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

File No.

Registered No.

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF
FATHER11. BIRTHPLACE
OF FATHER

(State or Country)

12. MAIDEN NAME
OF MOTHER13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Signed)

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH
in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 20
County of Shoshone
Primary Registration District No. 104
City of Wallace Providence HospitalFile No. 40167
Registered No. 83

If death occurs away from usual residence, give facts called for under special information.

BUREAU OF VITAL STATISTICS

2. FULL NAME

Patrick Ryan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-OWED OR DIVORCED

Mwhitesingle

(Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

64 Yrs. — Mos. — ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)mines

9. BIRTHPLACE

(State or Country)

Ireland

10. NAME OF FATHER

no information

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

no information

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. Fitzgerald
Wallace Ida

15.

Filed

Aug 2 1922 F. L. Jundey
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 1 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 23 1922 to Aug 1 1922that I last saw him alive on Aug 1 1922

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Heart attack = coronary
compensated coronary
fracture right femur

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

F. L. Jundey M. D.

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

Boise Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wallace Ida Aug 4 1922

20. UNDERTAKER

ADDRESS

Hard Und Co Wallace
Ida

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 40168
Registered No. 4

1. PLACE OF DEATH

County of ShoshoneRegistration District No. 70City of KalispellPrimary Registration District No. 1011(No. Providence Hospital)

If death occurs away from usual residence, give facts called for under special information.

STATISTICS

2. FULL NAME

John M^c Quire

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

married
(Write the word.)

6. DATE OF BIRTH

march 11th 1865
(Month) (Day) (Year)

7. AGE

57 Yrs. 6 Mos. 14 ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

miner

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

California

10. NAME OF FATHER

Angus M^c Quire

11. BIRTHPLACE OF FATHER

(State or Country)

Scotland

12. MAIDEN NAME OF MOTHER

Elizabeth Ross

13. BIRTHPLACE OF MOTHER

(State or Country)

Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

John M^c Quire
Hallace Ida

15.

Filed

8/26/22 J F Quire
Hallace Ida

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 22 22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1922 to Aug 25 1922
that I last saw him alive on Aug 25 1922
and that death occurred on the date stated above, at 3:45 P.

The CAUSE OF DEATH* was as follows:

Valgum Disease(Duration) several yrs. mos. ds.Contributors
(Secondary)(Duration) 2 yrs. mos. ds.

(Signed)

1922

(Address) Hallace Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

Hallace Ida
19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Hallace Ida Aug 28 1922

20. UNDERTAKER

Ward and Co
ADDRESS
Hallace Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40169**

1. PLACE OF DEATH. Registration District No. **20**
County of **Shoshone** Primary Registration District No. **104**
City of **Mullan** (Nat. St.)

Registered No. **5**
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME **Female infant for Garbano**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **F.** 4. COLOR OR RACE **W** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Single (Write the word.)**

6. DATE OF BIRTH **Aug 26 1922**
(Month) (Day) (Year)

7. AGE **6**
IF LESS than 1 day how many hrs. or mins. **20 mins.**

8. OCCUPATION
(a) Trade, profession or particular kind of work **None**
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) **Mullan Idaho**

10. NAME OF FATHER **Joe Garbano**

11. BIRTHPLACE OF FATHER
(State or Country) **Italy**

12. MAIDEN NAME OF MOTHER **Mary Sadi**

13. BIRTHPLACE OF MOTHER
(State or Country) **Italy**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **J R Bran**
(Address) **Wallace**

15. Filed **Aug 27 1922**
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH **Aug 26 1922**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **8/26/22** 191, to **8/26/22** 191, that I last saw her alive on **8/26/22** 191, and that death occurred on the date stated above, at **5 P.** M.
The CAUSE OF DEATH* was as follows:

Atelectasis
6 1/2 hours
(Duration) yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) **James R Bran** M. D.
8/27 1922 (Address) **Wallace**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.
Where was disease contracted if not at place of death?
Former or usual residence **None**

19. PLACE OF BURIAL OR REMOVAL **Mullan Idy** DATE OF BURIAL **Aug 27 1922**
20. UNDERTAKER **Hard Und Co.** ADDRESS **Wallace**
2da

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

Registration District No.

Primary Registration District No.

(Not over 1000)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many hrs

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15. DATE

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

M. D.

SEP 30 1922

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

Dr. Hansen

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(Name)

2. FULL NAME

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 23, 1922 to September 2, 1922

that I last saw him alive on September 2, 1922

and that death occurred on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH* was as follows:

General Anasarca & Pulmonary Stroma

(Duration)

Yrs. mos. ds.

Contributory (Secondary)

(Duration)

Yrs. mos. ds.

(Signed)

SEP 5 1922

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Ostern Idaho Sept 5 1922

20. UNDERTAKER

ADDRESS

B. E. Horstall, Wallace

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Shoshone
City of WallaceRegistration District No. 70Primary Registration District No. 104(No. Wallace Hospital)File No. 40173Registered No. 88

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lawrence C. Pratt

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED single
(Write the word.)

6. DATE OF BIRTH

July 4 1905
(Month) (Day) (Year)

7. AGE

17 Yrs. 1 Mos. 29 da.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Day Laborer

9. BIRTHPLACE

(State or Country)

Colorado

10. NAME OF FATHER

Harry M. Pratt

11. BIRTHPLACE OF FATHER

(State or Country)

Indiana

12. MAIDEN NAME OF MOTHER

Lottie M. Hugo

13. BIRTHPLACE OF MOTHER

(State or Country)

Peru

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Harry M. Pratt
Bolder Colorado

15.

Filed

Sept 7 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 2 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19..... to 19.....

that I last saw him alive on.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

of fracture of skull & cranium
of brain - caused by fall of high chimney

(Duration) Yrs..... mos.....

Contributory
(Secondary)

(Duration) yrs..... mos..... ds.

(Signed)

M. D.

SEP 10 1922 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

Bolder Colorado

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bolder ColoradoSept 7 1922

20. UNDERTAKER

ADDRESS

Ward and CoWallace
Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
40174
File No. _____
Registered No. 89

1. PLACE OF DEATH

County of

City of

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWER OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF
FATHER11. BIRTHPLACE
OF FATHER

(State or Country)

12. MAIDEN NAME
OF MOTHER13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15. Filed

19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

Sept 2 19 22, to Sept 6 19 22

that I last saw him alive on Sept 6 19 22

and that death occurred on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:

(Duration) 4 Yrs. mos. 4 ds.

Contributory
(Secondary)

(Signed)

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Shoshone*Registration District No. *70*City of *Sunset 2da*Primary Registration District No. *1011*(No. *As Home* St.)File No. *40175*Registered No. *90*

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Gertrude Weigels

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F.

4. COLOR OR RACE

*white*5. SINGLE, MARRIED, WID-
OWED OR DIVORCED*widowed*
(Write the word.)

6. DATE OF BIRTH

March 6 1865
(Month) (Day) (Year)

7. AGE

57 Yrs. *6* Mos. — ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).*As Home*

9. BIRTHPLACE

(State or Country)

Austria

10. NAME OF FATHER

Perhemick

11. BIRTHPLACE OF FATHER

(State or Country)

Austria

12. MAIDEN NAME OF MOTHER

not given

13. BIRTHPLACE OF MOTHER

(State or Country)

Austria

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. M. Anderson

(Address)

Wallace 2da

15.

Filed

Sept 8 1922
J. J. Jones
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 6 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *Aug 19 22* to *Sept 6 22*that I last saw *her* alive on *Sept 6 1922*
and that death occurred on the date stated above, at *10:45* P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Thrombosis of left

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Dr. M. W. Jones

(Address)

Wallace 2da

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

Sunset 2da

19. PLACE OF BURIAL OR REMOVAL

Wallace 2da

DATE OF BURIAL

Sept 8 1922

20. UNDERTAKER

Hard Und Co

ADDRESS

Wallace 2da

1. PLACE OF DEATH

County of Shoshone
City of Wallace

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
REGISTRATION DISTRICT NO. 70
PRINCIPAL REGISTRATION DISTRICT NO. 1011
STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 40176Registered No. 91

2. FULL NAME

Robert Gordon Murphy
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

single
(Write the word.)

6. DATE OF BIRTH

Aug 27 1922
(Month) (Day) (Year)

7. AGE

14 yrs. — mos. — ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

none

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Joe J. Murphy

11. BIRTHPLACE OF FATHER

(State or Country)

Iowa

12. MAIDEN NAME OF MOTHER

Mabel Ingersoll

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Geo W. McKeown
Wallace
(Address)

15. FILED

Sept 12 1922
J. L. Juntz
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 9 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 29 1922 to Sept 9 1922that I last saw him alive on Sept 8 P.M. 1922and that death occurred on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:

Distal embolism - (Obstruction probably Placenta)(Duration) Yrs. mos. 13 ds.

Contributory (Secondary)

none

(Duration) yrs. mos. ds.

(Signed)

C. S. Stone M. D.Sept 12 1922 (Address) Wallace, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wallace, Idaho Sept 12 1922

20. UNDERTAKER

ADDRESS

Brace Morrell Wallace

FORM V. S. No. 1-25 M. 1-19.

1. PLACE OF DEATH

Shoshone

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Alice F. James

PERSONAL AND STATISTICAL PARTICULARS

SEX

female white

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

single

6. DATE OF BIRTH

February 26 1886

7. AGE

36 Yrs. 6 mo. 18 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

at home

9. BIRTHPLACE

(State or Country)

Pa

10. NAME OF FATHER

Sidney James

11. BIRTHPLACE OF FATHER

(State or Country)

Wales

12. MAIDEN NAME OF MOTHER

Alice Phipps

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. A. M. Larren

(Address)

Wallace Id

15. Filed

Sept 12 1922 J L J

Local Registrar

RECEIVED CERTIFICATE OF DEATH

Registration District No. 70

Primary Registration District No. 1011

STATION

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

40177

Registered No.

92

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 14 1922

17. I HEREBY CERTIFY, That I attended deceased from

Aug 31 1922 to Sept 14 1922

that I last saw him alive on Sept 13 1922

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

myocarditis

(Duration) Yrs. mos. ds.

Contributory (Secondary) Intermittent Nephritis

(Duration) yrs. mos. ds.

(Signed) G. S. Stone M. D.

19. (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Wallace Idaho Sept 15 1922

20. UNDERTAKER

B. W. Werstell, Wallace, Id.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Shoshone
City of BurkeRegistration District No. 10Primary Registration District No. 1011(No. Theresele Mine St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John MurphyFile No. 40178Registered No. 2

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-OWED OR DIVORCED single
(Write the word.)

6. DATE OF BIRTH

(Month) 1 (Day) 1 (Year) 1922

7. AGE

42 Yrs. — Mos. — ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)miner

9. BIRTHPLACE

(State or Country)

Ireland

10. NAME OF FATHER

John Murphy

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Bridget Mc Garry

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mike J. Murphy(Address) Burke 2d St15. J. E. QuigleyFiled Sept 20th 1922 E. S. Stone Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 19 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19. to 19. Sept 19 1922
that I last saw him alive on Sept 19 1922
and that death occurred on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:

Falling rock crushed skull(Duration) Instant Yes Instant No Instant

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

9/19/22 (Address) Wallace 2da

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence Burke 2da

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Spokane Wash Sept 21 1922

20. UNDERTAKER

ADDRESS

Hardy & Co Wallace 2da

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **40179**
Registered No. **94**

1. PLACE OF DEATH

County of **Shoshone**
near **Mullan**
City of **Mullan**Registration District No. **7C**Primary Registration District No. **8911**(No. **Thas Selms Cliff Mullan**)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Frank Lambert

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

married
(Write the word.)

6. DATE OF BIRTH

May 26 1886
(Month) (Day) (Year)

7. AGE

36 Yrs. 3 Mos. 28 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).**Teamster**

9. BIRTHPLACE

(State or Country)

South Dakota

10. NAME OF FATHER

Frank Lambert

11. BIRTHPLACE OF FATHER

(State or Country)

no information

12. MAIDEN NAME OF MOTHER

Charlotte Bourne

13. BIRTHPLACE OF MOTHER

(State or Country)

no information

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Frank Lambert

(Address)

Mullan Idaho

15.

Filed

Oct 2 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 24 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

..... 19..... to 19.....
that I last saw him alive on..... 19.....
and that death occurred on the date stated above, at **1:30 P.M.**

The CAUSE OF DEATH* was as follows:

**Fracture Skull
Accidental by car
burned lungs**
(Duration) **1 day** ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

H. Mowery Coroner
9/25/22 (Address) **Wallace, Ida**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

Mullan Idaho

19. PLACE OF BURIAL OR REMOVAL

Mullan Ida

DATE OF BURIAL

Oct 3 1922

20. UNDERTAKER

Hardy & Co

ADDRESS

Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40180**
Registered No. **46**
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of **Shoshone**
City of **Burke**
Registration District No. **20**
Primary Registration District No. **1011**
(No. **George Gulch** St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Eugene Sage**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **M** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **married**
(Write the word.)

6. DATE OF BIRTH **December 11 1859**
(Month) (Day) (Year)

7. AGE **62** Yrs. **9** Mos. **13** ds.
IF LESS than 1 day how many..... hrs. or..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work **miner**
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) **Michigan**

10. NAME OF FATHER **Eugene Sage**

11. BIRTHPLACE OF FATHER
(State or Country) **Michigan**

12. MAIDEN NAME OF MOTHER **Mary Ellen Lyons**

13. BIRTHPLACE OF MOTHER
(State or Country) **Maine**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) **Eugene W. Sage**
(Address) **Burke Idaho**

15. **Sept 20 1922**
Filed **Sept 20 1922**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **Sept 26 1922**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Sept 25 1922** to **Sept 26 1922**
that I last saw him alive on **Sept 26 1922**
and that death occurred on the date stated above, at **7 a** M.
The CAUSE OF DEATH* was as follows:

Pulmonary Phthisis

(Duration) — Yrs. — mos. — ds.
Contributory (Secondary)
(Duration) — yrs. — mos. — ds.
(Signed) **Chas. A. Drinan M. D.**
Sept 28 1922 (Address) **Burke Ida**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days
Where was disease contracted if not at place of death?
Former or usual residence **Burke Idaho**

19. PLACE OF BURIAL OR REMOVAL **Wallace Ida** DATE OF BURIAL **Sept 30 1922**
20. UNDERTAKER **Ward and Co** ADDRESS **Wallace**

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40181**
Registered No. **16**

1. PLACE OF DEATH

County of **Shoshone** Registration District No. **20**
City of **Gem** Primary Registration District No. **104**
(No. **Residence** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Robert James Hodgkins

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **M.** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED **single**
(Write the word.)

6. DATE OF BIRTH

July 16 1922
(Month) (Day) (Year)

7. AGE

Yrs. **2** Mos. **20** ds. —
IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

none

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

J. G. Hodgkins

11. BIRTHPLACE OF FATHER

(State or Country)

Massachusetts

12. MAIDEN NAME OF MOTHER

Maudie Clark

13. BIRTHPLACE OF MOTHER

(State or Country)

North Dakota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. G. Hodgkins
Gem Idaho

15.

Filed

Oct 8 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 6 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 6 1922 to **Oct 6 1922**
that I last saw h. **m.** alive on **Oct 6 1922**
and that death occurred on the date stated above, at **1 p.** M.
The CAUSE OF DEATH* was as follows:

whetmal pneumonia

(Duration) Yrs. mos. **4** ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

James R. Bean M. D.

(Address)

Wallace

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

Gem Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wallace Ida Oct 8 1922

20. UNDERTAKER

ADDRESS

Ward Und Co Wallace Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Shoshone
City of WallaceRegistration District No. 70
Primary Registration District No. 1011
(No. Wallace Hospital)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jack HenryFile No. 40182
Registered No. 97

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDM white single
(Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

42 Yrs. — Mos. — ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)mines

9. BIRTHPLACE

(State or Country)

Switzerland

10. NAME OF FATHER

no information

11. BIRTHPLACE OF FATHER

(State or Country)

no information

12. MAIDEN NAME OF MOTHER

no information

13. BIRTHPLACE OF MOTHER

(State or Country)

no information

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) D. G. Bloncher
(Address) Wallace Idaho15. Oct 13 1922
Filed 7:25

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 9 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 9 1922 to Oct 9 1922
that I last saw him alive on Oct 9 1922
and that death occurred on the date stated above, at 7 p. M.

The CAUSE OF DEATH* was as follows:

Fracture Base of Skull
multiple fractures Rt thigh
+ leg
(Duration) few hours Yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Max T. Smith M. D.(Address) Wallace Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence Mullan Idaho19. PLACE OF BURIAL OR REMOVAL Wallace Ida DATE OF BURIAL Oct 13 192220. UNDERTAKER Hardy & Co ADDRESS Wallace Ida

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Shoshone
City of WallaceRegistration District No. 70Primary Registration District No. 1011(No. Providence Hospital)File No. 40183Registered No. 98

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Louis Graiff

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

single
(Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

50 Yrs. — Mos. — ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

mines

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Rumania

10. NAME OF FATHER

Graiff

11. BIRTHPLACE OF FATHER

(State or Country)

Rumania

12. MAIDEN NAME OF MOTHER

Marania Graiff

13. BIRTHPLACE OF MOTHER

(State or Country)

Rumania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Basil Rezzouilly

(Address)

Wallace Idaho

15.

Filed

Oct 21 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct181922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 20 1922 to Oct 18 1922
that I last saw him alive on Oct 18 1922
and that death occurred on the date stated above, at 2:30.

THE CAUSE OF DEATH* was as follows:

Thrombosis of the
placental vessels
above & below uterus

(Duration) Yrs. Mos. ds.

Contributory
(Secondary)

(Duration) Yrs. Mos. ds.

(Signed)

Dr. M. J. D.(Address) Wallace

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....Yrs.....Mos.....Days. In the State.....Yrs.....Mos.....Days

Where was disease contracted if not at place of death?

Former or usual residence

Wallace Idaho

19. PLACE OF BURIAL OR REMOVAL

Wallace Idaho

DATE OF BURIAL

Oct 21 1922

20. UNDERTAKER

Ward and Co

ADDRESS

Wallace Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

Registration District No.

70

City of

Primary Registration District No.

File No.

40184

Registered No.

99

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

(No. of St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15. Filed

19

Local Registrar

16. DATE OF DEATH

(Month)

(Day)

19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 19²² to Oct 27 19²²
that I last saw him alive on Oct 26 19²²
and that death occurred on the date stated above, at 5³⁰ A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma Prostatidis

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

James R Bran

M. D.

10/18/19²²

(Address)

Wallace

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wallace Ida

Oct 30 19²²

20. UNDERTAKER

ADDRESS

Barnett

Wallace

1. PLACE OF DEATH

County of *Shoshone*City of *Mullan*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Eric Ansel Luoma

CERTIFICATE OF DEATH

RECEIVED

NOV 27 1922

Registration District No. *70*City of *Mullan* Registration District No. *191*Residence *First Street*State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *40185*Registered No. *100*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

*white*5. SINGLE, MARRIED, WID-
OWED OR DIVORCED*married*
(Write the word.)

6. DATE OF BIRTH

Oct. 24th 1893
(Month) (Day) (Year)

7. AGE

49 Yrs. *6* Mos. *6* ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)*miner*

9. BIRTHPLACE

(State or Country)

Finland

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

Finland

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Finland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mrs. Eric A. Luoma*(Address) *Mullan, Ida*Filed *Oct Nov 22* *FL Jend*
19
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 30 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 18 1922, to *Oct 30 1922*that I last saw *him* alive on *Oct 30 1922*and that death occurred on the date stated above, at *2 P.M.*

The CAUSE OF DEATH* was as follows:

(Secondary) Meningitis(Duration) Yrs. mos. *17* ds.Contributory *Tuberculosis + Onchocerciasis*
(Secondary)(Duration) yrs. mos. *17* ds.(Signed) *F W Ralph* M. D.*Oct 31 1922* (Address) *Mullan, Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence *Mullan Idaho*

19. PLACE OF BURIAL OR REMOVAL

Wallace Ida

DATE OF BURIAL

Nov 2 1922

20. UNDERTAKER

Ward and Co

ADDRESS

Wallace Ida

VED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Shoshone Registration District No. 22
City of Burke Primary Registration District No. 101
(No. Hercules mine St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Michael WelshFile No. 40186
Registered No. 191

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-OWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH

Oct 4 1869
(Month) (Day) (Year)

7. AGE

53 Yrs. 4 Mos. 27 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Foreman at
Hercules mine

9. BIRTHPLACE

(State or Country)

Illinois

10. NAME OF FATHER

Michael Welsh

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Johanna Kennedy

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mr. M. E. Welsh
(Address) Burke Idaho

15.

Filed

Nov 6 1922 J. L. Jones
Local Registrar

16. DATE OF DEATH

Oct 31 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Oct 31 1922 to Oct 31 1922 that I last saw him alive on Oct 31 1922 and that death occurred on the date stated above, at 12.9 M. The CAUSE OF DEATH* was as follows:Fractured skull
(Duration) Yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

D. Char. A. Jones
Oct 31 1922 (Address) Burke Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

Burke Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Joseph's Nov 6 1922

20. UNDERTAKER

ADDRESS

Hardy and Co Wallace
Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Leton Registration District No. 77
City of Alriggs Primary Registration District No. 3176
(No. St.)File No. 40187
Registered No. 38

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Orlinda May Hansen
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female white Single
(Write the word.)

6. DATE OF BIRTH

May 2- 1922
(Month) (Day) (Year)

7. AGE

Yrs. 5 Mos. 73 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Infant.
Infant.

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

H. Hansen

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Maggie Ames

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

William Hansen

(Address)

Alriggs, Idaho

15.

Filed Nov 10- 1922

Martha Marker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

October 25 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 4 1922 to Oct- 25 1922
that last saw her alive on Sept 2- 1922
and that death occurred on the date stated above, at 12:45 PM.

The CAUSE OF DEATH* was as follows:

Chronic gastric enteritis.

(Duration) - Yrs. 5 mos. - ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

H H Culbertson M. D.

10/27.1922 (Address) Alriggs Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Clausen Cemetery Oct 28 1922

20. UNDERTAKER

ADDRESS

Alriggs

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40188**
Registered No.

1. PLACE OF DEATH

County of *Lincoln*
City of *Castleford*

Registration District No. *39*
Primary Registration District No. *2087*
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Not named

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*
(Write the word.)

6. DATE OF BIRTH *Nov 14 1922*
(Month) (Day) (Year)

7. AGE *✓* Yrs. *✓* Mos. *✓* ds. IF LESS than 1 day how many *5* hrs. or *✓* min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE *Castleford W. Va.*
(State or Country)

10. NAME OF FATHER *Leo. Hudson*

11. BIRTHPLACE OF FATHER *Arkansas*
(State or Country)

12. MAIDEN NAME OF MOTHER *Ora Kendall*

13. BIRTHPLACE OF MOTHER *Arkansas*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *Leo. Hudson*
(Address)

15. Filed *Nov. 15 1922*

J. H. Murphy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *Nov 14 1922*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Nov. 14 1922*, to *Nov. 14 1922* that I last saw her alive on *Nov. 14 1922* and that death occurred on the date stated above, at *8:30 P.M.*
The CAUSE OF DEATH* was as follows:
Premature Birth

(Duration) Yrs. mos. ds.
Contributory (Secondary)

(Duration) yrs. mos. ds.
(Signed) *J. H. Murphy* M. D.
Nov. 15 1922 (Address) *Buhl Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Buhl Ida* DATE OF BURIAL *11/15 1922*

20. UNDERTAKER *J. H. Johnson* ADDRESS *Buhl*

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40189**
Registered No. _____

1. PLACE OF DEATH

County of **Lewin Falls**
City of **Buhl**

Registration District No. **39**
Primary Registration District No. **2087**
(No. _____, St. _____)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Flora Ann Smithwick

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Married**
(Write the word.)

6. DATE OF BIRTH **Oct. 20 1850**
(Month) (Day) (Year)

7. AGE **72** Yrs. **25** Mos. **25** ds.
IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Indiana

10. NAME OF FATHER

Robt M Ryman

11. BIRTHPLACE OF FATHER

(State or Country)

Does not know

12. MAIDEN NAME OF MOTHER

Ella Blocksman

13. BIRTHPLACE OF MOTHER

(State or Country)

Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. M. Gilton

(Address)

Buhl Ida

15. Filed **Nov 15 1922**

J. H. Murphy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

91

16. DATE OF DEATH

Nov. 14 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Nov. 11 1922** to **Nov. 13 1922**
that I last saw her alive on **Nov. 13 1922**
and that death occurred on the date stated above, at **9:10 P.M.**

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) _____ Yrs. _____ mos. **6** ds.
Contributory (Secondary) **Myocarditis**

(Duration) _____ yrs. _____ mos. **9** ds.
(Signed) **Gilbert J. Ford D.C.**

11 15 1922 (Address) **Lewin Falls, Idaho.**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Buhl Idaho Nov 16 1922

20. UNDERTAKER

ADDRESS

J. H. Johnson Buhl

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1922

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40190**
Registered No. _____

1. PLACE OF DEATH

County of **Laramie**
City of **Duke**

Registration District No. **39**
Primary Registration District No. **2087**
(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Adeline Vanderford

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Married**
(Write the word.)

6. DATE OF BIRTH

July 13 1899
(Month) (Day) (Year)

7. AGE

23 Yrs. 3 Mos. 17 ds.
IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Anthony Larson

11. BIRTHPLACE OF FATHER

(State or Country)

Denmark

12. MAIDEN NAME OF MOTHER

Eliza Arnoldus

13. BIRTHPLACE OF MOTHER

(State or Country)

Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Walter Vanderford**
(Address) _____

15.

Filed **Nov. 1 1922** **J. N. Warple**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 30 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Dec 17 1921** to **Oct 30 1922**
that I last saw her alive on **Oct 30 1922**
and that death occurred on the date stated above, at **9:30 P.M.**

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
(Duration) **2 Yrs. 1 mos. 1 ds.**

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) **A. J. Threlkeld** M. D.

10/31/1922 (Address) **Buhl Bldg**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Buhl Bldg

DATE OF BURIAL

Nov 12 1922

20. UNDERTAKER

J. Johnson

ADDRESS

Buhl

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 59

County of *Boone*

Primary Registration District No. 2087

City of *Buhl*

(No.)

St.

File No. 40191

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Rudolph Zack Jr.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write in word.)

6. DATE OF BIRTH

Nov

(Month)

12

(Day)

1922

(Year)

7. AGE

Yrs.

Mos.

ds.

IF LESS than 1 day
how many hrs.
or min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

None

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Buhl

10. NAME OF FATHER

Rudolph Zack

11. BIRTHPLACE OF FATHER

(State or Country)

Bohemia

12. MAIDEN NAME OF MOTHER

Agnes Hejzmanek

13. BIRTHPLACE OF MOTHER

(State or Country)

Ckda

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Rudolph Zack

(Address)

Buhl Ida

15.

Filed *11-15*19*22*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov. 14

(Month)

14

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

11-12-1922 to *11-14-1922*that I last saw him alive on *11-14-1922*and that death occurred on the date stated above, at *3 a. m.*

The CAUSE OF DEATH* was as follows:

Organic Heart Dis.

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *Geo. Jennings* M. D.*11-14-1922* (Address) *Buhl, Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Bohler Cemetery

DATE OF BURIAL

Nov 15 1922

20. UNDERTAKER

Wentz & Dugg

ADDRESS

Buhl Ida

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Iron* *Falls*Registration District No. *37.*City of *"*Primary Registration District No. *1085.*(No. *13* *1927*th Ave., E.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Deodan Fredrick Shoppie
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

June 30 1902
(Month) (Day) (Year)

7. AGE

20 Yrs. *3* Mos. *5* ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employment (or employer).*Laborer.*

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

J. C. Shoppie

11. BIRTHPLACE OF FATHER

(State or Country)

Utah.

12. MAIDEN NAME OF MOTHER

Ada Rogers

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. C. Shoppie

(Address)

*Iron Falls*15. *Nov. 1-*Filed *1922*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 5 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

9/25/1922 to *10/3/1922*
that I last saw him alive on *10/4/1922*
and that death occurred on the date stated above, at *12:20* P. M.

The CAUSE OF DEATH* was as follows:

Dysphoria fever(Duration) _____ Yrs. _____ mos. *1* ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) *W. G. Pike* M. D.*10/6/1922* (Address) *Iron Falls, Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Iron Falls**Oct 7 1922*

20. UNDERTAKER

ADDRESS

*J. P. Foreman**Iron Falls*

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40195**
Registered No. _____

1. PLACE OF DEATH

County of *Twin Falls*
City of *Twin Falls*

Registration District No. *37.*
Primary Registration District No. *1085.*
(No. *County General Hospital.* St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Sarah Burt

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female White

Married
(Write the word.)

6. DATE OF BIRTH

Dec 15 1885
(Month) (Day) (Year)

7. AGE

66 Yrs. *9* Mos. *21* ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

House Wife

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

J W Cooper

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W H Burt
(Address) *Twin Falls, Idaho*

15.

Filed *November 11 1922*

John H. Laughlin
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct. 6th. 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June, 1920 to *Oct. 1922*

that I last saw her alive on *Oct. 6 1922*

and that death occurred on the date stated above, at *8 A.M.*

The CAUSE OF DEATH* was as follows:

Acute Dilatation of heart.

30 minutes (Duration)..... Yrs..... mos..... ds.

Contributory (Secondary)

Arteriosclerosis.

unknown (Duration)..... yrs..... mos..... ds.

(Signed)

Hal Bieder M. D.

Oct. 1922 (Address) *Twin Falls, Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Twin Falls

DATE OF BURIAL

Oct 9 1922

20. UNDERTAKER

J E Burt

ADDRESS

Twin Falls

CERTIFICATE OF DEATH

Morgan.
State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40197**

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No.

Primary Registration District No. **1085**

St.)

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE MARRIED, WIDOWED OR DIVORCED

Male

White

Single
(Write the word.)

6. DATE OF BIRTH

June 1

(Month)

1922
(Day) (Year)

7. AGE

Yrs. 4 Mos. 09 ds.

IF LESS than 1 day

how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Twin Falls, Ida.

10. NAME OF FATHER

D. K. Clark

11. BIRTHPLACE OF FATHER

(State or Country)

Neb

12. MAIDEN NAME OF MOTHER

Goulden Wilson

13. BIRTHPLACE OF MOTHER

(State or Country)

Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

D. K. Clark

Twin Falls, Ida.

15.

November 1 1922

Filed

19

John Houghton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 9

(Month)

1922
(Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 9 - 1922, to Oct 9 - 1922

that I last saw him alive on Oct 9 - 1922

and that death occurred on the date stated above, at 12:30 P.M.

The CAUSE OF DEATH* was as follows:

In attendance during death struggle
15 min. History of Ileocolitis

(Duration) Yrs. mos. 2 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. R. Morgan

M. D.

Oct 9 - 1922 (Address) Twin Falls, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Twin Falls

10-11-1922

20. UNDERTAKER

ADDRESS

J. F. Grossman

Twin Falls

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Twin Falls Registration District No. 37
 Primary Registration District No. 1085
 City of Princeton North St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

George Henry Leed

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 40198
 Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
 (Write the word.)

6. DATE OF BIRTH June 17 1889
 (Month) (Day) (Year)

7. AGE 67 Yrs. 3 Mos. 29 ds.
 IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

Day Labor

9. BIRTHPLACE

(State or Country)

Mich

10. NAME OF FATHER

Not known

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Will Whitell

(Address)

Twin Falls Idaho

15.

Filed Nov. 1-22 1922

John J. Longfellow
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 16 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 15 1922, to Oct 16 1922

that I last saw him alive on Oct 16 1922
 and that death occurred on the date stated above, at 5 PM

The CAUSE OF DEATH* was as follows:

met and arterio insufficiency with acute dilation of heart

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
 (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

How. Louchet M. D.

Oct 16 1922 (Address) Twin Falls Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Baise Idaho

1922

20. UNDERTAKER

ADDRESS

J. J. Dravitt

Twin Falls

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40199**

1. PLACE OF DEATH

County of **Twin Falls**Registration District No. **37.**Primary Registration District No. **1085.**City of **Burley**

(No. County Hospital. _____ St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

John Ericson B. Anderson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male**White****Married**
(Write the word.)

6. DATE OF BIRTH

Sept 30 1889
(Month) (Day) (Year)

7. AGE

32 Yrs. **0** Mos. **16** ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Mach.

(b) General nature of industry, business or establishment in which employed (or employer)

Etc.

9. BIRTHPLACE

(State or Country)

Sweden

10. NAME OF FATHER

B. B. Anderson

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME OF MOTHER

Majorete Ericson

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

B. B. Anderson

(Address)

Twin Falls, Ida.

15.

Filed

Nov. 1 -- 19 22

Local Registrar

John F. Koughlin

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 16 19 22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 15 1922 to Oct 16 1922that I last saw him alive on **Oct 16 1922**

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Shock from hemorrhage caused by own tools in machinery.
(Duration) _____ Yrs. _____ mos. _____ ds. $\frac{1}{2}$ Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) **John F. Koughlin** M. D.**10-18-1922** (Address) **Twin Falls, Ida.**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Twin Falls, Ida.

DATE OF BURIAL

10-18 19 22

20. UNDERTAKER

J. F. Grossman

ADDRESS

Twin Falls, Ida.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 34

County of *Terrell*

Primary Registration District No. 1080

City of *Terrell*(No. *1*)

St.)

Registered No. *40200*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Henry Kohner

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

Oct. 5

(Month)

5

(Day)

1878

(Year)

7. AGE

44 Yrs.Mos. *25*

ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Terrell, Texas

10. NAME OF FATHER

Don't know

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Notarization papers

(Address)

15.

Filed

*Nov 3 1922**John H. Loughlin*
Local Registrar

16. DATE OF DEATH

Oct.

(Month)

30

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19....., to

19.....

that I last saw h..... alive on..... 19.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Gun shot in head
(Suicidal)

(Duration)

Yrs.....

mos.....

ds.

Contributory
(Secondary)

(Duration)

yrs.....

mos.....

ds.

(Signed)

*P. J. Grossman**11/2 1922*

(Address)

Terrell

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death.....

yrs.....

mos.....

days.....

In the

State.....

yrs.....

mos.....

days.....

Where was disease contracted if not at place of death?.....

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Randolph Neb.

19.....

20. UNDERTAKER

ADDRESS

P. J. Grossman *Terrell*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

M. 1-16-13

DEATH

Reg.

District No.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

County of *Idaho Falls*Primary Registration District No. *1085*File No. *40201*City of *Idaho Falls*

(No. _____ St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *William Harry Harris*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male white married

6. DATE OF BIRTH.

June 9 1932
(Month) (Day) (Year)

7. AGE

49 Yrs. 4 Mos. 10 ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Painter

9. BIRTHPLACE

(State or Country)

Wisconsin

10. NAME OF FATHER

Henry Harris

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Mary Carter

13. BIRTHPLACE OF MOTHER

(State or Country)

Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. W. H. Harris

(Address)

Coldwell

15.

Filed

Oct 20 1932

Local Registrar

16. DATE OF DEATH

10 19 1932
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 *on 10/19* 19*P. 2*
that I last saw him alive on *10/19* 19*P. 2*
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

*Valvular heart disease
dealt before my arrival*

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) *C. D. Weaver* M. D.19 (Address) *Idaho Falls*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Coldwell

191

20. UNDERTAKER

ADDRESS

J. P. Grossman Idaho Falls

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Juniper*Registration District No. *34*Primary Registration District No. *1085*City of *Idaho Falls*(No. *1085* St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Marshall M. Pomeroy*Registered No. *40202*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

Feb 15 1894
(Month) (Day) (Year)

7. AGE

*68 Yrs. 8 Mos. 7 ds.*IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)*carpenter*

9. BIRTHPLACE

(State or Country)

Ill

10. NAME OF FATHER

Atis Pomeroy

11. BIRTHPLACE OF FATHER

(State or Country)

ahew

12. MAIDEN NAME OF MOTHER

Elebeth Riddle

13. BIRTHPLACE OF MOTHER

(State or Country)

not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Carl H. Pomeroy*

(Address)

15.

Filed *Oct 26 1922**John F. Conzath*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 23 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 21 1922 to Oct 23, 1922
that I last saw him alive on *Oct 23, 1922*
and that death occurred on the date stated above, at *12 M*

The CAUSE OF DEATH* was as follows:

Pneumonia(Duration) *0 Yrs. 0 mos. 5 ds.*Contributory *mitral stenosis*
(Secondary)(Duration) *? yrs. - mos. - ds.*(Signed) *E. M. Van Gort*, M. D.*10-25-1922* (Address) *Idaho Falls*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Idaho Falls Ida

DATE OF BURIAL

Oct 26 1922

20. UNDERTAKER

Edwin

ADDRESS

Idaho Falls

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 34
County of Twin Falls Primary Registration District No. 1085
City of " (No. " St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Elsie M. TuckerFile No. 40203
Registered No. "

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
(Write the word.)6. DATE OF BIRTH Sept 11 1888
(Month) (Day) (Year)7. AGE 34 Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

Housewife
Home

9. BIRTHPLACE

(State or Country)

Oregon

10. NAME OF FATHER

W.E. Savage

11. BIRTHPLACE OF FATHER

(State or Country)

Oregon

12. MAIDEN NAME OF MOTHER

Mattie A. Soren

13. BIRTHPLACE OF MOTHER

(State or Country)

Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. A. Tucker
(Address) Twin Falls Ida.15. Filed Oct 26 1922 John F. Boughton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 24 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Oct 22 1922 to Oct 24 1922
that I last saw h. W alive on Oct 24 1922
and that death occurred on the date stated above, at 9:15 PM

THE CAUSE OF DEATH* was as follows:

Primitives(Duration) 8 hours
Contributed by Thyroid toxaemia 2 yrs
Nephritis
(Duration) 2 yrs. mos. ds.
(Signed) H. F. Passer M. D.
Oct 26 1922 (Address) Twin Falls Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Twin Falls, Ida. 1922

20. UNDERTAKER ADDRESS

J. F. Grossman

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

✓ Scott
State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Elwin Falls Registration District No. 34
City of " Primary Registration District No. 1085
(No. 1085 St.)

File No. 40204

Registered No. _____

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Baby Wilson

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Oct 75 1922
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day
how many 10 hrs.
or 10 min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.

None

(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer).

None

9. BIRTHPLACE

(State or Country)

Elwin Falls, Ida.

10. NAME OF
FATHER

E. B. Wilson

11. BIRTHPLACE
OF FATHER

(State or Country)

Missouri

12. MAIDEN NAME
OF MOTHER

Carlo York

13. BIRTHPLACE
OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. B. Wilson

(Address)

Haystack, Ida.

15.

Filed Oct 26 1922

John Houghlin
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 75 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 24 1922 to Oct 25 1922

that I last saw h. er alive on Oct 24 1922

and that death occurred on the date stated above, at 9:45 A.M.

The CAUSE OF DEATH* was as follows:

Premature infant (5 1/2 mth)

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Chas. R. Scott M. D.

19 (Address) Elwin Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Haystack, Ida Oct 26 1922

20. UNDERTAKER

ADDRESS

J. J. Grossman Elwin Falls, Ida.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH *Lucin Falls* Registration District No. *34*
 County of *Lucin Falls* Primary Registration District No. *1080*
 City of *"* St. *"*

File No. *40205*

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME *Albert Knefel Sr.*

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Wid.*

6. DATE OF BIRTH *May 5 1854*
 (Month) (Day) (Year)

7. AGE *68* Yrs. *5* Mos. *23* ds.
 IF LESS than 1 day
 how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work *Retired*(b) General nature of industry, business or establishment in which employed (or employer) *P.O. Clerk*

9. BIRTHPLACE

(State or Country) *Germany*10. NAME OF FATHER *John Knefel*

11. BIRTHPLACE OF FATHER

(State or Country) *Germany*12. MAIDEN NAME OF MOTHER *Not Known*

13. BIRTHPLACE OF MOTHER

(State or Country) *Ger.*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Albert Knefel Jr.*(Address) *Lucin Falls*

15.

Filed *Oct-31* 1922 *John H. Haughlin*

Local Registrar

16. DATE OF DEATH *Oct 28 1922*
 (Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *10-28 1922* to *10-28 1922*

that I last saw him alive on *10-22 1922*
 and that death occurred on the date stated above, at *6:30 P.M.*
 The CAUSE OF DEATH* was as follows:

*Angina Pectoris*Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) *John H. Haughlin* M. D.(Address) *Lucin Falls Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL *Chicago Ill*DATE OF BURIAL *19*20. UNDERTAKER *P. J. Grossman*ADDRESS *Lucin Falls*

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40206**
Registered No.

1. PLACE OF DEATH **RECEIVED**
Registration District No. **34**
County of **Lovin Falls** **NOV 13 1922**
Primary Registration District No. **1288**
City of **BUREAU OF VITAL STATISTICS** (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Gale Clawson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX **Male** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Single**
(Write the word.)

6. DATE OF BIRTH

Feb **1922**
(Month) (Day) (Year)

7. AGE

8 Yrs. **8** Mos. **ds.** IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Child

9. BIRTHPLACE

(State or Country) **Lovin Falls**

10. NAME OF FATHER

O B Clawson

11. BIRTHPLACE OF FATHER

(State or Country) **Missouri**

12. MAIDEN NAME OF MOTHER

Minnie Dodge

13. BIRTHPLACE OF MOTHER

(State or Country) **don't know**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **J A Bussness**
(Address) **Lovin Falls Ida.**

15.

Filed **Oct 31** **1922** **John H Boughner**
Local Registrar

16. DATE OF DEATH

10 **30** **1922**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

10/29/1922 to **10/30/1922**
that I last saw him alive on **10/30/1922**
and that death occurred on the date stated above, at **7:30** M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) Yrs. **6** mos. **ds.**

Contributory
(Secondary)

(Duration) yrs. **6** mos. **ds.**

(Signed) **W. F. Pike**

M. D.

10/31/1922 (Address) **Lovin Falls Ida.**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

On Farm **19**

20. UNDERTAKER

ADDRESS

None

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 40207
Registered No. _____

1. PLACE OF DEATH

County of San Juan Registration District No. 84
City of BURN (No. _____) (St.) _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ida a Yantis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX fe 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)6. DATE OF BIRTH Oct 25 1877
(Month) (Day) (Year)7. AGE 45 Yrs. 6 Mos. ds.
IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work house wife
(b) General nature of industry, business or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country) Kentucky

10. NAME OF FATHER

James P. Gabbart

11. BIRTHPLACE OF FATHER

(State or Country) Kentucky

12. MAIDEN NAME OF MOTHER

addie Labond

13. BIRTHPLACE OF MOTHER

(State or Country) Ken

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) S. P. Yantis(Address) 330 3rd Ave Burn15. Filed Nov 3 1922 John H. Langhorne
Local Registrar

16. DATE OF DEATH

Nov 1 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Nov 1st 1922, to Nov 1st 1922 that I last saw her alive on Nov 1st 1922 and that death occurred on the date stated above, at 10 AM.

The CAUSE OF DEATH* was as follows:

uterine carcinoma
about 3 Yrs. mos. ds.
(Duration)

Contributory (Secondary)

(Duration) Yrs. mos. ds.(Signed) W. D. Parker M. D.(Address) Burn, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Burn

DATE OF BURIAL

11-3 1922

20. UNDERTAKER

J. E. ...

ADDRESS

Burn, IdahoMARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Shoshone Registration District No. 37
Bureau Registration District No. 1085
City of " State of " St.)File No. 40208

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robert D. L. McBride

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male White Widowed
(Write the word.)

6. DATE OF BIRTH

Aug 3 1878
(Month) (Day) (Year)

7. AGE

47 yrs. 20 mos. 20 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

Ditch rider
Salmon River Canal Co.

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

W. B. McBride

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Don't know

13. BIRTHPLACE OF MOTHER

(State or Country)

"

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Geo. J. Grover

(Address)

Haileston, Ida

15.

Filed Nov 3 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 73 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 19 1922, to Oct 23 1922,
that I last saw him alive on Oct 22 1922
and that death occurred on the date stated above, at 1:15 P. M.
The CAUSE OF DEATH* was as follows:Infection Meningitis
traumatic craniocerebral
(Duration) Yrs. Mos. Ds.
Contributory
(Secondary)
accidental fracture upper jaw molars

(Duration) yrs. mos. ds.

(Signed) Duncan Alexander M. D.Oct 19 22 (Address) Shoshone, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Shoshone Oct 24 1922

20. UNDERTAKER ADDRESS

R. J. Crossman Shoshone Ida

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Twin FallsRegistration District No. 37City of "Primary Registration District No. 1055

(No. _____ St.)

File No. 40209

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Manuel Trujillo

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

Mex white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

Not Known

(Month)

(Day)

(Year)

7. AGE

65

Yrs.

Mos.

ds.

IF LESS than 1 day

how many _____ hrs.

or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business or establishment in which employed (or employer)

Railroad

9. BIRTHPLACE

(State or Country)

Mexico

10. NAME OF FATHER

Not Known

11. BIRTHPLACE OF FATHER

(State or Country)

""

12. MAIDEN NAME OF MOTHER

""

13. BIRTHPLACE OF MOTHER

(State or Country)

""

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Bevity Hospital Records
Twin Falls

(Address)

15.

Filed Nov 3 1922John H. Houghton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov

(Month)

(Day)

1922
(Year)17. I HEREBY CERTIFY, That I attended deceased from Oct. 29, 1922, to Nov. 1, 1922that I last saw him alive on Nov 1, 1922 and that death occurred on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH* was as follows:

Poisoning, Dinitrochloral

(Duration) Yrs. mos. ds.

Contributory Pulmonary T.B.

(Secondary)

(Duration) yrs. mos. ds.

(Signed) Joseph Agal M. D.Nov 2, 1922 (Address) Twin Falls, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Twin Falls

DATE OF BURIAL

11-3 1922

20. UNDERTAKER

P. J. Grossman

ADDRESS

Twin Falls

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40210**

1. PLACE OF DEATH

County of **Juniata** Registration District No. **35**
City of **"** Primary Registration District No. **1085**
(No. **1** **CIT** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jack McMaster

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-OWED OR DIVORCED

Male **White** **Single**
(Write the word.)

6. DATE OF BIRTH

June **11** **1913**
(Month) (Day) (Year)

7. AGE

9 **3** **27** ds.
Yrs. Mos. If LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Geo McMaster

11. BIRTHPLACE OF FATHER

(State or Country)

Kan

12. MAIDEN NAME OF MOTHER

Celestia Babington

13. BIRTHPLACE OF MOTHER

(State or Country)

Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Geo McMaster

(Address)

Buhl Ida

15.

Filed **November 1** **1922**

John Houghton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct **8** **1922**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 7 **1922** to **Oct 8** **1922**
that I last saw him alive on **Oct 7** **1922**
and that death occurred on the date stated above, at **1:15** M.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis
Gangrene

(Duration) Yrs. mos. **6** ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. H. Houghton, D.

10/9/22 (Address) **Buhl Ida**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Buhl Ida **10-9-22**

20. UNDERTAKER

ADDRESS

R. J. Grossman **Juniata Ida**

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH *Thurston Pence*
 County of *Thurston* Registration District No. *37*
 City of *Three Creek* Primary Registration District No. *2885*
 (No.) (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

J. Williams Ireland

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. *40211*

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED

Male *White* *Single* (Write the word.)

6. DATE OF BIRTH

Sept. 20 1853
 (Month) (Day) (Year)

7. AGE

69 Yrs. *0* Mos. *7* ds.

IF LESS than 1 day
 how many _____ hrs.
 or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer)

Laborer
(Stockman)

9. BIRTHPLACE

(State or Country)

Don't know

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Thurston Pence
Hogerson, Ida

15.

Filed *Nov. 1 - 1922*

Local Registrar

16. DATE OF DEATH

Sept. 27 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 19____, to _____ 19____

that I last saw him _____ alive on _____ 19____

and that death occurred on the date stated above, at *4:15 P.*

The CAUSE OF DEATH* was as follows:

Pneumonia Interstitial
Serous
 (Duration) _____ Yrs. _____ mos. _____ ds.
 Contributory (Secondary) *autopsy findings*
 (Duration) _____ Yrs. _____ mos. _____ ds.
 (Signed) *John J. Coughlin*
10-2-1922 (Address) *Thurston Pence*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Thurston Pence *Oct. 2 1922*

20. UNDERTAKER

ADDRESS

J. J. Coughlin *Thurston Pence*

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 40212

Registered No. _____

1. PLACE OF DEATH

County of San ValleyCity of BuhlRegistration District No. 39Primary Registration District No. 2087

BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Rosie Stampel Schatz

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married

6. DATE OF BIRTH

Dec (Month) 25 (Day) 1899 (Year)

7. AGE

22 Yrs. 9 Mos. 11 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Housewife

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Chas. C. Stampel

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Rosie

13. BIRTHPLACE OF MOTHER

(State or Country)

Austria Hungary

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Chas. Stampel

(Address)

Buhl Ida

15.

Filed 10-7 1922J. H. Murphy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct. (Month) 6 (Day) 1922 (Year)17. I HEREBY CERTIFY, That I attended deceased from 8-16-1922 to 10-6-1922that I last saw him alive on 10-6-1922and that death occurred on the date stated above, at 3:20 P.M.

The CAUSE OF DEATH* was as follows:

Inflammatory Rheumatism with organic Heart Dis.(Duration) Yrs. 2 mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) H. S. Drumm M. D.10-6-1922 (Address) Buhl, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

San Valley Cemetery10-8 1922

20. UNDERTAKER

ADDRESS

W. W. DruggBuhl, Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40213**
Registered No.

1. PLACE OF DEATH

Registration District No. **39**
County of **Lincoln** Primary Registration District No. **2087**
City of **Buhl** STATE NO. **1** (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Bert Craigen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WID-OWED OR DIVORCED **Single**

6. DATE OF BIRTH

Feb - 12 1922
(Month) (Day) (Year)

7. AGE

8 Yrs. **10** Mos. **10** ds. IF LESS than 1 day how many..... hrs. or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed **10-24** 19**22**

J. H. Murphy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 22 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 16 1922 to **Oct 22 1922**
that I last saw him alive on **Oct 22 1922**
and that death occurred on the date stated above, at **10 A.M.**

The CAUSE OF DEATH* was as follows:

Asiatic Cholera
Cholera Infantum

(Duration) Yrs. mos. **15** ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

James Murray M. D.
Oct 22 1922 (Address) **Buhl, Ida.**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Buhl Cemetery **9-25 1922**

20. UNDERTAKER

ADDRESS

W. E. Miller & Sons, Buhl, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 40214

1. PLACE OF DEATH. Registration District No. 15
County of Valley Primary Registration District No.
City of (No. 13) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Samuel Parks

Registered No.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widower
(Write the word.)

6. DATE OF BIRTH Apr 25 1891
(Month) (Day) (Year)

7. AGE 41 yrs. 15 mos. 4 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION (a) Trade, profession, or particular kind of work farmer (b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Ill

10. NAME OF FATHER not given

11. BIRTHPLACE OF FATHER (State or Country) not given

12. MAIDEN NAME OF MOTHER not given

13. BIRTHPLACE OF MOTHER (State or Country) not given

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) G. E. Hoffle (Address) Cascade, Ida

15. Filed 191 Stella Cain Deputy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 27 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1910, to Aug 27 1922 that I last saw him alive on Aug 10 1922 and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows: General Decline

(Duration) yrs. mos. ds. Contributory (Secondary) old age

(Duration) yrs. mos. ds. (Signed) G. E. Hoffle M. D. 19 (Address) Cascade

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL,

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the of death yrs. mos. ds. State yrs. mos. ds. Where was Disease contracted, If not at place of death? Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL Crown Point 8-29-22

20. UNDERTAKER ADDRESS J. M. Cox Cascade

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 40215

Registered No. _____

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH Valley Registration District No. 15
County of Valley Primary Registration District No. _____
City of _____ (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Tokkenen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH

not given 1867
(Month) (Day) (Year)

7. AGE

55 yrs. 5 mos. 5 ds. IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Finland

10. NAME OF FATHER

not given

11. BIRTHPLACE OF FATHER

(State or Country)

Finland

12. MAIDEN NAME OF MOTHER

not given

13. BIRTHPLACE OF MOTHER

(State or Country)

Finland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

G E Hogg

(Address)

Cascade Ida

15.

Filed _____ 191 _____

Hella Coon

by Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 20 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 1 1912, to July 20 1922
that I last saw him alive on July 10 19122

and that death occurred on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(Duration) 3 yrs. 0 mos. 0 ds.

Contributory (Secondary)

(Duration) 0 yrs. 0 mos. 0 ds.(Signed) G E Hogg M. D.19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place yrs. mos. ds. In the State yrs. mos. ds.

Where was Disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL

Finnish Cemetery

DATE OF BURIAL

7-22 1922

20. UNDERTAKER

J M Cox

ADDRESS

Cascade

FORM V. S. No. 5-A—25 M. 1-19.

1. PLACE OF DEATH

County of Valley Registration District No. 15
City of McCall (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Anna R. Calkins

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 40216

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH

Sept 28 1897
(Month) (Day) (Year)

7. AGE

56 Yrs. _____ Mos. _____ ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Housewife

9. BIRTHPLACE

(State or Country)

Mo.

10. NAME OF FATHER

Oscar Russell

11. BIRTHPLACE OF FATHER

(State or Country)

Ind.

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

A. S. Calkins
Nampa Ida

15.

Filed

July 20th 1922Vella Curin
Refy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 15 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Call at death 19 19

that I last saw him _____ alive on _____ 19

and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Don't know (T. 109)

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)Don't know

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) H. C. Robinson M. D.7-17-1922 (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Nampa Ida7-17-1922

20. UNDERTAKER

ADDRESS

Wm. H. RobinsonNampa Ida

CERTIFICATE OF DEATH

1. PLACE OF DEATH
 County of Valley
 City of Valley St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No. 15

Primary Registration District No.

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 40217

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
 (Write the word.)

6. DATE OF BIRTH

..... 1
 (Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
 how many hrs.
 or min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work. farmer
 (b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) N.C.

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country) N.C.

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country) N.C.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) G. E. Hoggles

(Address)

15.

Filed

19 1922Local Registrar Wm D. Patterson

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 14 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

..... 19....., to 19.....
 that I last saw h. in alive on 10-13 1922
 and that death occurred on the date stated above, at 5-AM.

The CAUSE OF DEATH* was as follows:

shot murder

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) G. E. Hoggles

M. D.

19.....

(Address) Cascade

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cascade10-15-1922

20. UNDERTAKER

ADDRESS

J. M. CoxCascade

1. PLACE OF DEATH

County of Valley
City of Newwood

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED CERTIFICATE OF DEATH

Registration District No. 15
Primary Registration District No. 15
BUREAU OF VITAL STATISTICSState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 40218

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female Finnish

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

October 5 1922
(Month) (Day) (Year)

7. AGE

4 Yrs. 10 Mos. 13 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

none

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Henry Victor Kangas

11. BIRTHPLACE OF FATHER

(State or Country)

Finnland

12. MAIDEN NAME OF MOTHER

Annie Lizzie Etelaho.

13. BIRTHPLACE OF MOTHER

(State or Country)

Finnland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Dr. J. F. Rutledge

(Address)

Cascade, Idaho

15.

Filed

19Gilla Cain

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

October 5 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

10/4/22 1922 to 10/4 1922that I last saw her alive on 10/4 1922and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Dysentery(Duration) _____ Yrs. _____ mos. 6 ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) John F. Rutledge, M.D.10/4 1922 (Address) Cascade, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Newwood, Idaho

DATE OF BURIAL

10/8 1922

20. UNDERTAKER

None

ADDRESS

None

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11. NOV 18 1922
BUREAU OF VITAL STATISTICS
1. PLACE OF DEATH. District No. 15
County of Valley Primary Registration District No.
City of (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Norton L White

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 40219
Registered No.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH Jan 25 1920
(Month) (Day) (Year)

7. AGE 1 yrs. 9 mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

- (a) Trade, profession, or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Ida

10. NAME OF FATHER Paul White

11. BIRTHPLACE OF FATHER (State or Country) Mo

12. MAIDEN NAME OF MOTHER Mary Glass

13. BIRTHPLACE OF MOTHER (State or Country) Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. E. Hoff
(Address) Cascade

15. Filled 191 Little Cabin
Official Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 9 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY That I attended deceased from Saw Body 191 to 191

that I last saw h. alive on 191

and that death occurred on the date stated above, at 7 a.m.

The CAUSE OF DEATH* was as follows:

Acute Exantema

(Duration) yrs. mos. 4 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.
(Signed) C. E. Hoff M. D.
19 (Address) Cascade

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was Disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Maula Ida 9-4 1922

20. UNDERTAKER, ADDRESS
Robinson

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Washington Registration District No. 86
 City of Wenatch Registration District No. 1010
 (No. 1010) (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Carroll Jones

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 40220
 Registered No. 14

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
 (Write the word.)

6. DATE OF BIRTH

April 30 1922
 (Month) (Day) (Year)

7. AGE

4 Yrs. 4 Mos. 4 ds.

If LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

None

9. BIRTHPLACE

(State or Country)

Ida

10. NAME OF FATHER

James A. Jones

11. BIRTHPLACE OF FATHER

(State or Country)

Ida

12. MAIDEN NAME OF MOTHER

Eva Salting

13. BIRTHPLACE OF MOTHER

(State or Country)

Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

James A. Jones
Wenatch, Ida

(Address)

15.

Filed

4/27

1922

W. R. Hamblin
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 4 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 4 1922, to Sept 4 1922, that I last saw him alive on Sept 4 1922, and that death occurred on the date stated above, at 10:30 P.M.

The CAUSE OF DEATH* was as follows:

Enteric colitis

(Duration) Yrs. mos. ds.
 Contributory (Secondary) Premature birth
neurorhynch

(Signed) J. M. Waterhouse M. D.
 (Address) Wenatch, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Hillcrest Cemetery

DATE OF BURIAL

7-7-1922

20. UNDERTAKER

Northrup & McLean

ADDRESS

Wenatch, Ida

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Washington Registration District No. 86
 City of Weiser Primary Registration District No. 1010
 (No. 1010 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Harold Jones

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 40221
 Registered No. 73

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
 (Write the word.)

6. DATE OF BIRTH

Apr 30 1922
 (Month) (Day) (Year)

7. AGE

4 6 ds.
 Yrs. Mos. ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

None

9. BIRTHPLACE

(State or Country)

Ida:

10. NAME OF FATHER

Jas. A. Jones

11. BIRTHPLACE OF FATHER

(State or Country)

Ida

12. MAIDEN NAME OF MOTHER

Eva Salting

13. BIRTHPLACE OF MOTHER

(State or Country)

Ida:

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. L. Jansen
Weiser

15.

Filed

9/27 1922

W. H. Jansen
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 6 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 5 1922, to Sept 6 1922
 that I last saw him alive on Sept 6 1922
 and that death occurred on the date stated above, at 4 P. M.
 The CAUSE OF DEATH* was as follows:

ulcer colitis

(Duration) Yrs. mos. ds.
 Contributory (Secondary) Pernicious Anemia
 (Duration) Yrs. mos. ds.
 (Signed) Wm. Walckhaus M. D.
Sept 7 1922 (Address) Weiser Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Weiser Cemetery

DATE OF BURIAL

9-7 1922

20. UNDERTAKER

Northrup M. Co.

ADDRESS

Weiser Ida

1. PLACE OF DEATH

County of Washington
 City of Weiser

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED
CERTIFICATE OF DEATHRegistration District No. 26Primary Registration District No. 2112(No. 105)

St.)

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 40222Registered No. 10

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female whiteSingle
(Write the word.)

6. DATE OF BIRTH

June 2 1922
 (Month) (Day) (Year)

7. AGE

3 Yrs. 3 Mos. 15 ds.

IF LESS than 1 day
 how many..... hrs.
 or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

None

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Ida

10. NAME OF FATHER

Henry Witte

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Myrtle Shaw

13. BIRTHPLACE OF MOTHER

(State or Country)

Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Henry Witte

(Address)

Weiser Ida

15.

Filed 7/27 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 18 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 8 1922 to Sept 8 1922
 that I last saw h..... alive on.....
 and that death occurred on the date stated above, at 1 a.m.

The CAUSE OF DEATH* was as follows:

Enteric Colitis(Duration) Yrs. mos. 1 ds.Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

J. M. Watahogan

M. D.

7/19 1922 (Address) Weiser Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hillcrest Cemetery7/19 1922

20. UNDERTAKER

ADDRESS

Northam McCannWeiser Ida

RECEIVED
NOV 18 1922

CERTIFICATE OF DEATH

Finney
State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Washington Registration District No. 87
City of Wendell Registration District No. 2112
(No. _____) (St. _____)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Martha F. KeslerFile No. 40223
Registered No. 17

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE Wbr 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widowed
(Write the word.)

6. DATE OF BIRTH

Apr 6 1895
(Month) (Day) (Year)

7. AGE

77 Yrs. 5 Mos. 13 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Housewife

9. BIRTHPLACE

(State or Country)

Va.

10. NAME OF FATHER

Daniel Flora

11. BIRTHPLACE OF FATHER

(State or Country)

Va.

12. MAIDEN NAME OF MOTHER

Bamhart

13. BIRTHPLACE OF MOTHER

(State or Country)

Va.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Emma K. Miller
(Address) Weiser, Ida.15. Sept. 20th 1922 J R Hamblin
Filed _____ Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

September 19th 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Aug. 15th 1922, to Sep. 19th 1922, that I last saw her alive on Sep. 19th 1922, and that death occurred on the date stated above, at 9:45 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis with Myocarditis.(Duration) 5 Yrs. _____ mos. _____ ds.Contributory Acute Poly serositis
(Secondary)(Duration) _____ yrs. 1 mos. _____ ds.(Signed) Emma K. Miller M. D.9/23/22 (Address) Weiser Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Steele Creek Cemetery

DATE OF BURIAL

9-22-22

20. UNDERTAKER

Norman McLean

ADDRESS

Weiser, Ida.

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Washington Registration District No. 76
City of Weiser Primary Registration District No. 1010
(No. VITAL St.)

File No. 40224
Registered No. 78

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Daniel M. Uoder

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE Wht 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH

June 22 1889
(Month) (Day) (Year)

7. AGE

73 Yrs. 3 Mos. — ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Retired Farmer

9. BIRTHPLACE

(State or Country)

N. Y.

10. NAME OF FATHER

Isiah Uoder

11. BIRTHPLACE OF FATHER

(State or Country)

N. Y.

12. MAIDEN NAME OF MOTHER

Ledema Rider

13. BIRTHPLACE OF MOTHER

(State or Country)

V. Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

D. M. Uoder

(Address)

Weiser, Ida

15.

Filed

9/231922

M. K. Hamilton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

September 22 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 20 1922 to Sept 22 1922
that I last saw h. — alive on Sept 22 1922,
and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia - 7 Lines(Duration) 2 Yrs. — mos. — ds.Contributory
(Secondary)

(Duration) — yrs. — mos. — ds.

(Signed)

C. E. Gorman

M. D.

9/23 1922 (Address) Weiser, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death — yrs. — mos. — days. In the State — yrs. — mos. — days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Lanesboro, Iowa

DATE OF BURIAL

1922

20. UNDERTAKER

Northrup M. Gann

ADDRESS

Weiser, Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Washington Registration District No. 86
City of Wenatchee Primary Registration District No. 2112
(No. St.)

File No. 40225
Registered No. 19

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Chud Bloomer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE whr 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH

Dec 15 1892
(Month) (Day) (Year)

7. AGE

29 Yrs. 9 Mos. 17 ds.

IF LESS than 1 day
how many.....hrs.
or.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Va.

10. NAME OF FATHER

Anderson Bloomer

11. BIRTHPLACE OF FATHER

(State or Country)

Va.

12. MAIDEN NAME OF MOTHER

Northa Lawson

13. BIRTHPLACE OF MOTHER

(State or Country)

Va.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

A Bloomer
Wenatchee Ida

15.

Filed

10/311922

M. H. H. H. H. H.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 2nd 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 2nd 1922 to Oct 2nd 1922
that I last saw him alive on Oct 2nd 1922
and that death occurred on the date stated above, at 7:00 M.

The CAUSE OF DEATH* was as follows:

accidental injuries received from falling in front of sickle on moon, perforation of pyloric cavity & injury to spleen
(Duration) Yrs. mos. 4

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

M. H. H. H. H. M. D.10/3 1922 (Address) Wenatchee Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Hill cross Cemetery

DATE OF BURIAL

10-5-1922

20. UNDERTAKER

Northa & M. Bloomer

ADDRESS

Wenatchee Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of WashingtonRegistration District No. 86City of WenatcheePrimary Registration District No. 2112

(No.) (St.)

File No. 40226Registered No. 20

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Jerome Warrick

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Oct

(Month)

12

(Day)

1922

(Year)

7. AGE

— Yrs. 2 Mos. 2 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

None

(b) General nature of industry, business or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country)

Ida

10. NAME OF FATHER

John Jerome Warrick

11. BIRTHPLACE OF FATHER

(State or Country)

Penn.

12. MAIDEN NAME OF MOTHER

Gladys Colvig

13. BIRTHPLACE OF MOTHER

(State or Country)

Are

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

John J. Warrick
Wenatchee, Ida

15. Filed

Oct 13th1922W R Hamilton

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

10/13

(Month)

(Day)

1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

10/12 1922, to 10/13 1922that I last saw him alive on 10/13 1922and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Toxic Kidney of Pregnancy in Mother(Duration) Yrs. 6 mos. — ds.

Contributory (Secondary)

(Duration) yrs. 1 mos. — ds.

(Signed)

Edward F. Finner, M. D.10/14 1922 (Address) Wenatchee, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hillcrest Cemetery10-15 1922

20. UNDERTAKER

ADDRESS

Northam McCannWenatchee, Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Washington
City of WeiserRegistration District No. 6Primary Registration District No. 1010
(No. _____ St.)File No. 40227
Registered No. 21

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Carlton S. Foste

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male white

4. COLOR OR RACE

Dont Know
(Write the word.)

6. DATE OF BIRTH

Dont Know
(Month) (Day) (Year)

7. AGE

About 68 years
Yrs. Mos. ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Laborer

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Dont Know

10. NAME OF FATHER

Dont Know

11. BIRTHPLACE OF FATHER

(State or Country)

Dont Know

12. MAIDEN NAME OF MOTHER

Dont Know

13. BIRTHPLACE OF MOTHER

(State or Country)

Dont Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wm. H. Marshall

(Address)

15.

Filed

10/24/19241924W. H. Marshall

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 19 22
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Oct 10 1922 to Oct 19 1922
that I last saw him alive on Oct 19 1922
and that death occurred on the date stated above, at 3 P.M.
The CAUSE OF DEATH* was as follows:Embolism in vessel of Brain
& Paralysis(Duration) Yrs. mos. 8 ds.

Contributory (Secondary)

Injury(Duration) yrs. mos. 10 ds.

(Signed)

W. H. Marshall M. D.

(Address)

Weiser

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hillcrest Cemetery 10-25-22

20. UNDERTAKER

ADDRESS

Northam McCann Weiser

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 40228
 Registered No. 22

1. PLACE OF DEATH

County of Washington
 City of Weiser

Registration District No. 1010Principal Registration District No. 1010(No. 1010)St. IdahoRegistered No. 22

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John W. Wheelhouse
 If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

Wht

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

June 18
(Month)1897
(Day)1897
(Year)

7. AGE

75
Yrs.

Mos.

ds.

If LESS than 1 day
 how many..... hrs.
 or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Retired Farmer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

John Wheelhouse

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Margaret Hardung

13. BIRTHPLACE OF MOTHER

(State or Country)

Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Florence Pewe

(Address)

Weiser Idaho

15.

Filed

Oct 24 1922
W. R. Hunt

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 22
(Month)22
(Day)1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 22 1922 to 1922

that I last saw him alive on Oct 22 1922
 and that death occurred on the date stated above, at 11:30 PM

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) 1 yrs. 1 mos. 1 ds.
 Contributory (Secondary) General Scurvy

(Duration) 2 yrs. 2 mos. 2 ds.
 (Signed) J. M. Waterhouse M. D.

Oct 24 1922 (Address) Weiser Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hellerest Cemetery10/25/22

20. UNDERTAKER

ADDRESS

Northrup McCona Weiser Idaho

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 40229
Registered No. 12

1. PLACE OF DEATH
County of Twin Falls Registration District No. -36-
City of Humboldt Primary Registration District No.
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Angalie B Fisher

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH Mar 18 1911
(Month) (Day) (Year)

7. AGE 3 Yrs. 8 Mos. 3 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE
(State or Country)

Wis.

10. NAME OF FATHER

August Johnson

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER

Pauline Johnson

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. B. Fisher

(Address)

Humboldt, Ida.

15.

Filed

Nov-22 1922

J. D. Davis
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov-21 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 15 1922 to Nov-21 1922
that I last saw her alive on Nov-19 1922
and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma uterus
and sigmoid

(Duration) ? Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. D. Davis M. D.

11/22/1922 (Address) Humboldt, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Twin Falls, Ida.

DATE OF BURIAL

11-23-22

20. UNDERTAKER

J. Grossman

ADDRESS

Twin Falls

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

Registration District No. 79.
 County of Barnes Primary Registration District No. 8156
 City of Barnes Ferry (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Edward Charles Gale

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 40230

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

MWMarried

(Write the word.)

6. DATE OF BIRTH

Apr.41860

(Month)

(Day)

(Year)

7. AGE

62 Yrs. 6 Mos. 27 ds.

IF LESS than 1 day

how many _____ hrs.

or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Mich

10. NAME OF FATHER

Andrew Jackson Gale

11. BIRTHPLACE OF FATHER

(State or Country)

New York

12. MAIDEN NAME OF MOTHER

Martina Barker

13. BIRTHPLACE OF MOTHER

(State or Country)

New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Ida E. Gale

(Address)

Barnes Ferry, Id.

15.

Filed

Nov. 1st. 1922.E. E. Fry

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct311922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct. 311922

to

19that I last saw him alive on Oct. 31 1922and that death occurred on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris(Duration) 3 Yrs. _____ mos. _____ ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

11/1/1922

(Address)

Barnes Ferry, Id.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Barnes Ferry, Id.

DATE OF BURIAL

Nov 3 1922

20. UNDERTAKER

C. S. Cook

ADDRESS

Barnes Ferry

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40231**
Registered No. _____

1. PLACE OF DEATH

County of Boundary Registration District No. 7A
City of Porthill Primary Registration District No. 2156
(No. _____) (St.) _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Charles American Lafferty

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

M W Married
(Write the word.)

6. DATE OF BIRTH

Apr 6 1857
(Month) (Day) (Year)

7. AGE

65 Yrs. 6 Mos. 20 ds. IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Farmer

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. C. A. Lafferty
(Address) Porthill Idaho

15.

Filed Nov. 22, 1922.

ESM
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov. 1 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct. 16th 1922 to Nov. 1 1922
that I last saw him alive on Oct. 23 1922
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 10 Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

11/2 1922 (Address) Bonners Ferry, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Porthill Idaho

DATE OF BURIAL

Nov 4 1922

20. UNDERTAKER

ESM

ADDRESS

Bonners Ferry Idaho

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Boundary Registration District No. 79
 City of Lenia Primary Registration District No. 2156
 (No. 103 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Herbert L. Catlin

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 40232

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-OWED OR DIVORCED married
 (Write the word.)

6. DATE OF BIRTH

Oct 21, 1849 1
 (Month) (Day) (Year)

7. AGE

73 Yrs. 0 Mos. 17 ds.

IF LESS than 1 day
 how many _____ hrs.
 or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. cook - Ruby Gold Mining Co
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

New York
 (State or Country)

10. NAME OF FATHER

Wells Catlin

11. BIRTHPLACE OF FATHER

Little Valley, N Y
 (State or Country)

12. MAIDEN NAME OF MOTHER

Sarah Ann Not obt

13. BIRTHPLACE OF MOTHER

Little Valley, N Y
 (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Bertha Catlin

(Address) Lenia, Ida

15.

Filed Nov. 9th 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov. 8th, 1922.
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 1921, to Nov. 8 1922
 that I last saw him alive on Jan. 1922
 and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows

Nephritis (Chronic)

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
 (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

11/9 1922 (Address) Lenia, Ida ^{M.D.} (B)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place 7 yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence Lenia, Ida

19. PLACE OF BURIAL OR REMOVAL

Spokane, Wash

DATE OF BURIAL

Nov 10 1922

20. UNDERTAKER

Smith & Co

ADDRESS

Spokane

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Boundary
City of Boundary FerryRegistration District No. 79Primary Registration District No. 2156

(No. St.)

File No. 40233

Registered No.

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Frank BodensteinIf death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDSingle

6. DATE OF BIRTH

?

(Month)

(Day)

(Year)

7. AGE

35

Yrs.

Mos.

ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.Woodsman(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer).

9. BIRTHPLACE

(State or Country)

Germany10. NAME OF
FATHERUnknown11. BIRTHPLACE
OF FATHER

(State or Country)

Unknown12. MAIDEN NAME
OF MOTHERUnknown13. BIRTHPLACE
OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed Nov. 13th 1922.S. E. Sanders
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov.1322

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19....., to

19.....

that I last saw h..... alive on..... 19.....

and that death occurred on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Natural Cause(Myocardial Degeneration - old)

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

S. E. Sanders M.D.11/13/22

(Address)

Boundary Ferry*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place

of death

yrs.

mos.

days.

In the

State

yrs.

mos.

days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Sandpoint, Ida.

DATE OF BURIAL

Nov. 15th 22

20. UNDERTAKER

O. R. Stooker

ADDRESS

Boundary Ferry

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40234**

1. PLACE OF DEATH

County of **Bonner**
City of **Bonner Ferry**

Registration District No. **29**
Primary Registration District No. **215-6**
(No. St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Erret James Mackie

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

M

W

Infant
(Write the word.)

6. DATE OF BIRTH

Sept. 28 1919
(Month) (Day) (Year)

7. AGE

3 Yrs. 1 Mos. 15 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Canada

10. NAME OF FATHER

William Sime Mackie

11. BIRTHPLACE OF FATHER

(State or Country)

Scotland

12. MAIDEN NAME OF MOTHER

Tru Gertrude Lucha

13. BIRTHPLACE OF MOTHER

(State or Country)

Wisc.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

William Sime Mackie

15.

Filed

Nov. 13 1922

SS Fry
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov. 13 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept. 1922 to Nov. 13 1922

that I last saw him alive on **Nov. 11 1922**and that death occurred on the date stated above, at **4 P. M.**

The CAUSE OF DEATH* was as follows:

Lympho. Sarcoma
(abdominal)

(Duration) **2** Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

11/13 1922

(Address)

Bonner Ferry, Id.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Bonner Ferry Id.

DATE OF BURIAL

11/14 1922

20. UNDERTAKER

ORS Looney

ADDRESS

Bonner Ferry

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40235**

1. PLACE OF DEATH

County of *Boundary*City of *Eastport Ida.*Registration District No. *79*Primary Registration District No. *3156*

(No. _____ St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Clifford Ede

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

married
(Write the word.)

6. DATE OF BIRTH

Nov

(Month)

1

(Day)

1885

(Year)

7. AGE

37

Yrs.

Mos.

23

ds.

IF LESS than 1 day

how many _____ hrs.

or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Laborer

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

South Dakota

10. NAME OF FATHER

W. M. Ede

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Henrietta Baxter

13. BIRTHPLACE OF MOTHER

(State or Country)

Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Opal Ede

(Address)

Hellsboro Oregon

15.

Filed

*Nov 24th 1922**557m*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov

(Month)

24

(Day)

22

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19____, to

19____

that I last saw him _____ alive on _____ 19____,

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Admission pneumonia

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

E. E. Samuels

19____

(Address)

Carson

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

yrs.

mos.

days.

In the

State

yrs.

mos.

days

Where was disease contracted if not at place of death?

Died on train.

Former or usual residence

Fernie, B. C.

19. PLACE OF BURIAL OR REMOVAL

Portland Or

DATE OF BURIAL

19____

20. UNDERTAKER

Ed Stooker

ADDRESS

Bornier Ferry

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40236**
Registered No. **57**

1. PLACE OF DEATH

County of **Bennett**
City of **Stuart**

Registration District No. **32**
Primary Registration District No. **2049**
(No., St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lawrence Mullaney

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

married
(Write the word.)

6. DATE OF BIRTH

January 18
(Month) (Day) (Year)

7. AGE

47 Yrs. **9** Mos. **1** ds.

IF LESS than _____ day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Cigar Man, maker

(b) General nature of industry, business or establishment in which employed (or employer)

Business self.

9. BIRTHPLACE

(State or Country) **Hastings Minnesota**

10. NAME OF FATHER

Michael Mullaney

11. BIRTHPLACE OF FATHER

(State or Country) **Ireland**

12. MAIDEN NAME OF MOTHER

Mary Mullaney

13. BIRTHPLACE OF MOTHER

(State or Country) **Ireland**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Mrs. Maude Mullaney**
(Address) **St. Maries, Idaho.**

15.

Filed **11/12** **19 22** **Bennett**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 9th **19 22**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Nov 9** **19 22** to **Nov 9** **19 22**

that I last saw him alive on **Nov 9** **19 22**
and that death occurred on the date stated above, at **6:10 P.M.**

The CAUSE OF DEATH* was as follows:

Coronary Artery Disease

(Duration) **1** Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

R. D. Hall

M. D.

Nov 9 19 22 (Address) **St. Maries, Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Woodlawn Cemetery

DATE OF BURIAL

11-12-19 22

20. UNDERTAKER

Mitchell Merag

ADDRESS

St. Maries

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Benewah
City of FernwoodRegistration District No. 32
Primary Registration District No. 2049
(No. _____ St.)File No. 40237
Registered No. 58

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Leonard Reilly

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white5. SINGLE, MARRIED, WIDOWED OR DIVORCED
married
(Write the word.)

6. DATE OF BIRTH

Oct. 19 1892
(Month) (Day) (Year)

7. AGE

29 Yrs. _____ Mos. _____ ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Locomotive Engineer

9. BIRTHPLACE

(State or Country)

Washington

10. NAME OF FATHER

John F. Reilly

11. BIRTHPLACE OF FATHER

(State or Country)

N. Y. State

12. MAIDEN NAME OF MOTHER

Annie McCormick

13. BIRTHPLACE OF MOTHER

(State or Country)

New Jersey

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Leo Reilly

(Address)

Fernwood Ida.

15.

Filed 11-161922Drumayer

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov. 15 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov. 16 1922, to Nov 16 1922
that I last saw him alive on Nov 16 1922
and that death occurred on the date stated above, at 10:45 A.M.

The CAUSE OF DEATH* was as follows:

Broken left thigh and internal injuries caused by log rolling off from car. Work about 20 minutes after accident.

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) H. H. Allen Coroner M.D.11/16/1922 (Address) Benewah Co. Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Wandlauer Cemetery

DATE OF BURIAL

11-17 1922

20. UNDERTAKER

Mitchell & Manager of Marne Ida.

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Benevol
City of StmarRegistration District No. 32
Primary Registration District No. 2049
(No. _____ St.)File No. 40238
Registered No. 59

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

74. B. White

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

8.9.15
(Month) (Day) (Year)

7. AGE

27 apparently
Yrs. Mos. ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

woodman

(b) General nature of industry, business or establishment in which employed (or employer).

Rulledge Lumber Co.,

9. BIRTHPLACE

(State or Country)

England.

10. NAME OF FATHER

white

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

not known

13. BIRTHPLACE OF MOTHER

(State or Country)

England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ed. Leslie

(Address)

Clarkia Idaho.

15.

Filed

11-161922Omura

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov. 9th 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Nov 9th 1922 to Nov 9th 1922
that I last saw him live on Nov 9th 1922,
and that death occurred on the date stated above, at 6:40 P.M.

The CAUSE OF DEATH* was as follows:

Broken Back and wound on
Back of Head. Struck by a falling
timber at Camp # 31 - Rulledge Lumber
Co. Clarkia Idaho.
(Duration) _____ Yrs. _____ mos. _____ ds.Contributory
(Secondary)

_____(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

H. H. Aleson Coroner - Benevol Co. M. Id.
7/10 1922 (Address) Stmar Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Woodlawn Cem

DATE OF BURIAL

11-18-1922

20. UNDERTAKER

Mitchell & Munn

ADDRESS

Stmar Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
40239
File No. _____
Registered No. 60

1. PLACE OF DEATH

County of Bennett
City of St. Maries

Registration District No. 32
Primary Registration District No. 2049
(No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Bellen Connors

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED
(Write the word.)

6. DATE OF BIRTH

Oct 20 1922
(Month) (Day) (Year)

7. AGE

X Yrs. 1 Mos. 4 ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work _____
(b) General nature of industry, business or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country) St. Maries, Idaho

10. NAME OF FATHER

Mike Connors

11. BIRTHPLACE OF FATHER

(State or Country) Michigan

12. MAIDEN NAME OF MOTHER

Mercedes Livingston

13. BIRTHPLACE OF MOTHER

(State or Country) Michigan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mike Connors

(Address) St. Maries, Idaho

15.

Filed Nov 27 1922 Idaho

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov. 25 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, that I attended deceased from

Nov 25 1922 to Nov 25 1922

that I last saw him alive on Nov 25 1922

and that death occurred on the date stated above, at 11 M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) _____ Yrs. _____ mos. 3 ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. 1 ds.

(Signed)

Dr. J. L. Call

M. D.

Nov 27 1922 (Address) St. Maries, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Woodlawn

DATE OF BURIAL

Nov. 27 1922

20. UNDERTAKER

Michael M. M. M.

ADDRESS

St. Maries, Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bonner
City of ChateletRegistration District No. 32Primary Registration District No. 2049

(No. _____ St.)

File No. 40240Registered No. 61

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William W. Hawley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

widowed
(Write the word.)

6. DATE OF BIRTH

May 15 1843
(Month) (Day) (Year)

7. AGE

79 Yrs. 6 Mos. 11 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Rancher

(b) General nature of industry, business or establishment in which employed (or employer).

Retired - S. A. R.

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

Louis J. Hawley

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Sarah Bonner

13. BIRTHPLACE OF MOTHER

(State or Country)

Vermont

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. G. C. Stratton(Address) St. Maries, Idaho

15.

Filed Nov 30 1922 Quincy

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov. 26 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov. 26 1922 to Nov 26 1922
that I last saw him dead live on Nov 26 1922
and that death occurred on the date stated above, at 8:00 A.
The CAUSE OF DEATH* was as follows:Cerebral haemorrhage
apoplexy

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

H. H. Alcorn Coroner J. D.
11/26/1922 Bonner Co., Idaho
(Address) St. Maries, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Plummer Idaho

DATE OF BURIAL

12-1 1922

20. UNDERTAKER

Mitchell & Mearns

ADDRESS

St. Maries, Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40241**
Registered No. **62**

1. PLACE OF DEATH

County of **Bennett**
City of **St. Maris**

Registration District No. **32**
Primary Registration District No. **2049**
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Hugh Connor

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

1852
(Month) (Day) (Year)

7. AGE

70 apparently
Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

laborer

(b) General nature of industry, business or establishment in which employed (or employer)

incapacitated

9. BIRTHPLACE

(State or Country)

Glengary Ontario Ca.

10. NAME OF FATHER

not known

11. BIRTHPLACE OF FATHER

(State or Country)

not known

12. MAIDEN NAME OF MOTHER

not known

13. BIRTHPLACE OF MOTHER

(State or Country)

not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

O. E. Menger

(Address)

St. Maris, Ida

15.

Filed **Nov 30** 19**22**

O. E. Menger

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov. 29 19**22**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov. 29 19**22**, to **Nov 29** 19**22**

that I last saw him **dead** on **Nov 29** 19**22**

and that death occurred on the date stated above, at **A** M.

The CAUSE OF DEATH* was as follows:

Syphilis (systemic)

(Duration) Yrs. mos. ds.

Contributory **arterio sclerosis**

(Duration) yrs. mos. ds.

(Signed) **H. L. Alcorn** Coroner

12/1 19**22** (Address) **Bennett Co. St. Maris, Ida**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Woodlawn

DATE OF BURIAL

12-1 19**22**

20. UNDERTAKER

Mitchell & Menger

ADDRESS

St. Maris, Ida

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bernal
City of Emerald CreekRegistration District No. 32Primary Registration District No. 2049
(No., St.)File No. 40242
Registered No. 3

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Joseph B. Murphy

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED

single
(Write the word.)

6. DATE OF BIRTH

1892
(Month) (Day) (Year)

7. AGE

30 Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

laborer

(b) General nature of industry, business or establishment in which employed (or employer)

woodman

9. BIRTHPLACE

(State or Country)

not known

10. NAME OF FATHER

not known

11. BIRTHPLACE OF FATHER

(State or Country)

not known

12. MAIDEN NAME OF MOTHER

not known

13. BIRTHPLACE OF MOTHER

(State or Country)

not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. G. Murphy

(Address)

St. Mary's Idaho

15.

Filed

Dec 2 1922 Osmergen

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov. 29 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 29 1922 to Nov 29 1922that I last saw him alive on Nov 29 1922and that death occurred on the date stated above, at 525 P.

The CAUSE OF DEATH* was as follows:

Right arm crushed
Internal injury caused by
falling dead tree

(Duration) Yrs. mos. ds.

Contributory Internal bleeding
(Secondary)

(Duration) yrs. mos. ds.

(Signed) H. H. Olson Coroner of12/1 1922 (Address) St. Mary's Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Rushford Minn

DATE OF BURIAL

on arrival

20. UNDERTAKER

Mitchell & Murphy

ADDRESS

St. Mary's Idaho

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bennett
 City of Emida Ida.

Registration District No. 32Primary Registration District No. 2049

(No. _____)

(St. _____)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

X Francis Scott

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 40243Registered No. 66

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

married
 (Write the word.)

6. DATE OF BIRTH

March 12 1898
 (Month) (Day) (Year)

7. AGE

24 Yrs. 8 Mos. 15 ds.

IF LESS than 1 day
 how many _____ hrs.
 or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Housewife

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Farmington Washington

10. NAME OF FATHER

Albert R Knight

11. BIRTHPLACE OF FATHER

(State or Country)

Missouri

12. MAIDEN NAME OF MOTHER

Lena Madison

13. BIRTHPLACE OF MOTHER

(State or Country)

Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Asma Layb.

(Address)

Emida Ida

15.

Filed

Dec 7 1922Osmerger

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov. 28 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 27 1922 to Nov 28 1922

that I last saw him alive on Nov 27 1922and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Intestinal (strangulation)
obstruction.

(Duration) _____ Yrs. _____ mos. 2 ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Thos Barton M. D.

Dec 5 1922 (Address) 111 S. 1st. Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Farmington Wash

DATE OF BURIAL

Dec 12 1922

20. UNDERTAKER

Mitchell & Menger

ADDRESS

Emida Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 45244
Registered No. 275

1. PLACE OF DEATH
County of Ada Registration District No. 2
City of Boise Primary Registration District No. 1004
If death occurs away from usual residence, give facts called for under special information.
FULL NAME Ada R. Patrier

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F. 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-OWED OR DIVORCED Married
6. DATE OF BIRTH Nov 2, 1888
(Month) (Day) (Year)
7. AGE 64 Yrs. 1 Mos. 18 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

At Home

9. BIRTHPLACE

(State or Country)

Minnesota

10. NAME OF FATHER

Samuel Pitcher

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Carolina Parker

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Harry Strobs

(Address)

Boise Idaho

15.

Filed Dec 24 1922

R. N. Prady
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 20 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 2 1922, to Dec 20 1922 that I last saw her alive on Dec 20 1922 and that death occurred on the date stated above, at 12:10 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pyloric end of Stomach

(Duration) 1 Yrs. mos. ds.
Contributory (Secondary) Gastric Hemorrhage

(Duration) yrs. 3 mos. ds.
(Signed) T. N. Braxton M. D.

Dec 23 1922 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL
Morris Hill Cem.

DATE OF BURIAL
Dec 24 1922

20. UNDERTAKER

Scummers & Strobs

ADDRESS

Boise Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

1. PLACE OF DEATH RECEIVED
County of Union Registration District No. 2
City of Union Primary Registration District No. 1004
(No. 410 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harold M. Donald Brewer

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 40246

Registered No. 307

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED. Divorced
(Write the word.)

6. DATE OF BIRTH.

April 2 1897
(Month) (Day) (Year)

7. AGE

25 Yrs. 8 Mos. 25 ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

Labourer

9. BIRTHPLACE

(State or Country)

Wilkesboro N. C.

10. NAME OF FATHER

J. C. Brewer

11. BIRTHPLACE OF FATHER

(State or Country)

N. C.

12. MAIDEN NAME OF MOTHER

Mary Henderson

13. BIRTHPLACE OF MOTHER

(State or Country)

N. C.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mary Blaser

(Address)

Aurora Ore.

15.

Filed Dec 28 1922

R. R. Prutz
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 23 1922 to Dec 27 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 23 1922 to Dec 27 1922
that I last saw him alive on Dec 27 1922
and that death occurred on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

Traumatic rupture of liver
with severe hemorrhage
Concussion of brain

(Duration) Yrs. mos. 5 ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) Randolph T. M. B. B. B. M. D.

Dec 27 (Address) Boon, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence Valley, Geo. T. Laker

19. PLACE OF BURIAL OR REMOVAL

Aurora Oregon

DATE OF BURIAL

Dec 28 1922

20. UNDERTAKER

Shelby Whitfield

ADDRESS

Boon

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of *Ada*City of *Boise*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary J. Hixon

CERTIFICATE OF DEATH

Registration District No. *2*Registration District No. *4004*St. *St. Lukes Hospitals*State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *40247*Registered No. *297*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *F*4. COLOR OR RACE *White*5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Widow*

(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

(Year)

7. AGE

Yrs. *50*

Mos.

ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

At Home

9. BIRTHPLACE

(State or Country)

Minnesota

10. NAME OF FATHER

David P. Layman

11. BIRTHPLACE OF FATHER

(State or Country)

Illinois

12. MAIDEN NAME OF MOTHER

Margaret Hannah

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Harry Krebs

(Address)

Boise Idaho

15.

Filed *Dec 26* 19*22**R. H. [Signature]*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

*Dec 19 1922 to Dec 27 1922*that I last saw him alive on *Dec 27 1922*and that death occurred on the date stated above, at *2:48 P. M.*

The CAUSE OF DEATH* was as follows:

Acute Urinary Suppression

(Duration)

Yrs.

mos.

ds. *5*Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

James L. Stewart M. D.

(Address)

Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Morris Hill Cemetery

DATE OF BURIAL

Dec 27 1922

20. UNDERTAKER

Summers & Krebs

ADDRESS

Boise Idaho

1. PLACE OF DEATH

County of *Ada*City of *Boise*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No. *2*Primary Registration District No. *1004*

St.)

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *40248*Registered No. *29*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

m.

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the words)

6. DATE OF BIRTH

June 15 1922

(Month)

(Day)

(Year)

7. AGE

6 2

Yrs.

Mos.

ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Ivan O. Montgomery

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Marie M. Guinn

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ivan O. Montgomery

(Address)

15.

Filed

*Dec 18 1922**1922**R. H. Pratt*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 17

(Month)

(Day)

1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

*Dec 15 1922 to Dec 17 1922*that I last saw her alive on *Dec 15 1922*and that death occurred on the date stated above, at *3 A.M.*

The CAUSE OF DEATH* was as follows:

Capillary Bronchitis

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

*Edward J. Baird, M.D.**12/18/22*

(Address)

Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Morris Hill Cemetery

DATE OF BURIAL

Dec 19 1922

20. UNDERTAKER

Summer & Sons

ADDRESS

Boise, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-18

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 40249

Registered No. 22

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH. **RECEIVED**
JAN 6 Registration District No. 2
County of Ada Primary Registration District No. 1004
City of Boise (No. 310 Washington St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Janita Diers

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

Female White

Single
(Write the word.)

6. DATE OF BIRTH.

Oct 31 1922
(Month) (Day) (Year)

7. AGE

0 Yrs. 1 Mos. 14 ds.

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...

none

9. BIRTHPLACE

(State or Country)

Boise

10. NAME OF FATHER

Cecil Clyde Diers

11. BIRTHPLACE OF FATHER

(State or Country)

Id.

12. MAIDEN NAME OF MOTHER

Lola Ellsworth

13. BIRTHPLACE OF MOTHER

(State or Country)

Id.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

C. H. Parker

(Address)

15.

Filed Dec 14 1922

R. N. Prad.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 14 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 11 1922 to Dec 14 1922

that I last saw him alive on Dec 13 1922

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Cold and pneumonia

(Duration) Yrs. mos. 5 ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) C. H. Parker M. D.

19. (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death....yrs....mos....days In the State....yrs....mos....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Morris Hill Cemetery

DATE OF BURIAL

12/ 1922

20. UNDERTAKER

Schubert & Sons

ADDRESS

Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40250**
Registered No. **2822**

1. PLACE OF DEATH **Ada**
County of **Ada** (Registration District No. **2**)
City of **Boise** (Primary Registration District No. **1004**)
St. No. **1004** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Emma S. Sullivan**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **F.** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Married**

6. DATE OF BIRTH **Apr 26. - 1868**
(Month) (Day) (Year)

7. AGE **54** Yrs. **7** Mos. **16** ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION **at home**
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE **Iowa**
(State or Country)

10. NAME OF FATHER **Joseph Hartley**

11. BIRTHPLACE OF FATHER **Wisconsin**
(State or Country)

12. MAIDEN NAME OF MOTHER **Mildred Schormaker**

13. BIRTHPLACE OF MOTHER **Missouri**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) **Eugene Sullivan**
(Address)

15. Filed **Dec 12 1922** **R. H. Rad**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **Dec 12 1922**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **July 1922** to **Dec 12 1922**
that I last saw her alive on **Dec 12 1922**
and that death occurred on the date stated above, at **10:50 P. M.**

The CAUSE OF DEATH* was as follows:

Atrophic Cerebrosis

(Duration) **5** Yrs. mos. ds.
Contributory **Valvular Heart Disease**
(Secondary)

(Duration) yrs. mos. ds.

(Signed) **Harold W. Stone M.D.**

12/13/1922 (Address) **413 Overland Bldg.**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **Richland Oregon** DATE OF BURIAL **Dec 15 1922**

20. UNDERTAKER **Summers & Co.** ADDRESS **Boise Ida**

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 2County of AdaPrimary Registration District No. 1994City of BoiseNo. 816 N. 19th St.File No. 40251Registered No. 373

If death occurs away from usual residence, give facts called for under special information.

2. STATISTICAL

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX M4. COLOR OR RACE W.5. SINGLE, MARRIED, WID-
OWED OR DIVORCED(write the word.) Single

6. DATE OF BIRTH

Dec - 31 - 1922
(Month) (Day) (Year)

7. AGE

5 hoursIF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Boise Idaho

10. NAME OF FATHER

Wm Alfred Lane

11. BIRTHPLACE OF FATHER

(State or Country)

Mo

12. MAIDEN NAME OF MOTHER

Ada Coble

13. BIRTHPLACE OF MOTHER

(State or Country)

Boise Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W McBratney

(Address)

Boise Idaho

15.

Filed Jan 11923Local Registrar R. H. Prady

16. DATE OF DEATH

Dec 31 - 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Dec 31 - 1922 to Dec 31 - 1922 that I last saw her alive on Dec 31 - 1922 and that death occurred on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Protein poisoning from mother and acetate (Blue baby)

Contributory (Secondary)

Diarrhea of albuminuria on part of mother

(Signed)

C. R. Dutton

M. D.

1/2 1923 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Joplin Cemetery1/1 1923

20. UNDERTAKER

ADDRESS

W McBratneyBoise Idaho

Rev. Sumner

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. **40252**

Registered No. **312**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of **Ada** Registration District No. _____
City of **Bosse** Primary Registration District No. _____
St. Lukes Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
JAN 6 1923
BUREAU OF VITAL STATISTICS

Edwin Horace Ames

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

M **White** **Married**
(Write the word.)

6. DATE OF BIRTH

May 2-1834
(Month) (Day) (Year)

7. AGE

88 Yrs. **7** Mos. **29** ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Farmer

9. BIRTHPLACE

(State or Country)

Vermont

10. NAME OF FATHER

Alfred C Ames

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Madison

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Alonso F. Ames

(Address)

Heyburn Ida

15.

Filed

1-2

1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

126

16. DATE OF DEATH

Dec 31 22
Jan 1 23
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 19 22 to **Dec 31 19 22**
that I last saw him alive on **Dec 31 19 22**

and that death occurred on the date stated above, at **6 A.M.**

The CAUSE OF DEATH* was as follows:

**Hypertrophy of prostate
Gastric**

(Duration) Yrs. **9** mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed)

Dr. H. H. H. H.

M. D.

(Address)

Bosse

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Meridian Idaho

Jan 2 1923

20. UNDERTAKER

ADDRESS

Summers & Krebs **Bosse Idaho**

MARGIN RESERVE FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.
County of Ada **RECORD** Primary Registration District No.
City of Boise **JAN** (No. 1607 Resseguie St.)File No.: **40253**
Registered No. 311

If death occurs away from usual residence, give facts called for under special information.

BUREAU**STATE**

2. FULL NAME

Mrs. Janey Falle.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

120

3. SEX 3. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married.
(Write the word.)6. DATE OF BIRTH Oct. 25- 1859.
(Month) (Day) (Year)7. AGE 63 Yrs. 2 Mos. 6 ds. IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Housewife.

9. BIRTHPLACE

(State or Country)

Pa.

10. NAME OF FATHER

Samuel B. Park.

11. BIRTHPLACE OF FATHER

(State or Country)

Pa.

12. MAIDEN NAME OF MOTHER

Kate Schuttz

13. BIRTHPLACE OF MOTHER

(State or Country)

Pa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. McBratney

(Address)

Boise Idaho.15. Filed Jan 2 1922 R. N. Prall
Local Registrar

16. DATE OF DEATH

Dec - 31 - 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Dec 27 1922 to Dec 31 1922
that I last saw her alive on Dec 31 1922
and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis(Duration) 5 Yrs. mos. ds.

Contributory (Secondary)

Myocardial Infarction

(Duration) yrs. mos. ds.

(Signed)

T. N. Braxton

M. D.

1/2 1923. (Address) Boise, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery1/2 1923

20. UNDERTAKER

ADDRESS

W. McBratneyBoise, Idaho.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH **RECEIVED**
County of Ada Registration District No. 1623
City of Boise Primary Registration District No. 220
St. N. 5th St.

File No. 40254
Registered No. 31

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William S. Sloan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH Sept-19-1846
(Month) (Day) (Year)

7. AGE 76 Yrs. 3 Mos. 12 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Retired.
None

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

David Sloan

11. BIRTHPLACE OF FATHER

(State or Country)

U.S.A.

12. MAIDEN NAME OF MOTHER

Elizabeth Fritz

13. BIRTHPLACE OF MOTHER

(State or Country)

Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

C. A. Martin

(Address)

Boise Idaho

15. Filed 1-2-23 1923

R. H. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 31-1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1 1922, to Dec 27 1923, that I last saw him alive on Dec 27 1923, and that death occurred on the date stated above, at 11 M. The CAUSE OF DEATH* was as follows:
Softening of Brain

(Duration) 2 Yrs. 0 mos. 0 ds.

Contributory (Secondary)

(Duration) 0 yrs. 0 mos. 0 ds.

(Signed) J. R. McNamee M. D.

1923 (Address) Boise, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 0 yrs. 0 mos. 0 days. In the State 0 yrs. 0 mos. 0 days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Kuna Cemetery

DATE OF BURIAL

1/2 1923

20. UNDERTAKER

W. McBratney

ADDRESS

Boise Idaho

CERTIFICATE OF DEATH

1. PLACE OF DEATH **RECEIVED**
 County of *Ada* Registration District No. *2*
 City of *Boise* Primary Registration District No. *1004*
 If death occurs away from usual residence, give facts called for under special information. *St. Luke's Hospital.*

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. **40255**
 Registered No. *309*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Elizabeth R. Cripp

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *F.* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Widow (use word.)*

6. DATE OF BIRTH *Sept-4-1854*
 (Month) (Day) (Year)

7. AGE *68 Yrs 3 Mos 26 ds.* IF LESS than 1 day how many..... hrs. or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

at home

9. BIRTHPLACE

(State or Country)

Canada

10. NAME OF FATHER

Andrew Roberts

11. BIRTHPLACE OF FATHER

(State or Country)

Canada

12. MAIDEN NAME OF MOTHER

Mary Phillips

13. BIRTHPLACE OF MOTHER

(State or Country)

Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Chas E. Summers

(Address)

Boise Idaho

15.

Filed *Dec 30* 19*22*

R. M. Pack
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

92

16. DATE OF DEATH

12 30 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

12/28 1922 to 12/30 1922
 that I last saw her alive on *12/29 1922*
 and that death occurred on the date stated above, at *7 A* M.

The CAUSE OF DEATH* was as follows:

Bilateral lobar pneumonia

(Duration) Yrs. mos. ds.

Contributory (Secondary) *hypertension*

(Duration) yrs. mos. ds.

(Signed) *Paul F. ...* M. D.

12/30 1922 (Address) *Boise Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Caldwell Idaho Jan 1 1922

20. UNDERTAKER

ADDRESS

Summers & Sons

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. **40256**
Registered No. **30**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. **PLACE OF DEATH**

County of Ada Registration District No. 2
City of Baize Primary Registration District No. 1004
City of Baize Precinct No. 100728 Fairview St.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *m.* 4. COLOR OR RACE *wh.* 5. SINGLE, MARRIED, WID-
OWED OR, DIVORCED *single*
(Write the word.)

6. DATE OF BIRTH Dec 29 - 1922
(Month) (Day) (Year)

7. AGE *Still Born* IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work....
(b) General nature of industry, business or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE
OF FATHER

(State or Country)

12. MAIDEN NAME
OF MOTHER

13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS ~~TRUE TO~~ THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY. That I attended deceased from

Dec 29 1922 to Dec 30 1922
that I last saw him ~~alive~~ ^{dead} on Dec 30 1922,
and that death occurred on the date stated above, at 2:10 AM

The CAUSE OF DEATH* was as follows:

Prematurity & Congenital deformity.

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary) Lived only 10 min. & died
before I arrived (Duration) yrs. mos. ds.
(Signed) J. H. Branton M. D.
Dec 30 1922 (Address) Pointe-a-laux.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. ~~LENGTH OF RESIDENCE (For Hospitals, Institutions,~~
~~Transients or Recent Residents.)~~

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted
if not at place of death?.....

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

SYMS-YORK CO., PRINTER & BINDERS, BOISE 51088

WITH UNFADING INK — THIS IS A PERMANENT RECORD

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

RECEIVED
Admitted 1923
County of Boise
City of Boise

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 40257
Registered No. 306

1. PLACE OF DEATH Admitted 1923
Registration District No. 2
Primary Registration District No. 1004
(No. Boise) (City of Boise) (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mrs. Emma Margaret Esteldson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH Apr 13 - 1883
(Month) (Day) (Year)

7. AGE 39 Yrs. 8 Mos. 12 ds. 1 LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer).

Housewife

9. BIRTHPLACE

(State or Country)

Sweden.

10. NAME OF FATHER

Andrew Paulson.

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden.

12. MAIDEN NAME OF MOTHER

Marie Johnson

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wm. M. Bratney

(Address)

Boise Idaho.

15.

Filed

Dec 27 1922

R. H. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

122

16. DATE OF DEATH

Dec 25 - 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 12 1922, to Dec 25 1922

that I last saw him alive on Dec 24 1922, and that death occurred on the date stated above, at 5 A. M.

The CAUSE OF DEATH* was as follows:

Admission disease

(Duration) 4 Yrs. mos. ds.

Contributory (Secondary)

Swing work

Engraver

(Duration) yrs. mos. ds.

(Signed)

H. M. Johnson

M. D.

12/26/22 (Address) Boise Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery

12/27/22

20. UNDERTAKER

ADDRESS

Wm. M. Bratney

Boise Idaho.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 40258
Registered No. 305

1. PLACE OF DEATH

County of *Adams*City of *Baltimore*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No. *2*Primary Registration District No. *1004*(No. *2014 Harrison Blvd.*)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

*M. White**Married*
(Write the word.)

6. DATE OF BIRTH

April 30 1882
(Month) (Day) (Year)

7. AGE

40 Yrs. *6* Mos. *6* ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

Traveling Salesman

9. BIRTHPLACE

(State or Country)

New York

10. NAME OF FATHER

Charles. Carol Spinner

11. BIRTHPLACE OF FATHER

(State or Country)

New York

12. MAIDEN NAME OF MOTHER

Harriet Ames

13. BIRTHPLACE OF MOTHER

(State or Country)

New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mrs Chas F. Spinner*(Address) *2014 Harrison Blvd.*

15.

Filed *Dec 26 1922**R. H. Prady*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

December 26 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

*Dec. 23 1922, to Dec. 25 1922*that I last saw him alive on *Dec. 25, 1922*and that death occurred on the date stated above, at *5.10 A.M.*

The CAUSE OF DEATH* was as follows:

Influenza Pneumonia, bilateral(Duration) Yrs. *4* mos. *4* ds.Contributory
(Secondary)(Duration) yrs. *4* mos. *4* ds.(Signed) *Harold W. Stone* M. D.*Dec. 26 1922* (Address) *413 Overland Bldg., Boise*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. *4* mos. *4* days. In the State yrs. *4* mos. *4* days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Herkimer N.Y.**Dec 30 1922*

20. UNDERTAKER

ADDRESS

Chummers & Krebs Boise Idaho

CERTIFICATE OF DEATH.

1. PLACE OF DEATH.

County of Ada Registration District No. 2
 City of Boise Primary Registration District No. 1004
 (No. 522 N. 7th St. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Warren A Lindsey

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

40259

File No.

Registered No. 314

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
 (Write the word.)

6. DATE OF BIRTH.

July 29th 1846
 (Month) (Day) (Year)

7. AGE

76 Yrs. Mos. ds.

IF LESS than 1 day
 how many hrs. or min.

8. OCCUPATION

(a) Trade, profession or particular kind of work...
 (b) General nature of industry, business, or establishment in which employed (or employer).....

Attorney at Law

9. BIRTHPLACE

(State or Country)

Knox Co. Ohio.

10. NAME OF FATHER

Lebenizer Lindsey

11. BIRTHPLACE OF FATHER

(State or Country)

Scotland

12. MAIDEN NAME OF MOTHER

Maria Hawk.

13. BIRTHPLACE OF MOTHER

(State or Country)

Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Lebenizer Lindsey
 (Address) 107 Jefferson Boise Ida

15.

Filed

Dec 26 1922

R. H. Pratt
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 25th 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 2 1912, to Dec 25 1922
 that I last saw him alive on Dec 24 1922
 and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Arterio sclerosis

(Duration) Yrs. mos. ds.

Contributory
 (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. C. Smith M. D.

19. (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death....yrs....mos....days In the State....yrs....mos....days

Where was disease contracted if not at place of death?

Former or usual residence Boise, Idaho.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Marion Hill Cemetery 12/27 1922

20. UNDERTAKER

ADDRESS

Schreiber & Sidenfaden Boise, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

40280

1. PLACE OF DEATH

County of Ada JAN 6 1923
 City of Boise 1604 N. 9th St.
 Registration District No. 2
 Primary Registration District No. 1604 N. 9th
 (No. 1604 N. 9th St.)

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Samuel Hovary

File No. _____
 Registered No. 113

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

81

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

male white Married

6. DATE OF BIRTH

April 24 1873
 (Month) (Day) (Year)

7. AGE

79 Yrs. 8 Mos. 1 ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

Retired

9. BIRTHPLACE

(State or Country) Independence, Indiana

10. NAME OF FATHER

Not obtainable

11. BIRTHPLACE OF FATHER

(State or Country) " "

12. MAIDEN NAME OF MOTHER

" "

13. BIRTHPLACE OF MOTHER

(State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. S. Hovary

(Address) 1604 N. 9th St. Boise

15.

Filed Dec 26 19 22

R. N. Rath
Local Registrar

16. DATE OF DEATH

Dec. 25 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 10 1922, to Dec 25 1922

that I last saw him alive on Dec 24 1922

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

artery sclerosis

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Dr. C. W. Smith M. D.

19. (Address) Boise, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted
if not at place of death? _____

Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Morris Hill Cemetery 12/28 1922

20. UNDERTAKER ADDRESS

Subaru Undertaking Co. Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

Aug 20 1922

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
40261

1. PLACE OF DEATH

County of AdaRegistration District No. 2City of BoisePrimary Registration District No. 1004(No. 426 2 14)

St.)

File No. 40261Registered No. 3122

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lee Powell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

M WhiteMarried
(Write the word)

6. DATE OF BIRTH

May 13 - 1864
(Month) (Day) (Year)

7. AGE

58 Yrs. 7 Mos. 11 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

Farmer.

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

Missouri

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs Lee Powell

(Address)

426 S. 14th Boise Id

15.

Filed

Dec 26 19 22R. H. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

45

16. DATE OF DEATH

Dec 24 19 22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

12-4-7 19 22 to 12-24 19 22that I last saw him alive on 12-21 19 22and that death occurred on the date stated above, at 8:45 P.M.

The CAUSE OF DEATH* was as follows:

Cancer of Kidney(Duration) Yrs. 6 mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) D. H. Hays M. D.12-25 19 22 (Address) Boise Id

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery Dec 26 19 22

20. UNDERTAKER

ADDRESS

Hummer & Krebs Boise Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Ada Registration District No. 2
City of Ada Primary Registration District No. 1004
(No. 7 House St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Andrew Leonard

File No. 40269
Registered No. 31

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE White. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED widower
(Write the word.)

6. DATE OF BIRTH

April 28 1844
(Month) (Day) (Year)

7. AGE

78 Yrs. 7 Mos. 26 ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Alabama

10. NAME OF FATHER

David Leonard

11. BIRTHPLACE OF FATHER

(State or Country) Alabama

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Leonard

(Address) 605 Hugo St.

15.

Filed Dec 26 1922

R. A. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

12 24 19 22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 19 22 to Dec 24 19 22
that I last saw him alive on Dec 23 19 22
and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Chronic Bright's
Jaundice
(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Ed. A. Prange M.D.

1922 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Morris Hill Cemetery

DATE OF BURIAL

Dec 26 1922

20. UNDERTAKER

Summers & Krebs Boise Idaho

FORM V. S. No. 5-25 M. 1-16-12

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40263**
Registered No. **201**

1. PLACE OF DEATH **Adm** Registration District No. **2**
County of **Ada** Primary Registration District No. **1004**
City of **Bonanza** (No. **410** State St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Pearl Transue

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH **9**

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Single**
(Write the word.)

6. DATE OF BIRTH.

(Month) **1916** (Day) (Year)

7. AGE

6 Yrs. Mos. ds.

IF LESS than 1 day
how many hrs. or min.

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).

Student

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

S. H. Transue

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

May Viane

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

S. H. Transue**Eagle Ida**

15.

Filed

Dec 26**1912****R. H. Pratt**

Local Registrar

16. DATE OF DEATH

Dec **24** **1922**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec **23** **1922** to **Dec** **24** **1922**

that I last saw him alive on **Dec** **24** **1922**

and that death occurred on the date stated above, at **10:45** A.M.

The CAUSE OF DEATH* was as follows:

Laryngeal diphtheria

(Duration) Yrs. mos. **7** ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) **D. P. Hays** M. D.

12-16-1922 (Address) **Bonanza Ida**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death....yrs....mos....days In the State....yrs....mos....days

Where was disease contracted if not at place of death?

Former or usual residence

Eagle Ida

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Star Cemetery**12/27 1922**

20. UNDERTAKER

ADDRESS

Schnecker Midwayden Bonanza

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No: **40264**
Registered No. **21**

1. PLACE OF DEATH

Registration District No. **2**
County of **Ada** Primary Registration District No. **1004**
City of **Boise** (No. **Boise Barracks** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Elbert C. Maxwell**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Single**
(Write the word.)

6. DATE OF BIRTH

April 7 1898
(Month) (Day) (Year)

7. AGE

25 Yrs **8** Mos **16** ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work **Farmer**
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) **Sherman Co., Oregon**

10. NAME OF FATHER

Harrison Maxwell

11. BIRTHPLACE OF FATHER

(State or Country) **Arkansas**

12. MAIDEN NAME OF MOTHER

Isabel Noyes

13. BIRTHPLACE OF MOTHER

(State or Country) **Nebraska.**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Mrs. I. B. Maxwell**
(Address) **Portland, Oregon**

15.

Filed **Dec 25 19 22**

R. W. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec. 23 19 22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Nov. 16 19 22**, to **Dec. 23, 19 22** at **5:10 P.**
that I last saw him alive on **Dec. 23, 19 22** at **5:10 P.**
and that death occurred on the date stated above, at **5:10 P.** M.

The CAUSE OF DEATH* was as follows:

Tuberculosis, pulmonary, chronic

Unknown (Duration) Yrs. mos. ds.

Contributory **None**
(Secondary)

(Signed) **Robert D. MERRICK** Medical Officer in Charge
C. F. E. (Duration) **1** mos. ds.

Dec. 24 19 22 (Address) **Boise, Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death **0** yrs **1** mos **7** days In the **Unknown** State yrs. mos. days

Where was disease contracted if not at place of death? **Unknown**

Former or usual residence **Portland, Oregon**

19. PLACE OF BURIAL OR REMOVAL

Portland, Oregon

DATE OF BURIAL

19

20. UNDERTAKER

Wm. McBratney

ADDRESS

Boise, Idaho

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

No. *Dr. Luke's Hospital*. St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. **40265**Registered No. *215*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

*Dec 26 1922**R. H. Pratt*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec. 23 - 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

12 - 23 1922 to *12 - 23 1922*that I last saw him alive on *12 - 23 1922*and that death occurred on the date stated above, at *1:55 P.M.*

The CAUSE OF DEATH* was as follows:

*Fracture base skull
due to fall from on stone
building*
(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

12/26/22

(Address)

Boise, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Morris Hill Cemetery**12/26/22*

20. UNDERTAKER

ADDRESS

*Wm McBratney**Boise Idaho.*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2
County of Ada
City of Boise W. 42nd Main St St.)
File No. 40266

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lewis Eaton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX M. 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH.

Mar 2nd 1875
(Month) (Day) (Year)

7. AGE

47 Yrs. Mos. ds.

IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

R. R. Engineer

9. BIRTHPLACE

(State or Country)

Richland Center Wis

10. NAME OF FATHER

Chas. Eaton

11. BIRTHPLACE OF FATHER

(State or Country)

Wis

12. MAIDEN NAME OF MOTHER

Elnocha Chitwood

13. BIRTHPLACE OF MOTHER

(State or Country)

Wis

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Mrs. Lewis Eaton
Ashton, Idaho

15.

Filed

Dec. 23, 1922

R. H. Padg.
Local Registrar

16. DATE OF DEATH

December 22 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 20 1922 to Dec 22 1922, that I last saw him alive on Dec 22 1922, and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris due to Tertiary Syphilis

(Duration) many Yrs. mos. ds.

Contributory (Secondary)

(Duration) 2 yrs. mos. ds.

(Signed)

L. P. Meach

M. D.

12/23/22 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

Valley Co. Idaho

19. PLACE OF BURIAL OR REMOVAL

Ashton Idaho

DATE OF BURIAL

12/23 1922

20. UNDERTAKER

ADDRESS

Schreberg & Vidangradu Boise

RECEIVED

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Ada Registration District No. 2
City of Boise Registration District No. 1004
State of Idaho 17/12 Colorado St.)File No. 40267Registered No. 1922

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Kenneth Eugene Thornton
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH.

March 27 1922
(Month) (Day) (Year)

7. AGE

8 Yrs. 25 Mos. 25 ds.IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....maize

9. BIRTHPLACE

(State or Country)

Boise

10. NAME OF FATHER

Leroy Thornton

11. BIRTHPLACE OF FATHER

(State or Country)

Wash.

12. MAIDEN NAME OF MOTHER

Laura May Rose

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Leroy Thornton(Address) 1297 Colorado

15.

Filed Dec 22 1922R.H. Pugh

Local Registrar

MEDICAL CERTIFICATE OF DEATH

91

16. DATE OF DEATH

Dec 21 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 9th 1922, to Dec 20th 1922,
that I last saw him alive on Dec 20th 1922
and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia(Duration) Yrs. mos. 12 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) B.W. Mather M. D.12/21 1922 (Address) 317 Overland Bldg. Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence Bo. Boise Idaho

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Meridian Cemetery 12/22 1922

20. UNDERTAKER ADDRESS

Springfield Burial Home Boise

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40268**
Registered No. **277**

1. PLACE OF DEATH

County of **Ada** Registration District No. **2**
City of **Boise** Primary Registration District No. **1004**
City of **Boise** **Street 7th Street** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Louise Fack Chalk

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **M** 4. COLOR OR RACE **Yellow** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Married**
(Write the words.)

6. DATE OF BIRTH

1857
(Month) (Day) (Year)

7. AGE

65
Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Cook

9. BIRTHPLACE

(State or Country)

China

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Harry W. George
211 So. 7th St.

15.

Filed

12/23 19 **22**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. CAUSE OF DEATH

Influenza about the 21
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 22 19 **22** to **19**

that I last saw him alive on **19**

and that death occurred on the date stated above, at **19** M.

The CAUSE OF DEATH* was as follows:

I found dead, think that he was frozen to death
(Duration) mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

1/2 19 22 (Address) **Boise Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

Funeral Home
Boise Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40269**
Registered No. **29**

1. PLACE OF DEATH

County of *Ada*City of *Boise*

If death occurs away from usual residence, give facts called for under special information.

Registration District No. *2*Primary Registration District No. *1004*(No. *104219 East Bennett* St.)

2. FULL NAME

Nels F. Nelson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED*M. White* *Marrried* *(Married)*

6. DATE OF BIRTH

July 6 - 1846
(Month) (Day) (Year)

7. AGE

*76 Yrs. 5 Mos. 11 ds.*IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

Merchant

9. BIRTHPLACE

(State or Country)

Norway

10. NAME OF FATHER

Lars Nelson

11. BIRTHPLACE OF FATHER

(State or Country)

Norway

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Oscar L. Nelson

(Address)

15.

Filed

*Dec 18 1922**R. H. Bick*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

120

16. DATE OF DEATH

Dec 17 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

*Nov. 21 1922 to Dec. 11 1922*that I last saw him alive on *Dec. 11 1922*and that death occurred on the date stated above, at *2 P.M.*

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis -
chronic poisoning

(Duration) Yrs. mos. ds.

Contributory (Secondary)

Chronic interstitial nephritis

(Duration) yrs. mos. ds.

(Signed)

C. L. Dutton M. D.*Dec 17 1922*(Address) *Chelmsford Bldg Boise*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Morris Hill Cem.**Dec 14 1922*

20. UNDERTAKER

ADDRESS

*Summers & Co.**Boise, Ida*

FORM V: S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH **RECEIVED**
 Registration District No. **3**
 County of **Adrian** Primary Registration District No. **1004**
 City of **Bonneville** (No. **Bonneville** St.)

File No. **40271**
 Registered No. **227**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Eugene A. Ford

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED.

Male White Widowed
 (Write the word.)

6. DATE OF BIRTH.

April 20 1855
 (Month) (Day) (Year)

7. AGE

67 Yrs. **7** Mos. **16** ds.

IF LESS than 1 day
 how many hrs. or
 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
 (b) General nature of industry, business, or establishment in which employed (or employer).....

Farming

9. BIRTHPLACE

(State or Country)

Ill.

10. NAME OF FATHER

William Ford

11. BIRTHPLACE OF FATHER

(State or Country)

U. S.

12. MAIDEN NAME OF MOTHER

Mary Ann Rhoads

13. BIRTHPLACE OF MOTHER

(State or Country)

Am.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Ralph E. Ford

(Address)

Bonneville, Ida. R # 5

15.

Filed

12-18**1912****R. H. Pratt**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec. 16 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Nov 28 1922** to **Dec 5 1922** that I last saw him alive on **Dec 5 1922** and that death occurred on the date stated above, at M. The CAUSE OF DEATH* was as follows:

Intestinal Tumor

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) **Dr. E. M. Mason**12/18/1922 (Address) **415 McCarty Bldg**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted
 if not at place of death? ☒

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Dry Creek Cemetery**12-18 1922**

20. UNDERTAKER

ADDRESS

Schneide & Schaefer**Mason**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

1. PLACE OF DEATH. **RECEIVED**
Registration District No. 2
County of Ada JAN 6 1923
City of Boise Primary Registration District No. 1004
STATISTICAL No. 419 St. 14

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Wm. T. Logan

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 40273Registered No. 287

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED. Divorced
(Write the word.)

6. DATE OF BIRTH.

April 1st 1885
(Month) (Day) (Year)

7. AGE

37 Yrs. 8 Mos. 10 ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Shipping Clerk
in Furniture Store

9. BIRTHPLACE

(State or Country)

Hamms Creek, Idaho.

10. NAME OF FATHER

Wm. G. Logan

11. BIRTHPLACE OF FATHER

(State or Country)

Nebr.

12. MAIDEN NAME OF MOTHER

Eva Van Dike

13. BIRTHPLACE OF MOTHER

(State or Country)

Michigan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Wm. T. Logan

15.

Filed

Dec 16, 1922

R. S. Pax
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 15th 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1910 191 to Dec 15th 1922 1922.
that I last saw him alive on Dec 14th 1922
and that death occurred on the date stated above, at 10 M.

The CAUSE OF DEATH* was as follows:

Unsur on brain
and takes dorsalis -

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed)

Wm. T. Logan M. D.
(Address) Boise, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Wm. T. Logan 12/12/22 1922

20. UNDERTAKER

ADDRESS

Schnecker Widener, Boise

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Statistics

40274

1. PLACE OF DEATH

County of

City of

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Registration District No.

Primary Registration District No.

(No. 1428 E. State St.)

File No.

Registered No. 285

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
(or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF
FATHER11. BIRTHPLACE
OF FATHER

(State or Country)

12. MAIDEN NAME
OF MOTHER13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

12-14

1922

R. H. Pratt

Local Registrar

16. DATE OF DEATH

I HEREBY CERTIFY, That I attended deceased from
Nov 19th 1922 to Dec 13th 1922
that I last saw her alive on Dec 10th 1922
and that death occurred on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Dilatation of weak-
ness caused from valvular
disease following typhoid

(Duration)..... Yrs..... mos..... ds.

Contributory
(Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed)

12-13-1922 (Address) Boise Id.

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mills Hill Cemetery 12/15/22

20. UNDERTAKER

ADDRESS

Schubert & Schumacher Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH
in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of cert.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Idaho*
City of *Boise*

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
JAN 10 1923Registration District No. *2*Primary Registration District No. *1004*(No. *110 West Danmoch* St.)

2. FULL NAME

*Matilda A. Farr*State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *40275*Registered No. *284*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *F* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*

6. DATE OF BIRTH

March 20

(Month)

(Day)

1845
(Year)

7. AGE

77 Yrs. *8* Mos. *22* ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).*at Home*

9. BIRTHPLACE

(State or Country)

England.

10. NAME OF FATHER

William Connett

11. BIRTHPLACE OF FATHER

(State or Country)

England.

12. MAIDEN NAME OF MOTHER

Mary Watkins.

13. BIRTHPLACE OF MOTHER

(State or Country)

England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Carrie C. Farr

(Address)

110 W. Bennoch

15.

Filed *Dec 13* 19 *22**R. H. Pratt*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 12
(Month) (Day)*1922*
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

1919 19 *22* to *12/12* 19 *22*that I last saw *her* alive on *12/12* 19 *22*and that death occurred on the date stated above, at *11:33* M.

The CAUSE OF DEATH* was as follows:

Hemiplegia

(Duration) Yrs. mos. ds.

Contributory *Arterio-sclerosis*
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *Frederic A. Pinner* M. D.*12/13 1922* (Address) *Overland Bldg*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Morris Hill Cem.

DATE OF BURIAL

Dec 17 19 *22*

20. UNDERTAKER

Summers & Co.

ADDRESS

Boise Idaho

CERTIFICATE OF DEATH

1. PLACE OF DEATH

Registration District No. 2
 County of Blaine Registration District No. 1004
 City of Blaine St. Idaho

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED
 JAN 6 1923
 BUREAU OF VITAL STATISTICS

E. G. Amack

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 40276

Registered No. 282

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH Sept 16 1857
 (Month) (Day) (Year)

7. AGE 65 Yrs. 3 Mos. ds.
 IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

Farmer

9. BIRTHPLACE

(State or Country) MO

10. NAME OF FATHER

David Amack

11. BIRTHPLACE OF FATHER

(State or Country) unknown

12. MAIDEN NAME OF MOTHER

Wilson

13. BIRTHPLACE OF MOTHER

(State or Country) unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Emma Amack Miller
 (Address) 1606 N. 8th St. Boise

15.

Filed 12-11-1922 R. H. Pratt
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 11 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-7-1919 to 12-11-1922
 that I last saw him alive on 12-11-1922
 and that death occurred on the date stated above, at 4:28 PM.

The CAUSE OF DEATH* was as follows:

Uremic Poisoning

(Duration) Yrs. mos. ds.
 Contributory (Secondary) Chronic Interstitial Nephritis

(Duration) yrs. mos. ds.
 (Signed) C. L. Sutton M. D.
12/11/22 (Address) Overland Blvd Boise Idaho

*State the Disease Causing Death; or in deaths from violent causes state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Meridian Id 19

20. UNDERTAKER ADDRESS

W. B. Matier Meridian

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

Registration District No. 2
 County of Ada 1922 Primary Registration District No. 1004
 City of Boise No. St. Luke's Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Walter Kieper

Stewart
 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 40277

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

M White Single
 (Write the word.)

6. DATE OF BIRTH

June 12 1899
 (Month) (Day) (Year)

7. AGE

23 Yrs. 5 Mos. 28 ds. IF LESS than 1 day
 how many..... hrs.
 or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer)

Farmer.

9. BIRTHPLACE

(State or Country)

Wisconsin

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

Herman Kieper

Germany

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Alfina Busch

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address) Frank Kieper

Jefferson Oregon R. H. Pack

Filed Dec 11 1922 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 10 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1st 1922 to Dec 10 1922
 that I last saw him alive on Dec 10 1922
 and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Cerebrospinal meningitis
(Pneumococcus)

(Duration) Yrs. mos. 7 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) James H. Stewart M. D.

(Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Talbot Oregon Dec. 13 1922

20. UNDERTAKER

ADDRESS

Summers & Krebs Boise Idaho

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Ada Registration District No. 2
 City of Boise Primary Registration District No. 11004
 (No. 313 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Elmira Irene Johansen

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 40278
 Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
 (write the word.)

6. DATE OF BIRTH June 11, 1922
 (Month) (Day) (Year)

7. AGE 5 26 ds.
 Yrs. Mos. ds. IF LESS than 1 day
 how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

None

9. BIRTHPLACE

(State or Country) Boise Idaho

10. NAME OF FATHER

Benjamin Johansen

11. BIRTHPLACE OF FATHER

(State or Country) Iowa

12. MAIDEN NAME OF MOTHER

Myrtle Cooper

13. BIRTHPLACE OF MOTHER

(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm M. Bratney
 (Address) Boise Idaho

15. Filed 12-8 19 22 R. H. Pratt
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 7 - 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 7 1922 to Dec 7 1922
 that I last saw h. u at on Dec 7 1922

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Unknown
Probably Pneumonia

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
 (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

P. P. French M. P.
12/7/22 Boise, Idaho
 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Morris Hill Cemetery

DATE OF BURIAL

12/8/22

20. UNDERTAKER

Wm M. Bratney Boise Idaho
 Address

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

RECEIVED

Registration District No.

Primary Registration District No.

File No.

Registered No.

2. FULL NAME

If death occurred in a hospital, institution or camp, give NAME instead of address and number

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

19

Dec 8 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

Dec 6 1922 to Dec 7 1922

that I last saw her alive on Dec 7 1922

and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

General peritonitis following a ruptured appendix

(Duration) Yrs. mos. 4 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Wm. Goelsch M. D.

12/9/1922 (Address) Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. 2 days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence Smiths Ferry, Idaho.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery 1922

20. UNDERTAKER

ADDRESS

Sunderland Funeral Home

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of form.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 2
 County of Ada Primary Registration District No. 1004
 City of Bonne South 14th St.)

File No. 40280
 Registered No. 222

If death occurs away from
 usual residence, give facts
 called for under special in-
 formation.

2. FULL NAME

Donald Drobney

If death occurred in a hos-
 pital, institution or camp,
 give its NAME instead of
 street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED Baby
 (Write the word.)

6. DATE OF BIRTH

Dec 6 1922
 (Month) (Day) (Year)

7. AGE

IF LESS than 1 day
 how many 1 hrs.
 or 1 min.?

8. OCCUPATION

(a) Trade, profession or
 particular kind of work
 (b) General nature of in-
 dustry, business or estab-
 lishment in which employ-
 ed (or employer)

9. BIRTHPLACE

(State or Country)

Ada Co. Idaho

10. NAME OF FATHER

James Drobney

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Elizabeth Butler

13. BIRTHPLACE OF MOTHER

(State or Country)

Nevada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

James Drobney

(Address)

Bonne

15. Filed

Dec 6 1922R. N. Crad

Local Registrar

16. DATE OF DEATH

Dec 6 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Dec 6 1922 to Dec 6 1922

that I last saw him alive on Dec 6 1922
 and that death occurred on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

Infantile(Duration) Yrs. mos. 1 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. H. Tallman M. D.12/6 1922 (Address) Bonne Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state
 (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death... yrs... mos... days. In the State... yrs... mos... days

Where was disease contracted
 if not at place of death?

Former or
 usual residence

19. PLACE OF BURIAL OR REMOVAL

Grandview

DATE OF BURIAL

12/7 1922

20. UNDERTAKER

Leitch & Kidneyman

ADDRESS

Bonne

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
40281

1. PLACE OF DEATH
 County of Ada, Registration District No. 2
 City of Boise, Primary Registration District No. 1004
 State No. 810, East Jefferson, St.)

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Warren Alonzo Fay

File No. _____
 Registered No. 211

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH May 26 - 1861
(Month) (Day) (Year)

7. AGE 61 Yrs. 6 Mos. 9 ds. IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer).

Stockman

9. BIRTHPLACE

(State or Country)

Illinois

10. NAME OF FATHER

Augustus L. Fay

11. BIRTHPLACE OF FATHER

(State or Country)

N.Y.

12. MAIDEN NAME OF MOTHER

Martha A. Vanoske

13. BIRTHPLACE OF MOTHER

(State or Country)

N.Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wm. McBratney

(Address)

Boise, Ida.

15.

Filed Dec 6 1922

R. N. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

40

16. DATE OF DEATH

Dec. 5 - 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Oct 3 1922 to Dec 5 1922
that I last saw him alive on Oct 10 1922
and that death occurred on the date stated above, at 3a. M.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

(Duration) Yrs. 10 mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

M. H. Tallman

12/5 1922 (Address) Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Morris Hill Cemetery

DATE OF BURIAL

12/8/22

20. UNDERTAKER

Wm. McBratney

ADDRESS

Boise

Idaho

RECEIVED
JAN 5 1923
BUREAU OF
STATISTICS

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Ada
City of near BoiseRegistration District No. 2Primary Registration District No. 1004(No. Soldiers Home St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Pete J. Nelson CarsonState of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 40282Registered No. 276

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M White

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Widower
(Write the word.)

6. DATE OF BIRTH

May 4 1841
(Month) (Day) (Year)

7. AGE

81 Yrs. 6 Mos. 29 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)Carpenter

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

Isaac W. Carson

11. BIRTHPLACE OF FATHER

(State or Country)

Kentucky

12. MAIDEN NAME OF MOTHER

Mary Sweet

13. BIRTHPLACE OF MOTHER

(State or Country)

Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Lela Ballison

(Address)

1309 - N 6 -

15.

Filed Dec 4 1922R. S. Prad
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 3 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 1 1922 to Dec 3 1922
that I last saw him alive on Nov. 20 1922and that death occurred on the date stated above, at 8:00 PM.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) Yrs. mos. ds.

Contributory
(Secondary)Senile dementia

(Duration) 1 yrs. 0 mos. 0 ds.

(Signed)

Roscoe B. Ward M. D.12/4 1922 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery, Dec. 5 1922

20. UNDERTAKER

ADDRESS

Hummers & Krebs Boise Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40283**
Registered No. **1051**

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

No.

STATION

2. FULL NAME

Collector Station
Laura Ann Knepper

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

12-4-1922

G. H. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw her alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

Carcinoma of colon

(Duration) 2 Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) *Harold W. Stimp* M. D.(Address) *Boise Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Morris Hill Cemetery 12/4/22

20. UNDERTAKER

ADDRESS

Wm McBratney *Boise Idaho*

FORM V. S. No. 5-25 M. 2-19.

1. PLACE OF DEATH

County of AdaCity of Franklin School St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
JAN 6
BUREAU
STATERegistration District No. 8Primary Registration District No. 2008(No. Franklin School St.)

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 40284Registered No. 106

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Margaret Benson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F.

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married

6. DATE OF BIRTH

Nov 26

(Month)

(Day)

1885

(Year)

7. AGE

37 Yrs.Mos. 12 ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

at home

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Oliver Belmont

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Margaret Manning

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

M. J. Benson

(Address)

15.

Filed

12-81922P. W. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec

(Month)

8

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 81922

to

Dec 81922

that I last saw him alive on..... 19.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Patient had passed away before I saw her. supposed heart disease the cause

Contributory (Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

J. W. Cannon

M. D.

12/8/22

(Address)

Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Blackfoot Idaho

DATE OF BURIAL

19.....

20. UNDERTAKER

Summers & Co.

ADDRESS

Boise Idaho

REC-1

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40285**
Registered No. **107**

1. PLACE OF DEATH

County of **Ada**

City of

Registration District No.

Primary Registration District No.

(No. **3 Miles West of Boise** St.)

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Norma Elsie Ferguson

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED**F** **White****Single**
(Write the word.)

6. DATE OF BIRTH

November 26, 1922
(Month) (Day) (Year)

7. AGE

12 ds.
Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)**None**

9. BIRTHPLACE

(State or Country)

Idaho10. NAME OF
FATHER**Emmett P. Ferguson**11. BIRTHPLACE
OF FATHER

(State or Country)

Idaho12. MAIDEN NAME
OF MOTHER**Julia H. Ayres**13. BIRTHPLACE
OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Emmett P. Ferguson
P. O. Box 1, Boise, Idaho

15.

Filed

12-8**1922****R. J. Pratt**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec.
(Month)**7**
(Day)**1922**
(Year)17. I HEREBY CERTIFY, That I attended deceased from
Dec 5, 1922 to **Dec 7, 1922**that I last saw him alive on **Dec 7, 1922**and that death occurred on the date stated above, at **2 P.M.**

The CAUSE OF DEATH* was as follows:

Pneumonia (double lobes)(Duration) Yrs. mos. **4** ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) **H. M. Johnson** M. D.**Dec 7, 1922** (Address) **Boise 517 2nd St. B.**

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Star Idaho**Dec 8, 1922**

20. UNDERTAKER

ADDRESS

Thurman & Krebs Boise Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40286**
Registered No. **109-**

1. PLACE OF DEATH **Idaho**
County of **Ada**
City of **Boise**
Registration District No. **8**
Primary Registration District No. **3008**
(No. **3** Miles W of Boise St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Carmie Jane Harris

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **F** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Widow**
(Write the word.)
6. DATE OF BIRTH **April 2, 1864**
(Month) (Day) (Year)
7. AGE **58** Yrs. **8** Mos. **16** ds.
IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

At Home

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Barry Wride

11. BIRTHPLACE OF FATHER

(State or Country)

Wales

12. MAIDEN NAME OF MOTHER

Hannah Selman

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

James Harris
Route 2 Boise Idaho

15.

Filed

12/21

1922

R. H. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

December 18, 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Dec 18, 1922** to **19**
that I last saw him **saw** alive on **19**
and that death occurred on the date stated above, at **9 P.** M.

The CAUSE OF DEATH* was as follows:

Valvular heart disease

Family Physician out of the State
(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

Signed **Chas E. Summer** **Coroner**
1/20 1922 (Address) **Boise Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Boise Idaho **Dec 22, 1922**

20. UNDERTAKER

ADDRESS

Summer? Mrs. Boise Idaho

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 11-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 40287

Registered No. 1408

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH JAN 6
County of Ada
City of Boise
Registration District No. 8
Primary Registration District No. 2008
(No. Near Franklin School St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Manda Overton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH.

Mar 18th 1844
(Month) (Day) (Year)

7. AGE

78 Yrs. 8 Mos. 29 ds.

If LESS than 1 day
how many hrs. or
min.

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...

Housekeeper

9. BIRTHPLACE

(State or Country)

Miami Co., Ohio

10. NAME OF FATHER

John Shroyer

11. BIRTHPLACE OF FATHER

(State or Country)

Penn

12. MAIDEN NAME OF MOTHER

Elizabeth Roll

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs L. F. Knig

(Address)

Santa Anna Calif

15.

Filed

12-18

1912

D. H. Pratt

Local Registrar

MEDICAL CERTIFICATE OF DEATH

41

16. DATE OF DEATH

Dec 17th 1912
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 8, 1912, to Dec 17, 1912, that I last saw her alive on Dec 17, 1912, and that death occurred on the date stated above, at 12 noon

The CAUSE OF DEATH* was as follows:

Cancer of bowels

(Duration) Yrs. 6 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) D. P. H. M. D.

1278 1912 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death....yrs....mos....days In the State....yrs....mos....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Morris Hill Cemetery 12/16/1912

20. UNDERTAKER

Schweizer Undertaking Co. Boise

ADDRESS

Dr. Hume

40288

FORM V. S. No. 5-A-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 2

Registered No. 52

If death occurred in a hospital, institution or camp, give its NAME, institution, street and number.

1. PLACE OF DEATH

County of Ada Registration District No. 124
City of Runa Primary Registration District No. 7202
(No. 1923 St.)

If death occurs away from usual residence, give facts called for under special information.

BUREAU OF VITAL STATISTICS

2. FULL NAME

Julius Clayton Martin

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH

Dec 13 1858
(Month) (Day) (Year)

7. AGE

63 Yrs. 10 Mos. 3 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Village Pumpman

9. BIRTHPLACE

(State or Country)

West Va.

10. NAME OF FATHER

John E. Martin

11. BIRTHPLACE OF FATHER

(State or Country)

U. S. A.

12. MAIDEN NAME OF MOTHER

Mary Carothers

13. BIRTHPLACE OF MOTHER

(State or Country)

U. S. A.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. Martin
Runa, Idaho.

15.

Filed 12-30 1922

Local Registrar

16. DATE OF DEATH

October 16 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Oct. 4- 1922, to Oct. 16- 1922, that I last saw him alive on Oct. 16- 1922, and that death occurred on the date stated above, at 7:00 P.M.

The CAUSE OF DEATH* was as follows:

Injury caused in lifting on culbert, breaking loose inner lining of Pulmonary artery in lower lobe of rt Lung, blocking flow of blood in same.
(Duration) Yrs. mos. 14 ds.Contributory Arteriosclerosis.
(Secondary) Can not tell duration of

the sclerosis (Duration) yrs. mos. ds.

(Signed) F. J. Calenar M. D.10-17-19-22 (Address) Runa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Runa Idaho10-19-1922

20. UNDERTAKER

ADDRESS

F. R. RobinsonRampa

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

JAN 5 1923 CERTIFICATE OF DEATH

40289

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada
City of KunaRegistration District No. 124
Primary Registration District No. 2202
(No. _____ St.)File No. 2
Registered No. 53

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Kerney Wayne Bell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH

August 5th 1898
(Month) (Day) (Year)

7. AGE

24 Yrs. 2 Mos. 25 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Bank Clerk

9. BIRTHPLACE

(State or Country) Dade Co Mo

10. NAME OF FATHER

Samuel Bell

11. BIRTHPLACE OF FATHER

(State or Country) Dade Co Mo

12. MAIDEN NAME OF MOTHER

Nettie Jerome

13. BIRTHPLACE OF MOTHER

(State or Country) Dade Co Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Nettie Bell

(Address)

Kuna Idaho

15.

Filed

12-301922W C Stevens
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

November 30th 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Nov 19 1922 to Dec 26 1922
that I last saw him alive on Nov 23 1922
and that death occurred on the date stated above, at 4:57 A.M.
The CAUSE OF DEATH* was as follows:Hemorrhage of bowels(Duration) _____ Yrs. _____ mos. 2 ds.
Contributory (Secondary) Miliary Tuberculosis

(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed) Horace P Belknap M. D.12-1-22 (Address) Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Kuna

DATE OF BURIAL

12-1 1922

20. UNDERTAKER

F P Robinson

ADDRESS

Nampa

FORM V. S. No. 5-A-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada
City of Meridian

Registration District No.

Primary Registration District No.

(No. St.)

File No. 24
Registered No. 40290

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary Elizabeth Brown

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Widow
(Write the word.)

6. DATE OF BIRTH

March 23 1922
(Month) (Day) (Year)

7. AGE

66 Yrs. 8 Mos. 9 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)Agriculture

9. BIRTHPLACE

(State or Country)

Virginia

10. NAME OF FATHER

James W. Jones

11. BIRTHPLACE OF FATHER

(State or Country)

Virginia

12. MAIDEN NAME OF MOTHER

Martha Webb

13. BIRTHPLACE OF MOTHER

(State or Country)

Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. C. E. Sandy
Meridian, Idaho

(Address)

15.

Filed 12-3 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 2 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
Dec 2 1922 to Dec 2 1922that I last saw her alive on Dec 2 1922
and that death occurred on the date stated above, at 10:30 M.The CAUSE OF DEATH was as follows:
(Acute attack of free bladder trouble)
Cholecystitis.(Duration) Yrs. Several mos. 1 ds.
Contributory (Secondary) Mitral Insufficiency
(Duration) Yrs. Several mos. 1 ds.(Signed) Thos E. Mangum M. D.Dec 3 1922 (Address) Meridian, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Jarvis Cemetery

DATE OF BURIAL

Dec 4 1922

20. UNDERTAKER

W. B. Tate Meridian, Ida.

ADDRESS

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada
City of MeridianRegistration District No. 11
Primary Registration District No. _____
(No. _____, St.)File No. 26
Registered No. 40291

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary Rachel Lewis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female White

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED
single
(Write the word.)

6. DATE OF BIRTH

Oct 23 1922
(Month) (Day) (Year)

7. AGE

2 Yrs. 2 Mos. 2 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).infant

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Lester W. Lewis

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Clara Wheeler

13. BIRTHPLACE OF MOTHER

(State or Country)

Colorado

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Lester Lewis
Meridian, Ida. R.R. 2.

15.

Filed

Dec. 24 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec. 23 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
Dec. 20 1922 to Dec. 23 1922that I last saw her alive on Dec. 20 1922
and that death occurred on the date stated above, at 9:30 A.M.

The CAUSE OF DEATH* was as follows:

Bronchial
pneumonia(Duration) _____ Yrs. _____ mos. 3 ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

H. F. May

M. D.

12/24 1922 (Address) Meridian, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Meridian CemeteryDec. 24 1922

20. UNDERTAKER

ADDRESS

W. D. Mather Meridian Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada
City of Meridian

Registration District No.

Primary Registration District No.

(No. St.)

File No. 27
Registered No. 40292

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Wesley Beaty

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH

Feb 12 1850
(Month) (Day) (Year)

7. AGE

72 Yrs. 10 Mos. 10 ds.IF LESS than 1 day
how many hrs.
or min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Farmer

9. BIRTHPLACE

(State or Country)

Fulton Co Ill

10. NAME OF FATHER

Samuel Beaty

11. BIRTHPLACE OF FATHER

(State or Country)

Virginia

12. MAIDEN NAME OF MOTHER

Synthia Lane

13. BIRTHPLACE OF MOTHER

(State or Country)

Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. R. W. H. H. H. H.

(Address)

Meridian Idaho

15.

Filed 12-27 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

91

16. DATE OF DEATH

Dec 23 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 17 1922 to Dec 22 1922that I last saw him alive on Nov 22 1922

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Branchial Aneurism(Duration) Yrs. mos. 14 ds.
Contributory (Secondary) Cocaine(Duration) yrs. 9 mos. ds.(Signed) H. F. Neal M. D.12/22 1922 (Address) Meridian Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Meridian County Dec 24 1922

20. UNDERTAKER

ADDRESS

W. B. Matus Meridian Id

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada
City of Meridian

Registration District No.

Primary Registration District No.

(No. St.)

File No. 28
Registered No. 40293

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Judi Warren Walt

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDFemale White Widow
(Write the word.)

6. DATE OF BIRTH

Nov. 17 18.27
(Month) (Day) (Year)

7. AGE

85 Yrs. 1 Mos. 10 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Homemaker
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE

(State or Country) Ill.

10. NAME OF FATHER

Richard Bourne

11. BIRTHPLACE OF FATHER

(State or Country) Mass.

12. MAIDEN NAME OF MOTHER

Laura Barthus

13. BIRTHPLACE OF MOTHER

(State or Country) Mass.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

W. B. West
Meridian, Idaho

15.

Filed 12-28 19.22

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec. 27 19.22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1-1 1921, to 12-27 1922
that I last saw him alive on 12-10 1922
and that death occurred on the date stated above, at 6524.

The CAUSE OF DEATH* was as follows:

Natural Regurgitation(Duration) 2 Yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

H. F. Neal

M. D.

19 (Address) Meridian, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Meridian Cemetery19.22

20. UNDERTAKER

ADDRESS

W. B. Matney Meridian

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada
City of MeridianRegistration District No. 11

Primary Registration District No. _____

(No. _____ St.)

File No. 29
Registered No. 40294

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

David H. Wood

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDMale White Single
(Write the word.)

6. DATE OF BIRTH

Sept 2 thurs 1920
(Month) (Day) (Year)

7. AGE

2 Yrs. 3 Mos. 27 ds.IF LESS than 1 day
how many hrs.
or 20 min.

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Ada Co. Idaho

10. NAME OF FATHER

Melvin Wood

11. BIRTHPLACE OF FATHER

(State or Country) Missouri

12. MAIDEN NAME OF MOTHER

Atha Rea

13. BIRTHPLACE OF MOTHER

(State or Country) Arkansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Bondar Rea
(Address) Meridian

15.

Filed 12/31 1922 JHF Neal
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec. 30 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec. 28 1922 to Dec 30 1922that I last saw him alive on Dec 29 1922and that death occurred on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia(Duration) Yrs. mos. 3 ds.Contributory
(Secondary)Leukemia (Duration) 2 yrs. 2 mos. 27 ds.(Signed) JHF Neal M. D.1/27/1922 (Address) Meridian

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Meridian Casket

DATE OF BURIAL

Dec 31 1922

20. UNDERTAKER

W. Blumauer Meridian Id

County of Ada

Registration District No.

City of Meridian

Primary Registration District No.

If death occurs away from usual residence, give facts called for under special information.

(No. St.)

2. FULL NAME

Elizabeth Kustbaum

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX. 4. COLOR OR RACE. 5. Single, married, Widowed or Divorced.

Female WhiteWidow
(Write the Word.)

6. DATE OF BIRTH.

July 17 1840
(Month) (Day) (Year)

7. AGE.

82 Yrs. 5 Mos. 4 ds
IF LESS than 1 day, how many hrs. or min.?

8. OCCUPATION.

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE.

(State or Country.) Ashland Co Ohio

10. NAME OF FATHER.

Jacob Bechtel

11. BIRTHPLACE OF FATHER.

(State or Country.) Berks Co Penn

12. MAIDEN NAME OF MOTHER.

Anna Froyer

13. BIRTHPLACE OF MOTHER.

(State or Country.) Lancaster Co Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. E. S. Serrano
(Address) 1219 Jeff St Boise Idaho15. Filed 22 23 1922Local Registrar W. E. Serrano

Place Where Remains are To Be Sent

Date of Shipment

Deatody Hanson Dec 24 1922SHIPPING UNDERTAKER W. E. SerranoADDRESS Meridian Idaho

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH.

Dec 21 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 1 1922 to Dec 21 1922that I last saw her alive on Dec 20 1922and that death occurred on the date stated above, at 11:50 P.M.

The CAUSE OF DEATH was as follows:

Myocarditis

.....

(Duration) 5 Years mos. ds.Contributory Senility

(Secondary)

(Duration) Years mos. ds.

Signed J. R. Numbers Jr. M. D.Dec 22 1922 (Address) Meridian Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (for hospitals, Institutions, Transient or Recent Residents.)

At place in the

of death yrs. mos. ds State yrs. mos. ds

Where was disease contracted

if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL.

Date of Burial

....., 192..

20. UNDERTAKER.

Address

County of AdaRegistration District No. 11City of Meridian

Primary Registration District No. _____

Bureau of Vital Statistics

File No. 23Registered No. 40296

If death occurs away
from usual residence,
give facts called for
under special informa-
tion.

(No. _____ St.)

2. FULL NAME Miss Ruth Lewis

If death occurred in a
hospital, institution or
camp, give its NAME
instead of street and
number.

PERSONAL AND STATISTICAL PARTICULARS.

3. SEX. 4. COLOR OR RACE. 5. Single, Married, Wid-
owed or Divorced.Female white Single6. DATE OF BIRTH. April 26, 1881
(Month) (Day) (Year)7. AGE. 29 Yrs. 7 Mos. 18 ds.
IF LESS than 1 day,
how many hrs. or
min.?8. OCCUPATION.
(a) Trade, profession or
particular kind of work. Dr. enuiss
(b) General nature of in-
dustry, business, or es-
tablishment in which em-
ployed (or employer)9. BIRTHPLACE.
(State or Country.) Iowa10. NAME OF
FATHER Unknown11. BIRTHPLACE
OF FATHER.
(State or Country.) Unknown12. MAIDEN NAME
OF MOTHER. Unknown13. BIRTHPLACE
OF MOTHER.
(State or County.) Unknown14. THE ABOVE IS TRUE TO THE BEST OF MY
KNOWLEDGE.(Informant) L. B. Mansfield
(Address) Meridian, Ida15. Filed 12-27, 1922 H. F. Neal
Local Registrar.Place Where Remains are to be Sent Meridian, Idaho
Date of Shipment Nov 17, 1922SHIPPING UNDERTAKER W. B. Butler
ADDRESS Meridian Firm Name _____

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH. Nov 15, 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
Oct 30, 1922, to Nov 15, 1922;
that I last saw her alive on Nov 15, 1922,
and that death occurred on the date stated above, at 8:15 P.M.
The CAUSE OF DEATH was as follows:Chronic Nephritis(Duration) 3 Years _____ mos. _____ ds.Contributory Myocarditis
(Secondary.)(Duration) 3 Years _____ mos. _____ ds.Signed L. R. Number 1 M. D.Nov 6, 1922. (Address) Meridian, Ida* State the Disease Causing Death; or in deaths from
Violent Causes, state (1) Means of Injury; and (2) whether
Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institu-
tions, Transient or Recent Residents.)

At place _____ in the _____

of death _____ yrs. _____ mos. _____ days State _____ yrs. _____ mos. _____ ds

Where was disease contracted _____

if not at place of death? _____

Former or
usual residence _____19. PLACE OF BURIAL
OR REMOVAL _____ Date of Burial
_____, 19____

20. UNDERTAKER _____ Address _____

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada
City of MeridianRegistration District No. 17

Primary Registration District No. _____

(No. _____, _____ St.)

File No. 22Registered No. 40297

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Alexander B. Staliker

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male | White | Married
(Write the word.)

6. DATE OF BIRTH

March 23 - 1882
(Month) (Day) (Year)

7. AGE

70 Yrs. 7 Mos. 19 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Merchant

9. BIRTHPLACE

(State or Country) Salt Lake Co. Utah

10. NAME OF FATHER

Alexander Staliker

11. BIRTHPLACE OF FATHER

(State or Country) Scotland

12. MAIDEN NAME OF MOTHER

Atenshia Smith

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Robert B. Staliker

(Address)

Meridian Idaho

15.

Filed 11-15-1922H. F. Neal

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 12 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Nov 10 1922 to Nov 12 1922that I last saw him alive on Nov 12 1922and that death occurred on the date stated above, at A. M.

The CAUSE OF DEATH* was as follows:

Bright's Plethora with
arterial leakage

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

H. F. Neal M. D.11-10-1922 (Address) Meridian Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Meridian Idaho

DATE OF BURIAL

Nov 15 1922

20. UNDERTAKER

H. F. Neal

ADDRESS

Meridian Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 8

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. **40298**

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF

County of Idaho
City of Coeur d'Alene

Registration District No. _____
Primary Registration District No. _____
(No. 1223 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mrs. Augusta Forestall

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Female

4. COLOR OR RACE

C

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widow

(Write the word.)

6. DATE OF BIRTH.

(Month) _____ (Day) _____ 1 (Year) _____

7. AGE

80

Yrs. _____ Mos. _____ ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

Music Teacher

9. BIRTHPLACE

(State or Country)

Wis

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) _____

(Address) _____

15.

Filed

Dec 30

1912

Wm. M. ...
Local Registrar

16. DATE OF DEATH

Dec

2

1912

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 1 1912 to Dec 2 1912

that I last saw him alive on Dec 2 1912

and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

*Infantile of age 5
morphine addict.*

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed) *W. M. ...* M. D.19. Address *Coeur d'Alene*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Coeur d'Alene

Dec 4 1912

20. UNDERTAKER

ADDRESS

Tucker

Coeur d'Alene

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
DIVISION OF PUBLIC HEALTH

BOISE

JAMES W. HAWKINS, M. D., DIRECTOR
ECHO DELL WATSON, CHIEF CLERK

BARZILLA W. CLARK, GOVERNOR
EX-OFFICIO COMMISSIONER
OF PUBLIC WELFARE

August 11, 1938

Alvin Thurston, M.D.
Council, Idaho.

#40298

Dear Dr. Thurston:

In checking over our files we find a death record of a lady, a widow, who died at Council Dec.2,1922.

In some unaccountable way, this record was placed on file without a name on the certificate. Is it possible that you can supply this name by further description? She was a music teacher, born in the State of Wisconsin and died at the age of 80 years, cause of death being given "Infirmities of age and Morphine addict. Certificate was signed by W.M.Brown M.D. She was buried in the I.O.O.F. cemetery and the name of the undertaker was Fisher.

Will appreciate it very much if you are able to supply this lady's name.

Thanking you, we are,

Very truly yours,

DIVISION OF PUBLIC HEALTH

Pearl Dillingham

Pearl Dillingham
Registrar of Vital Statistics

PBA

Mrs Augusta Forestall

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40299**
Registered No.

1. PLACE OF DEATH
County of Adams Registration District No.
City of Wesley Primary Registration District No.
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Haynes

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH May 11 1899
(Month) (Day) (Year)

7. AGE 42 Yrs. 11 Mos. 22 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION Rancher
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE Iowa
(State or Country)

10. NAME OF FATHER Engene C. Haynes

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER Elma C. Haynes

13. BIRTHPLACE OF MOTHER Iowa
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Engene C. Haynes
(Address) Council, Idaho

15. Filed Dec 30 1922 W M Brown
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 3 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 19 to 19
that I last saw him alive on 1 19
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH was as follows:
Pneumonia

(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) W M Brown M. D.
19 (Address) Council, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Centerville Iowa DATE OF BURIAL 19

20. UNDERTAKER Northam McCann ADDRESS Wesley Ida

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **40300**

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Adams Registration District No. _____
City of Hammer St. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Johnson

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.MaleW

(Write the word.)

6. DATE OF BIRTH

One
(Month)20
(Day)1922
(Year)

7. AGE

9 Yrs. 9 Mos. 9 ds.IF LESS than 1 day
how many hrs. or
..... min. >|

8. OCCUPATION

(a) Trade, profession or
particular kind of work...
(b) General nature of in-
dustry, business, or estab-
lishment in which employ-
ed (or employer).....

9. BIRTHPLACE

(State or Country)

Idaho10. NAME OF
FATHERGay Johnson11. BIRTHPLACE
OF FATHER

(State or Country)

N. E.12. MAIDEN NAME
OF MOTHERAnnie Gausel13. BIRTHPLACE
OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Gay Johnson
Hammer

15.

Filed

Dec. 30 1922W. M. D. Mann

Local Registrar

16. DATE OF DEATH

Dec
(Month)29
(Day)1922
(Year)17. I HEREBY CERTIFY, That I attended deceased from
Dec 20 1922, to 29 1922that I last saw him alive on Dec 24 1922
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

hemorrhage

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

W. M. D. Mann M. D.
Dec 30 1922 (Address) Hammer*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted
if not at place of death?.....Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cottonwood CreekDec 30 1922

20. UNDERTAKER

ADDRESS

Mann

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Adams
City of Bear

Registration District No. _____

Primary Registration District No. _____

File No. 40301

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant Dibble

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

single
(Write the word.)

6. DATE OF BIRTH.

Sept 20 1922
(Month) (Day) (Year)

7. AGE

8 yrs. 8 mos. 8 ds.IF LESS than 1 day
how many _____ hrs. or
_____ min.

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...Infant

9. BIRTHPLACE

(State or Country)

Bear, Idaho

10. NAME OF FATHER

E. E. Dibble

11. BIRTHPLACE OF FATHER

(State or Country)

Washington

12. MAIDEN NAME OF MOTHER

Alberta Rice

13. BIRTHPLACE OF MOTHER

(State or Country)

Ore

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

C. E. Dibble
Bear, Idaho

(Address)

15.

Filed Dec 30 1922 MM Brown
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 27 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Sept 20 191, to ✓ 19122,that I last saw her alive on Sept 24 1922,and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

(Duration) Yrs. 8 mos. 8 ds.Contributory Premature birth
(Secondary)(Duration) yrs. 8 mos. 8 ds.(Signed) W. M. Brown M. D.Sept 27, 1922 (Address) Council

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death....yrs.....mos.....days In the State....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Bear Creek Cemetery

DATE OF BURIAL

191

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **40302**

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Adams Registration District No.
City of Council Primary Registration District No.
(No.) St.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Heather

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH.

Dec 14 1922
(Month) (Day) (Year)

7. AGE

Yrs. Mos. 4 ds.IF LESS than 1 day
how many hrs. or
..... min.?)

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

G. J. Heather

11. BIRTHPLACE OF FATHER

(State or Country) Mo

12. MAIDEN NAME OF MOTHER

Lutha Wheeler

13. BIRTHPLACE OF MOTHER

(State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Formant)

(Address) Council

16. DATE OF DEATH

Dec 17 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Dec 14 191... to Dec 14 191...
that I last saw him alive on Dec 14 191...
and that death occurred on the date stated above, at ... M.

The CAUSE OF DEATH* was as follows:

Found dead during night

(Duration) ... Yrs. mos. ds.

Contributory
(Secondary)

(Duration) ... yrs. mos. ds.

(Signed) Wm. Brown M. D.Nov 1922 (Address) Council

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. mos. days. In the State ... yrs. mos. days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cotton Wood Cem. Dec 16 191...

20. UNDERTAKER

ADDRESS

None

1. PLACE OF DEATH

County of Barnock Registration District No. 1216
City of Lucerne Primary Registration District No. 84
(Not a St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WID- OWED OR DIVORCED
Female	white	single (Write the word.)

6. DATE OF BIRTH _____

 (Month) (Day) (Year)

7. AGE 65 Yrs. Mos. ds. IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work....
(b) General nature of industry, business or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) *Sweden*

10. NAME OF FATHER

**11. BIRTHPLACE
OF FATHER**
(State or Country)

**12. MAIDEN NAME
OF MOTHER**

**13. BIRTHPLACE
OF MOTHER**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) D. W. Arave
(Address) Lava Hot Spgs., Idaho.

15. Filed 12-1 1922 *W. J. Rael*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec. 2 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 10, 1922 to Nov 25 1922
that I last saw her alive on, August 1922
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Sanctity. Had been up
and about & stated she was tired
of life. Pined out with out any visible
cause (Depression) Yrs. mos. ds.

Contributory (Secondary) Eczema (Chronic)
(Duration) 2 yrs. 0 mos. 0 ds.

(Signed) Carl W. Clark M. D.
1922 (Address) Procella St.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 6 yrs. 0 mos. 0 days. In the State 6 yrs. 0 mos. 0 days.

Where was disease contracted
if not at place of death?.....

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	19

20. UNDERTAKER	ADDRESS

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

40304

1. PLACE OF DEATH

County of Bannock
City of Bancroft

Registration District No. 2161Primary Registration District No. 84(No. 2161 St.)File No. 40304

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Eloise Collett

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

Nov 10 1922
(Month) (Day) (Year)

7. AGE

Yrs. 1 Mos. 7 ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Bancroft Ida

10. NAME OF FATHER

Fred Collett

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Saine Higgins

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(Address) _____

15.

Filed 1-1 1923 W. B. Bach
Local Registrar

MEDICAL CERTIFICATE OF DEATH

91

16. DATE OF DEATH

12-17 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

12-8 1922, to 12-17 1922

that I last saw her alive on 12-17 1922

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Pneumo-pneumonia

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W. B. Bach M. D.

19 _____ (Address) Bancroft

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

_____ 19 _____

20. UNDERTAKER

ADDRESS

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **40306**

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Banewell
City of BanewellRegistration District No. 24Primary Registration District No. 2161

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Elsie Corlett

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

Mar 10 1922
(Month) (Day) (Year)

7. AGE

Yrs. 1 Mos. _____ ds. _____IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Banewell Ida

10. NAME OF FATHER

Fred Culbert

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Soune Higgins

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(Address) _____

15.

Filed 1-1 1923 W.B. Bach

Local Registrar

MEDICAL CERTIFICATE OF DEATH

91

16. DATE OF DEATH

Dec 10 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 8 1922 to Dec 10 1922that I last saw her alive on Dec 9 1922

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Breast - pneumonia

_____ (Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

W.B. Bach

M. D.

_____ 19 _____ (Address) Banewell

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of BancroftCity of Bancroft

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 84Primary Registration District No. 2161

(No. _____) (St.)

2. FULL NAME Leah SeimmanState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 40306

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M4. COLOR OR RACE W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

March 1 1919
(Month) (Day) (Year)

7. AGE

3 Yrs. 9 Mos. _____ ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Bancroft Ida.10. NAME OF FATHER J. E. Seimman

11. BIRTHPLACE OF FATHER

(State or Country) Utah12. MAIDEN NAME OF MOTHER Bella George

13. BIRTHPLACE OF MOTHER

(State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(Address) _____

15.

Filed 1-1 1919Local Registrar W. B. B.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

12 18 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19
that I last saw h. _____ alive on 19
and that death occurred on the date stated above, at _____ M.
The CAUSE OF DEATH was as follows:
Broncho-Pneumonia

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory (Secondary) Influenza

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W. B. B. M. D.19 (Address) Bancroft

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Bannock*City of *Lava Hot Springs*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Jesse William Baker*Registration District No. *2161*Primary Registration District No. *84*File No. *40307*

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

married
(Write the word.)

6. DATE OF BIRTH

Sept 1
August
(Month) (Day) (Year)*1845*
(Year)

7. AGE

77 Yrs. *19* Mos. *19* ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Retired Farmer

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

Jesse W. Baker, Sr.

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Frances Kelly

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Albert S. Baker

(Address)

Lava Hot Springs

15.

Filed *12-1**1922**Heather Reed*

Local Registrar

16. DATE OF DEATH

Sept 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 10 19*22* to *Sept 19* 19*22*
that I last saw him alive on *Sept 19* 19*22*
and that death occurred on the date stated above, at *10:20 P.*

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage(Duration) Yrs. *8* mos. *8* ds.

Contributory (Secondary)

Hemiplegia(Duration) Yrs. *8* mos. *8* ds.

(Signed)

John M. Waste M. D.

19

(Address)

McCannon, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death *26* yrs. *5* mos. *5* days. In the State *26* yrs. *5* mos. *5* days.

Where was disease contracted if not at place of death?

Former or usual residence

Utah

19. PLACE OF BURIAL OR REMOVAL

Lava Hot Springs

DATE OF BURIAL

Sept 22 1922

20. UNDERTAKER

S. B. Kelly - acting

ADDRESS

Lava

CERTIFICATE OF DEATH

40310

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Barnes Registration District No. 28
 City of Pocatello Primary Registration District No. 2141
 (No. 359 M. Harrison St.)

File No. 55
 Registered No. 3956

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Joseph W. Blackburn

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Male white Married

6. DATE OF BIRTH

Aug 26 1848
 (Month) (Day) (Year)

7. AGE

74 Yrs. 2 Mos. 15 ds.

IF LESS than 1 day
how many hrs.
or min. ?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.

(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

General Foreman
O. S. & Sons

9. BIRTHPLACE

(State or Country)

Penn.

10. NAME OF
FATHER

Blackburn

11. BIRTHPLACE
OF FATHER

(State or Country)

unknown

12. MAIDEN NAME
OF MOTHER13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Arney Blackburn
 (Address) 359 M. Harrison

15.

Filled Nov 10 1922

J. Young
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 10 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

8/1 1922 to 11/10 1922

that I last saw him alive on 11/9 1922

and that death occurred on the date stated above, at 40 A.M.

The CAUSE OF DEATH* was as follows:

Pernicious Anaemia.

(Duration) 1 Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) W. A. Wright M. D.

Nov 10 1922 (Address) Pocatello, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
if not at place of death?

Former or usual residence Pocatello, Ida

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Mt View Cem Nov 12 1922

20. UNDERTAKER ADDRESS

M. C. Harvndt Co. Pocatello
Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

40311

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock Registration District No. 2161City of Pasco (No. 116 St.)File No. 55Registered No. 3961

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Narcisse Sarell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

French Indian5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDDivorced
(Write the word.)

6. DATE OF BIRTH

June 14 1852
(Month) (Day) (Year)

7. AGE

60 Yrs. 5 Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Retired Farmer

9. BIRTHPLACE

(State or Country)

Wyo

10. NAME OF FATHER

Charles Sarell

11. BIRTHPLACE OF FATHER

(State or Country)

France

12. MAIDEN NAME OF MOTHER

unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs Joseph Rainey(Address) 416 S. 4th

15.

Filed

4/15 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov. 14 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 1 1922, to Nov 14 1922
that I last saw him alive on Nov 14 1922
and that death occurred on the date stated above, at 6 AM.

The CAUSE OF DEATH* was as follows:

Gastric Ulceration and Hemorrhage of Stomach -(Duration) Yrs. 6 mos. 14 ds.Contributory Age
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. F. Miller

M. D.

Nov 14 1922 (Address) 503 N 11th Pasco

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Mountain View Nov 16 1922

20. UNDERTAKER

Schumacher & Son

ADDRESS

City of Pasco

FORM V. S. No. 5-12 M. 6-15-17.

RECEIVED
OCT 18 1922

CERTIFICATE OF DEATH

40312

State of Idaho
BOARD OF HEALTH

Bureau of Vital Statistics

File No. 36

Registered No. 3967

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Bannock Registration District No. 28City of Pocatello Registration District No. 2161

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Peter Savage

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

Mexican

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single

6. DATE OF BIRTH.

Not known

7. AGE

about 30IF LESS than 1 day
how many . . . hrs. or
Mos. ds. min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)Labo
O. S. L. R. R. Co.

9. BIRTHPLACE

(State or Country)

Old Mexico

10. NAME OF FATHER

Not known

11. BIRTHPLACE OF FATHER

(State or Country)

Old Mexico

12. MAIDEN NAME OF MOTHER

Not known

13. BIRTHPLACE OF MOTHER

(State or Country)

Old Mexico

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

O. S. L. R. R. Co.

(Address)

Pocatello, Idaho

15.

Filed

1920

1922

H. L. McHan
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 17 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 10 1922 to Oct 17 1922that I last saw him alive on Oct 17 1922and that death occurred on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:

Tuberculosis Larynx

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) J. H. Young M. D.1922 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place yrs. mos. days, State yrs. mos. days

Where was disease contracted
if not at place of death?Former or
usual residence Pocatello, Ida

19. PLACE OF BURIAL OR REMOVAL

Not View Cem Oct 10 192220. UNDERTAKER
H. L. McHANADDRESS
POCATELLO, IDAHO

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

40313

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock Registration District No. 28City of PocatelloPrimary Registration District No. 2461File No. 56Registered No. 3949

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Rodolfo Battasar

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male MexicanSingle

6. DATE OF BIRTH

Oct 141922

(Month)

(Day)

(Year)

7. AGE

1 Yrs.8 Mos.ds.

IF LESS than 1 day

how many hrs.or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

none

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Pocatello Ida

10. NAME OF FATHER

Pablo Battasar

11. BIRTHPLACE OF FATHER

(State or Country)

Mexico

12. MAIDEN NAME OF MOTHER

Inez Duran

13. BIRTHPLACE OF MOTHER

(State or Country)

Mexico

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Pablo Battasar

(Address)

522 E. Bridger St.

15.

Filed

Nov 21 1922Local Registrar J. Young

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 211922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

11 19..... to 19.....

that I last saw him..... alive on..... 19.....

and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

Acute Pneumonia

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

S. S. Ferguson11/21/1922(Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death..... yrs..... mos..... ds.

In the

State..... yrs..... mos..... days

Where was disease contracted if not at place of death? Life

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mt View CemNov 22 1922

20. UNDERTAKER

ADDRESS

M. O. Hand undt Co Pocatello Ida

CERTIFICATE OF DEATH

40314

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH *RECEIVED*
 County *Blaine* Registration District No. *28*
 City of *Pocahontas* Registration District No. *2161* File No. *55*
 If death occurs away from usual residence, give facts called for under special information. *St. Mary's Hospital* Registered No. *3953*
 If death occurred in a hospital, institution or camp, give its NAME instead of street and number. *Paesea Vigliaturo*

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *Italian* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*
 (Write the word.)

6. DATE OF BIRTH *May 3rd 1900*
 (Month) (Day) (Year)

7. AGE *22* Yrs. *5* Mos. *28* ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION *Housewife*
 (a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE *Italy*
 (State or Country)

10. NAME OF FATHER *Joe Faleo*

11. BIRTHPLACE OF FATHER *Italy*
 (State or Country)

12. MAIDEN NAME OF MOTHER *Anna Gaccione*

13. BIRTHPLACE OF MOTHER *Italy*
 (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Sam Vigliaturo*
 (Address) *626 S. 3rd*

15. *11/1* 1922

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *Oct 31st* 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Oct 28th 1922* to *Oct 31st 1922*
 that I last saw her alive on *Oct 31st 1922*
 and that death occurred on the date stated above, at *3p.* M.
 The CAUSE OF DEATH* was as follows:
Flu

(Duration) Yrs. mos. ds.
 Contributory (Secondary) *Confinement*

(Duration) yrs. mos. ds.
 (Signed) *Surgeon* M. D.
 1922 (Address) *Pocatello Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Mountain View* DATE OF BURIAL *Nov 4 1922*

20. UNDERTAKER *Schumacher* ADDRESS *Idaho City*

RECEIVED

CERTIFICATE OF DEATH

40315

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

DEC 30 1922

BUREAU OF VITAL STATISTICS

STATISTICS

American Room E. C. Cott

S. H. Connors

Registration District No.

Registration District No.

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Nov 4 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct. 31

(Month)

(Day)

1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

Acute Alcohol Poisoning.

(Duration)

Yrs.

mos.

ds.

Contributory (Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

S. S. Ferguson Coroner

(Address)

Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

Montpelier Ida

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

40316

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Blaine Registration District No. 28City of BozelleRegistration District No. 2141File No. 55Registered No. 3950

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Harold Hatch

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-OWED OR DIVORCED Infant

(Write the word.)

6. DATE OF BIRTH

October 25 1922
(Month) (Day) (Year)

7. AGE

1 Yrs. 10 Mos. 10 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

Infant

9. BIRTHPLACE

(State or Country) Payley Idaho

10. NAME OF FATHER

J. Hatch

11. BIRTHPLACE OF FATHER

(State or Country) Hatch Idaho

12. MAIDEN NAME OF MOTHER

Lottie E. Osseman

13. BIRTHPLACE OF MOTHER

(State or Country) Payley Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. Hatch(Address) Bozelle

15.

Filed 11/5 1922Local Registrar J. H. Young

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

November 5 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

11/1 1922 to 11/5 1922
that I last saw him alive on 11/4 1922
and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Infective Enteritis

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) J. H. Young M. D.11/5 1922 (Address) Bozelle Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Bozelle

DATE OF BURIAL

11/6 1922

20. UNDERTAKER

Shumaker & Hall

ADDRESS

Bozelle

CERTIFICATE OF DEATH

40317

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Barnett* Registration District No. *28*
City of *Pocatello* Primary Registration District No. *216*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Bertha Sick Sell*File No. *55*Registered No. *5957*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WID-OWED OR DIVORCED *Widow*

6. DATE OF BIRTH

August 5 1860
(Month) (Day) (Year)

7. AGE

*62 Yrs. 3 Mos. 2 ds.*IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).*House keeper*

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

Otto Sick

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Not known

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mrs Emma Laguerie*
(Address) *1525 N. Arthur Ave*15. Filed *Nov 8 1922*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 7 1922
(Month) (Day) (Year)17. HEREBY CERTIFY, That I attended deceased from *Oct 30 1922* to *Nov 7 1922*that I last saw her alive on *Nov 6 1922*
and that death occurred on the date stated above, at *2:20 am* M.

The CAUSE OF DEATH* was as follows:

Diabetes Insipidus(Duration) *47 Yrs. 8 mos. 8 ds.*Contributory (Secondary) *Infectious*(Duration) *8 yrs. 8 mos. 8 ds.*(Signed) *Thos F. Mullen* M. D.*11/8/22* (Address) *Kane Bldg*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death *38* yrs. *38* mos. *38* days. In the State *38* yrs. *38* mos. *38* days.

Where was disease contracted if not at place of death?

Former or usual residence *Germany*19. PLACE OF BURIAL OR REMOVAL *Pocatello* DATE OF BURIAL *Nov 9 1922*20. UNDERTAKER *McHardy & Co. Pocatello* ADDRESS

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

40318

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock Registration District No. 28
City of POCATELLO, IDAHO Primary Registration District No. 216/
(No. 323 1/2 North Main St.)

If death occurs away from usual residence, give facts called for under special information.

File No. 55
Registered No. 3958

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Gee Lee

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE Chinese 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Married

6. DATE OF BIRTH

Oct 19 1866
(Month) (Day) (Year)

7. AGE

56 Yrs. — 24 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Restaurant proprietor

9. BIRTHPLACE

(State or Country)

China

10. NAME OF FATHER

Hang Do.

11. BIRTHPLACE OF FATHER

(State or Country)

China

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

China

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Dean Lee

(Address)

POCATELLO, IDAHO

15.

Filed Nov 11 1922J. P. Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 11 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
Sept 2 1922 to late 1922that I last saw him alive on Nov 2 1922
and that death occurred on the date stated above, at 5:00 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease(Duration) One Yrs. mos. ds.Contributory
(Secondary)Decompensation(Duration) 3 yrs. mos. ds.

(Signed)

D. J. Howard M. D.11/11 1922 (Address) Pocatello, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 1 yrs. 4 mos. days. In the State 1 yrs. 4 mos. days

Where was disease contracted if not at place of death?

Former or usual residence

Walla Walla, Wash

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Walla Walla, WashNov 11 1922

20. UNDERTAKER

ADDRESS

H. L. McHANPOCATELLO, IDAHO

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

40320

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Blaine Registration District No. 2161
City of Gasquet Primary Registration District No. 435 St. S. Piffet
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME Infant (Andrews)
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Baby
(Write the word.)

6. DATE OF BIRTH Nov 14 1922
(Month) (Day) (Year)

7. AGE 10 1/2 yrs. 1 mos. 1 ds.
IF LESS than 1 day how many 10 1/2 hrs. or 10 1/2 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE Idaho
(State or Country)

10. NAME OF FATHER J. O. Andrews

11. BIRTHPLACE OF FATHER Ind
(State or Country)

12. MAIDEN NAME OF MOTHER Leona Moore

13. BIRTHPLACE OF MOTHER Utah
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. O. Andrews
(Address) Gasquet Idaho

15. Filed 11/13 1922
Local Registrar J. Young

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 12 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov - 1911, to Nov 12 1922
that I last saw him alive on Nov 12 1922
and that death occurred on the date stated above, at 4:30 P. M.
The CAUSE OF DEATH* was as follows:
Blue baby -

(Duration) 7 yrs. 7 mos. 1 ds.
Contributory Pneumonia - 7 mos.
(Secondary)
(Duration) 7 yrs. 7 mos. 1 ds.
(Signed) J. Young M. D.
11/13/22 (Address) Bozart

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 7 yrs. 7 mos. 1 ds. In the State 7 yrs. 7 mos. 1 ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Mountain View DATE OF BURIAL Nov 13 1922

20. UNDERTAKER Schumacher & Sons ADDRESS Bozart

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

40321

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Bannock* Registration District No. *28*City of *Pocatello*Registration District No. *28*File No. *56*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*James J. Patton*Registered No. *3962*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widowed
(Write the word.)

6. DATE OF BIRTH

Sept 9th 1850
(Month) (Day) (Year)

7. AGE

62 Yrs. *2* Mos. *5* ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Contractor

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Ireland

10. NAME OF FATHER

(unknown) Patton

11. BIRTHPLACE OF FATHER

(State or Country)

unknown

12. MAIDEN NAME OF MOTHER

unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Marie J. Patton
(Address) *128 S. 2nd*

15.

Filed

11/15 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 14 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

*Oct 23 1922 to Nov 14 1922*that I last saw him alive on *Nov 13 1922*

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Hypostatic pneumonia and acute nephritis(Duration) Yrs. mos. *7* ds.

Contributory (Secondary)

Fractured femur(Duration) yrs. mos. *22* ds.

(Signed)

*Wm. Newton M.D.**Nov 14 1922* (Address) *Pocatello, Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Mountain View**Nov 17 1922*

20. UNDERTAKER

ADDRESS

*Schumacher & Co**Idaho City*

RECEIVED
DEC 30 1922

CERTIFICATE OF DEATH

40322

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

District No.

Registration District No.

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Signed)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

40323

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME Angus McDonald

Registration District No. 28
Primary Registration District No. 2161
St. Brus Hob
File No. 56
Registered No. 3964
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
6. DATE OF BIRTH Dec 25 1986
(Month) (Day) (Year)
7. AGE 62 Yrs. 10 Mos. 23 ds.
IF LESS than 1 day how many hrs. or min.?
8. OCCUPATION miner
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).
9. BIRTHPLACE Canada
(State or Country)
10. NAME OF FATHER Angus McDonald
11. BIRTHPLACE OF FATHER Canada
(State or Country)
12. MAIDEN NAME OF MOTHER Amie McMillan
13. BIRTHPLACE OF MOTHER Canada
(State or Country)

16. DATE OF DEATH Nov 17 1922
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Nov 12th 1922 to Nov 17th 1922
that I last saw him alive on Nov 17th 1922
and that death occurred on the date stated above, at 5:30 A.M.
The CAUSE OF DEATH* was as follows:
asthma

(Duration) 3 Yrs. mos. ds.
Contributory Heart failure
(Secondary)
(Duration) yrs. mos. ds.
(Signed) certified M. D.
11/17/1922 (Address) Pocatello Id
*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs J. H. Gundry
(Address) farm apt Pocatello
15. Filed Nov 17 1922
Local Registrar

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days.
Where was disease contracted if not at place of death?
Former or usual residence Nevada
19. PLACE OF BURIAL OR REMOVAL Mt View Cem
20. UNDERTAKER McHardy & Co
ADDRESS Pocatello

CERTIFICATE OF DEATH

40324

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No.

Primary Registration District No.

28

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

1922 (Year)

I HEREBY CERTIFY, That I attended deceased from June 1920, to Nov 15 1922, that I last saw him alive on Nov 15 1922, and that death occurred on the date stated above, at 7³⁰ P. M.

The CAUSE OF DEATH* was as follows:

Diabetes mellitus

(Duration) 3 Yrs. mos. ds.
Contributory (Secondary) Respiratory Distress(Duration) 3 yrs. mos. 3 ds.
(Signed) D. C. Ray M. D.

11-17-22 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

40325

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock Registration District No. 28City of Pocatello (If in city or town, give name of hospital, etc.) St. Joseph's Hospital St. 2161

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

L. L. ChristensenFile No. 56Registered No. 3966

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

Unknown

(Month)

(Day)

1862
(Year)

7. AGE

60 Yrs. — Mos. — ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Sweden

10. NAME OF FATHER

Nicholas Christensen

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME OF MOTHER

Anna Elizabeth

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Eust Johnson

(Address)

Firth, Idaho

15.

Filed

11/1819 22

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

November 17 19 22
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Nov 16 1922, to Nov 17 1922that I last saw him alive on Nov 17 1922and that death occurred on the date stated above, at 8:30 P.M.

The CAUSE OF DEATH* was as follows:

Shock following operation.

(Duration) Yrs. — mos. — ds.

Contributory
(Secondary)Cancer of rectum

(Duration) Yrs. — mos. — ds.

(Signed)

J. H. Smith M. D.Nov 18 19 22 (Address) Pocatello, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death — yrs. — mos. — days. In the State 10 yrs. — mos. — days

Where was disease contracted if not at place of death?

Former or usual residence

Pocatello, Idaho

19. PLACE OF BURIAL OR REMOVAL

Bonnet, Idaho

DATE OF BURIAL

Nov 20 19 22

20. UNDERTAKER

Schumacher & Hall

ADDRESS

Pocatello

CERTIFICATE OF DEATH

40326
28State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Blaine Registration District No. 12/161City of Pocatello (No. 12/161)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Wichibol W. ServiceFile No. 56Registered No. 3968

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDWidowed

(Write the word.)

6. DATE OF BIRTH

May 27, 1853
(Month) (Day) (Year)

7. AGE

69 Yrs. 5 Mos. 21 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Coal & Lumber Dealer

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

John R. Service

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Genette Wilky

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Walter Service(Address) Pocatello Id.

15.

Filed 11/20 1922J. H. H. H.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

80

16. DATE OF DEATH

11 (Month) 18 (Day) 22 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

11/17 1922 to 11/17 1922
that I last saw him alive on 11/17 1922
and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Angina pectoris(Duration) Yrs. mos. ds.
Contributory (Secondary) aged - had coarctation of aorta and chest pain for several days
(Duration) yrs. mos. ds.
(Signed) J. H. H. H. M. D.
11/20 1922 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Mountain View Nov 20 1922

20. UNDERTAKER

ADDRESS

Schumacher & Sons Pocatello

1. PLACE OF DEATH

County of Bannock Registration District No. 2161City of Pocatello No. 11807

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ernest Albert GrenfellFile No. 56Registered No. 3970

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single

6. DATE OF BIRTH

Aug 28 1880
(Month) (Day) (Year)

7. AGE

42 Yrs. 2 Mos. 24 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Stationary engineer
retired

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

Ernest Grenfell

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Annie Ellis

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Elsie Martin

(Address)

Bellevue, Idaho

15. Filed

Nov 22 1922J. H. [unclear]
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 21 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Nov 20 1922 to Nov 21 1922that I last saw him alive on Nov 21 1922
and that death occurred on the date stated above, at 9:30 P.M.

The CAUSE OF DEATH* was as follows:

Had automobile accident
Crushing pelvis and resulting
internal injuries and internal
injuries (Duration) Yrs. mos. 1 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

John J. [unclear] M. D.(Address) Pocatello, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

Bellevue Idaho

19. PLACE OF BURIAL OR REMOVAL

Bellevue, Idaho

DATE OF BURIAL

Nov 22 1922

20. UNDERTAKER

W. C. Han Underlaking Pocatello Ida

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

40328

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock Registration District No. 28
City of Pocatello Primary Registration District No. 2461
(No. St Anthony Hospital)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

David BohrerFile No. 56Registered No. 3971

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

married
(Write the word.)

6. DATE OF BIRTH

May 28 1853
(Month) (Day) (Year)

7. AGE

69 yrs. 5 mos. 23 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Retired

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

David Bohrer

11. BIRTHPLACE OF FATHER

(State or Country)

Pennsylvania

12. MAIDEN NAME OF MOTHER

Elizabeth Van Schoyck

13. BIRTHPLACE OF MOTHER

(State or Country)

Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Chas H Bohrer

(Address)

1025 - So 4th

15.

Filed

11/22 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

November 21 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

11-14 1922 to 11-21 1922that I last saw him alive on 11-21 1922and that death occurred on the date stated above, at 4:30 PM

The CAUSE OF DEATH was as follows:

Bronchial pneumonia(Duration) Yrs. mos. 7 ds.Contributory
(Secondary)myocardial infarction

(Duration) Yrs. mos. ds.

(Signed)

D. C. Ray

M. D.

11-22-1922 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Mountain View Cem

DATE OF BURIAL

Nov 22 1922

20. UNDERTAKER

Schumacher & Hall

ADDRESS

Pocatello

RECEIVED

CERTIFICATE OF DEATH

40329

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Campano* Registration District No. *28*
City of *Pocatello* Primary Registration District No. *2161*
St. *Idaho*File No. *56*
Registered No. *3972*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Elmer Bonner Jr

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*
(Write the word.)

6. DATE OF BIRTH

August 7 1922
(Month) (Day) (Year)

7. AGE

no Yrs. *3* Mos. *16* ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).*None*

9. BIRTHPLACE

(State or Country)

Ashton

10. NAME OF FATHER

E. Elmer Bonner

11. BIRTHPLACE OF FATHER

(State or Country)

Salina Utah

12. MAIDEN NAME OF MOTHER

Pearl L. Force

13. BIRTHPLACE OF MOTHER

(State or Country)

Salt Lake City Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Elmer Bonner

(Address)

121 So. Fairfield

15.

Filed

*11/24 1922**J. L. Young*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

91

16. DATE OF DEATH

Nov 24 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *Nov. 22 1922* to *Nov. 24 1922*that I last saw him alive on *Nov. 24 1922*
and that death occurred on the date stated above, at *7 A.M.*

The CAUSE OF DEATH* was as follows:

Pneumonia(Duration) Yrs. mos. *4 w/3 d.*Contributory
(Secondary)*none*

(Duration) yrs. mos. ds.

(Signed)

*W. E. Howard M. D.**11/24 1922* (Address) *Pocatello Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Ashton Ida. Nov 23 1922

20. UNDERTAKER

ADDRESS

W. E. McFarland Pocatello Ida.

FORM V. S. No. 5-A—25 M. 1-19.

1. PLACE OF DEATH

County of *Dumfries*City of *Porter*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED

CERTIFICATE OF DEATH

Registration District No. *28*Primary Registration District No. *2161*State *Ill*to *hospital*

40330

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *56*Registered No. *3923*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

*Male**White**Single*
(Write the word.)

6. DATE OF BIRTH

Unknown

(Month)

(Day)

(Year)

7. AGE

*74 years and near 75*IF LESS than 1 day
how many hrs.

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

*Retired
Laplace*

9. BIRTHPLACE

(State or Country)

Mass-

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J.B. Smith

(Address)

Palmer St

15.

Filed

11/27 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 25

(Month)

(Day)

19. *22*
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 23 1922 to Nov 25 1922
that I last saw him alive on *Nov 25 1922*
and that death occurred on the date stated above, at *10 AM*

The CAUSE OF DEATH* was as follows:

*Carcinoma of Stomach
and small intestine.*(Duration) *probably 6 mos.* ds.Contributory
(Secondary)*Smoking*(Duration) *1 yr.* mos. ds.

(Signed)

*Carl W. Clark M. D.**11/26 1922* (Address) *Proctor St*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs mos days In the State yrs mos days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Proctor St Nov 28 1922

20. UNDERTAKER

ADDRESS

Thurman Tree City

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

40331

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. *36*
Registered No. *3974*
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of *Bannock* Registration District No. *28*

City of *Pocatello* (No. *202*)
If death occurs away from usual residence, give facts called for under special information.
St. *Clark*

2. FULL NAME

David Wesley Wood

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male white

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married

6. DATE OF BIRTH.

Sept. 11, 1844
(Month) (Day) (Year)

7. AGE

*78 Yrs. 2 Mos. 13 ds.*IF LESS than 1 day
how many " hrs. or
" min.?"

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Attorney at law

9. BIRTHPLACE

(State or Country)

St. Vernon Ohio

10. NAME OF FATHER

Jonathan Wood

11. BIRTHPLACE OF FATHER

(State or Country)

Not Known

12. MAIDEN NAME OF MOTHER

*"**"*

13. BIRTHPLACE OF MOTHER

(State or Country)

"

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Mrs. Clara Wood
202 W. Clark St.

15.

Filed

Nov 27 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 24, 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 14, 1922 to Nov 26, 1922
that I last saw him alive on *Nov 26, 1922*and that death occurred on the date stated above, at *10:35 P.* M.

The CAUSE OF DEATH* was as follows:

Infarct Insufficiency(Duration) *2 Yrs.* mos. ds.

Contributory (Secondary)

Paralytic Stroke(Duration) *17 Yrs. 6 mos.* ds.

(Signed)

W. H. Brown M. D.
11/24/1922 (Address) *Pocatello, Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death *2 yrs.* mos. days, State *2 yrs.* mos. days

Where was disease contracted

if not at place of death?

Former or usual residence

Washington D. C.

19. PLACE OF BURIAL OR REMOVAL

St. View Cemetery

DATE OF BURIAL

Nov 28, 1922

20. UNDERTAKER

M. J. Brown and Co. Pocatello, Ida.

ADDRESS

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

40332

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock Registration District No. 28
City of Pocatillo Primary Registration District No. 2161
City of Pocatillo No. 1912 George J. A. Grunberg (St.)

If death occurs away from usual residence, give facts called for under special information.

BUREAU OF VITAL STATISTICS

File No. 56
Registered No. 3975

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH September 6 1882
(Month) (Day) (Year)

7. AGE 40 Yrs. 2 Mos. 20 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Butcher
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Norway

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. Geo. Grunberg
(Address) 7th 9th

15. Filed 11/28 1922 J. Grunberg
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

November 26 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 21 1922 to Nov 26 1922 that I last saw him alive on Nov 26 1922 and that death occurred on the date stated above, at 79 M. The CAUSE OF DEATH* was as follows:

Repeated ulcer of stomach - General peritonitis
(Duration) Yrs. mos. 3 ds.

Contributory operated
(Secondary)

(Duration) yrs. mos. ds.

(Signed) W. H. Grunberg M. D.

Nov 21 (Address) 7th 9th

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mountain View Nov 27 1922

20. UNDERTAKER

ADDRESS

Schumacher & Hall Pocatillo

1. PLACE OF DEATH

County of Barnes
City of PortervilleRegistration District No. 28Primary Registration District No. 2141(No. 354 - So Garfield St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Harry E DayFile No. 56Registered No. 3976

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDChild
(Write the word.)

6. DATE OF BIRTH

September 17 1922
(Month) (Day) (Year)

7. AGE

2 Yrs. 12 Mos. 12 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)Infant

9. BIRTHPLACE

(State or Country)

Burley Idaho

10. NAME OF FATHER

E. S. Day

11. BIRTHPLACE OF FATHER

(State or Country)

Draper Utah

12. MAIDEN NAME OF MOTHER

Jennie Nelson

13. BIRTHPLACE OF MOTHER

(State or Country)

Logan Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. S. Day

(Address)

Porterville

15.

Filed

11/30 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

November 29 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 27 1922 to Nov 29 1922that I last saw him alive on Nov 28 1922and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia follow-
ing cold.

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

11/29 1922

(Address)

Porterville Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Mountain View Bur

DATE OF BURIAL

11/30 1922

20. UNDERTAKER

Schumacher & Hall

ADDRESS

Port

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

40334

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 56
Registered No. 3917

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Bannock
City of Pocatella
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME Frank Hughes Miller

RECEIVED
JAN 1922
BUREAU
STAT

Registration District No. 28
Primary Registration District No. 2161
No. General Hospital St.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)
6. DATE OF BIRTH April 7 1872
(Month) (Day) (Year)
7. AGE 50 Yrs. 7 Mos. 24 ds.
IF LESS than 1 day how many..... hrs. or..... min.?

8. OCCUPATION Farmer
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE Utah
(State or Country)

10. NAME OF FATHER Rueben Miller

11. BIRTHPLACE OF FATHER Pa.
(State or Country)

12. MAIDEN NAME OF MOTHER Jane Hughes

13. BIRTHPLACE OF MOTHER England
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Frank Miller
(Address) Blackfoot

15. Filed 12/1 1922
Local Registrar H. J. Young

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 1 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 26 1922, to Dec 1 1922 that I last saw him alive on Nov 30 1922 and that death occurred on the date stated above, at 4:26 P.M.

The CAUSE OF DEATH* was as follows:
2d Paresis of intestines

(Duration) Yrs. mos. ds.
Contributory (Secondary) acute gangrenous appendicitis (peritonitis)
(Duration) yrs. mos. ds.
(Signed) H. C. Lawrie M. D.
Dec 1 1922 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Blackfoot DATE OF BURIAL Dec 5 1922
20. UNDERTAKER E. H. Galt ADDRESS Blackfoot

40335

FORM V. S. No. 5-A-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock
City of Pocatello

Registration District No.

Primary Registration District No.

(No. General Hospital St.)File No. 56Registered No. 3479If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Ezra Thomas HamfIf death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDWidow
(Write the word.)

6. DATE OF BIRTH

February
(Month)1
(Day)1855
(Year)

7. AGE

67 Yrs. 10 Mos. - ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)Janitor

9. BIRTHPLACE

(State or Country)

England10. NAME OF
FATHERWilliam Hamf11. BIRTHPLACE
OF FATHER

(State or Country)

England12. MAIDEN NAME
OF MOTHERMary Hagdelin13. BIRTHPLACE
OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mr. H. F. Mott

(Address)

442 - S. Arthur

15.

Filed

12/2 1922J. Young

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

December 1
(Month)1
(Day)1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

11-27-1922 to 12-1-1922that I last saw him alive on 12-1-1922and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Bilateral lobar pneumonia(Duration) Yrs. mos. 5 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

12/2 1922 (Address) Pocatello*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Richmond UtahDec 4 1922

20. UNDERTAKER

ADDRESS

Schumacher & HallPocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH
in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

40335

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 56
Registered No. 3981

1. PLACE OF DEATH

County of Bannock
City of PocatilloRegistration District No. 28
Primary Registration District No. 2161
(No. _____ St.)If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Clarence KellyIf death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male white

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED, OR DIVORCEDSingle widower
(Write the word.)

6. DATE OF BIRTH

Nov 2 1873
(Month) (Day) (Year)

7. AGE

49 Yrs. 1 Mos. 2 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min. ?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)RR Brakeman

9. BIRTHPLACE

(State or Country)

Utah10. NAME OF
FATHERW. H. Kelly11. BIRTHPLACE
OF FATHER

(State or Country)

Illinois12. MAIDEN NAME
OF MOTHEREliza J. Turpin13. BIRTHPLACE
OF MOTHER

(State or Country)

Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

George M. Kelly
2862 So 7 E apt.
Salt Lake City Ut.

15.

Filed

174 1922J. F. McHan
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 4 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 5 1922 to 19
that I last saw him few days of death 19
and that death occurred on the date stated above, at about 2 P.M.

The CAUSE OF DEATH* was as follows:

Thrombosis of right heart.
(Pulmonary completely filled with
antimorbid clots)

(Duration) Yrs. _____ mos. _____ ds.

Contributory (Secondary) Unresolved Pneumonia (Chor)
Lower lobe right lung(Duration) Yrs. _____ mos. 16 ds.(Signed) C. W. Clark M. D.12/5 1922 (Address) Pocatillo Idaho*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted
if not at place of death?Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Mt View Cemetery 174 1922

20. UNDERTAKER ADDRESS

W. F. McHan Pocatillo
Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

40337

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No.)

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

Nov. 29 1922, to Nov. 30 1922

that I last saw him alive on Nov. 29 1922

and that death occurred on the date stated above, at 3:00 A.M.

The CAUSE OF DEATH* was as follows:

Premature birth

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

11/30/1922 (Address) Pocatello, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mt View Cem Dec 1 1922

20. UNDERTAKER

ADDRESS

McNan & Sons Co. Pocatello, Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

40338

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Cannock*
City of *Pocatello*Registration District No. *28*Primary Registration District No. *2161*(No. *211 W Young* St.)File No. *54*Registered No. *3980*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Carrie Virginia Poage

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Oct 11 1922
(Month) (Day) (Year)

7. AGE

1 Yrs. *20* Mos. *20* ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)*None*

9. BIRTHPLACE

(State or Country)

Pocatello Ida.

10. NAME OF FATHER

Earl Poage

11. BIRTHPLACE OF FATHER

(State or Country)

Nebraska

12. MAIDEN NAME OF MOTHER

Iva Gardner

13. BIRTHPLACE OF MOTHER

(State or Country)

Teton Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Earl Poage

(Address)

211 W Young

15.

Filed

*12/2 1922**W. H. Prodder*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 1 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *Nov 29 1922* to *Dec 1 1922*
that I last saw him alive on *Dec 1 1922*
and that death occurred on the date stated above, at *9:30 PM*.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia(Duration) Yrs. mos. *3* ds.Contributory
(Secondary)*None*

(Duration) Yrs. mos. ds.

(Signed)

*W. H. Prodder M. D.**12/2 1922* (Address) *Pocatello Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Salt Lake City Utah**Dec 3 1922*

20. UNDERTAKER

ADDRESS

*W. H. McHan**Pocatello Ida.*

1. PLACE OF DEATH

County of Bannock
City of Postville

Registration District No. _____

Primary Registration District No. _____

(No. General Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Polly Sameda ShumwayFile No. 56Registered No. 3982

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

March11890

(Month)

(Day)

(Year)

7. AGE

52

Yrs.

9

Mos.

5

ds.

IF LESS than 1 day

how many _____ hrs.

or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

House wife

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Franklin Idaho

10. NAME OF FATHER

James Parker

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Polly Micham

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. J. Shumway

(Address)

Mc Cammon

15.

Filed

12/6 72

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

December 6

(Month)

(Day)

1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec. 1 1922 to Dec 6 1922that I last saw her alive on Dec 5 1922and that death occurred on the date stated above, at 8:00 M.

The CAUSE OF DEATH* was as follows:

Operation Visceral hernia 12/4/22
Posthuma

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)Strangulation

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Samuel C. Swin M. D.12/6 1922 (Address) Postville Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Mc Cammon Idaho

DATE OF BURIAL

Dec 8 1922

20. UNDERTAKER

Schumacher & Hall

ADDRESS

Postville

40340

FORM V. S. No. 3-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

Registration District No.

Primary Registration District No.

(No.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

19 22

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Signed)

12/11/1922 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

40341
28State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

Registration District No.

Primary Registration District No.

(No.)

2161

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

16. DATE OF DEATH

(Month)

(Day)

1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 14 1922 to Dec 14 1922

that I last saw him alive on Dec 14 1922

and that death occurred on the date stated above, at 12:30 M.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

M. D.

1/4 1922 (Address) Pocatello, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

40342

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock
City of Pocatello

Registration District No.

Primary Registration District No.

(No. St. Anthonys Hosp.)

File No. 56

Registered No. 3985

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

May Martha Kochling

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-OWED OR DIVORCED

Female white Married

6. DATE OF BIRTH

May 2 1880
(Month) (Day) (Year)

7. AGE

42 Yrs. 7 Mos. 13 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

House wife

9. BIRTHPLACE

(State or Country) Nevada

10. NAME OF FATHER

William Gibson

11. BIRTHPLACE OF FATHER

(State or Country) Ireland

12. MAIDEN NAME OF MOTHER

Helen McDermott

13. BIRTHPLACE OF MOTHER

(State or Country) Nevada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joseph Kochling
(Address) Hailey Idaho

15. Filed Dec 16 1922

J. Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec. 15 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 25 1922 to Dec 14 1922

that I last saw her alive on Dec 14 1922
and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) Yrs. 1 mos. ds

Contributory (Secondary) Casemonia of Cervix and hemorrhage

(Duration) Yrs. Indefinite mos. ds

(Signed) R. M. Newton M. D.

12/16/1922 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 8 yrs 10 mos 10 ds in the Pocatello State Idaho yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence Hailey Idaho

19. PLACE OF BURIAL OR REMOVAL

Hailey Idaho

DATE OF BURIAL

12/18 1922

20. UNDERTAKER

McCawendatt Co. Pocatello Idaho

ADDRESS

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

40343

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock
City of PocatelloRegistration District No. 28
Primary Registration District No. 2161
(No. 522 N. 9th St.)File No. 56
Registered No. 3986

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William Downey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED married
(write the word)

6. DATE OF BIRTH

Apr 3rd 1849
(Month) (Day) (Year)

7. AGE

73 Yrs. 7 Mos. 13 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Retired

9. BIRTHPLACE

(State or Country)

Ireland

10. NAME OF FATHER

Thomas Downey

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

James O. Downey
(Address) 555 S. Hayes

15.

Filed 12/16 1922Local Registrar W. H. Young

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 16 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
Sept 10th 1922 to Dec 16th 1922
that I last saw him alive on Dec 16th 1922
and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

nephritis(Duration) Yrs. 6 mos. ds.
Contributory enlarged prostate
(Secondary)(Duration) 18 yrs. mos. ds.(Signed) W. H. Young M. D.Dec 16 1922 (Address) Pocatello, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mountain View Dec 16 1922

20. UNDERTAKER

ADDRESS

Schumacher Hay Pocatello
Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

40344

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of *Bannock*
City of *Pocatello*

Registration District No. *28*
Primary Registration District No. *2141*
(No. *820 E. Lander* St.)

File No. *57*
Registered No. *3987*

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME *Harriett Cass*

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *married*
(Write the word.)

6. DATE OF BIRTH *Nov 13 1856*
(Month) (Day) (Year)

7. AGE *66* Yrs. *1* Mos. *7* ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION *Housewife*
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE *Indiana*
(State or Country)

10. NAME OF FATHER *John Harris*

11. BIRTHPLACE OF FATHER *Not Known*
(State or Country)

12. MAIDEN NAME OF MOTHER *Francis Young*

13. BIRTHPLACE OF MOTHER *Not Known*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *Ralph Cass*
(Address) *820 E. Lander*

15. Filed *12/20* 19 *22*
Local Registrar *R. F. Young*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *Dec 20 1922*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *July 1921* to *Dec 19 1922* that I last saw her alive on *Dec 19 1922* and that death occurred on the date stated above, at *4:30 A.M.*

The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage

(Duration) *about 3 Yrs.* mos. ds.

Contributory (Secondary) (Duration) yrs. mos. ds.

(Signed) *J. C. Ray* M. D.
1220 1922 (Address) *Pocatello Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Denver Colo.* DATE OF BURIAL *Dec 23 1922*

20. UNDERTAKER *R. F. McMan* ADDRESS *Pocatello Idaho*

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

40345

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Bannock*
City of *Pocatello*Registration District No. _____
Primary Registration District No. *261*
(No. *St. Anthony Hospital* St.)File No. *57*
Registered No. *3488*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Clarence R. Jarbae

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*
(Write the word.)6. DATE OF BIRTH *June 28-1871*
(Month) (Day) (Year)7. AGE *51* Yrs. *5* Mos. *27* ds.
IF LESS than 1 day how many..... hrs. or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)*Trainman*

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

*William H. Jarbae**W.V.G.*

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

*Margaret Bingen**Ohio*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

C. Jarbae
Pocatello, Ida.

15.

Filed

1/26 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

December 25th 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *Dec. 10th 1922* to *Dec. 25th 1922* that I last saw him alive on *Dec. 24th 1922* and that death occurred on the date stated above, at *3:01 P.M.*
The CAUSE OF DEATH* was as follows:
*Primary Syphilis**Unknown* (Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed)

12/25 1922

(Address)

W.A. Blumhagen M.D.
Pocatello, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Anthony Hospital Pocatello, Ida. *Dec 27 1922*

20. UNDERTAKER

ADDRESS

Schumacher & Co. Pocatello, Ida.

40846

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

FORM V. S. No. 5-A-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Bannock*
City of *Pocatello*

Registration District No. _____

Primary Registration District No. _____

(No. *St. Anthony Hospital* St.)File No. *57*Registered No. *3989*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Sister Mary Raphael

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

*Female White**Single*
(Write the word.)

6. DATE OF BIRTH

February 24 1893
(Month) (Day) (Year)

7. AGE

29 Yrs. *10* Mos. _____ ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Nursing

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Hills, Iowa

10. NAME OF FATHER

Mrs. Cyril Rohrer

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Mary Fife

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Res. Mother Cecelia Cerv. and

(Address)

St. Anthony's Hosp.

15.

Filed

1/24 1922

Local Registrar

16. DATE OF DEATH

Dec 24 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Spt 1 1922 to Dec 24 1922
that I last saw her alive on *Dec 23 1922*
and that death occurred on the date stated above, at *8 A.M.*

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis(Duration) Yrs. *10* mos. _____ ds.Contributory
(Secondary)

(Duration) yrs. _____ mos. _____ ds.

(Signed)

A. M. Newton

M. D.

Dec 25 1922 (Address) *Pocatello, Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Mountain View**12-27-1922*

20. UNDERTAKER

ADDRESS

*Schumacher & Co**Pocatello Ida*

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED

CERTIFICATE OF DEATH

40347 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock Registration District No. 28City of BlackfootPrimary Registration District No. 2161File No. 57Registered No. 3990

If death occurs away from usual residence, give fact called for under special information.

2. FULL NAME

W. W. Person

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

widowed
(Write the word.)

6. DATE OF BIRTH

Not Known
(Month) (Day) (Year)

7. AGE

56

Yrs. — Mos. — ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Watchmaker

(b) General nature of industry, business or establishment in which employed (or employer)

railroad man.

9. BIRTHPLACE

(State or Country)

Not Known.

10. NAME OF FATHER

"

"

11. BIRTHPLACE OF FATHER

(State or Country)

"

"

12. MAIDEN NAME OF MOTHER

"

"

13. BIRTHPLACE OF MOTHER

(State or Country)

"

"

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Conu Ferguson
Temple Pharmacy

15.

Filed 12/28 1928

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 23 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

.....19..... to19.....

that I last saw him alive on19.....

and that death occurred on the date stated above, atM.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

12/29/22 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

McVie Cemetery 12/29/1922

20. UNDERTAKER

ADDRESS

W. E. McHan Pocatello Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

40348

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 12th
(No. 12th)

File No. 57
Registered No. 3991

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Dr. C. D. Brahman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED unknown
(Write the word.)

6. DATE OF BIRTH Not known
(Month) (Day) (Year)

7. AGE about 65 years IF LESS than 1 day how many... hrs. or... min.?
Yrs. Mos. ds.

8. OCCUPATION
(a) Trade, profession or particular kind of work Miner
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) General Information
(Address) Pocatello Ida.

15. Filed 12/30 1922
Local Registrar W. J. Wacker

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 25 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1st 1922 to Dec 25 1922
that I last saw him alive on Dec 25th 1922
and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:
Cancer of the bladder

(Duration) Yrs. mos. ds.
Contributory (Secondary) nephritis
(Duration) yrs. mos. ds.

(Signed) Dr. C. D. Brahman M. D.
Dec 22 (Address) Pocatello Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death... yrs... mos... days. In the State... yrs... mos... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Shelley Ida DATE OF BURIAL 12/31 1922

20. UNDERTAKER W. J. Wacker ADDRESS Pocatello

1. PLACE OF DEATH

County of Bannock Registration District No. 53
Primary Registration District No. 2160
City of Swan Lake (No. _____ St.)

File No. _____
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Sillie Fisher Hadley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

married
(Write the word.)

6. DATE OF BIRTH

Jan 13 1886
(Month) (Day) (Year)

7. AGE

36 Yrs. 10 Mos. 28 ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

housewife

9. BIRTHPLACE

(State or Country)

Boahtiful, Idaho

10. NAME OF FATHER

Geo. C. Fisher

11. BIRTHPLACE OF FATHER

(State or Country)

Boahtiful, Idaho

12. MAIDEN NAME OF MOTHER

Rose B. Poore

13. BIRTHPLACE OF MOTHER

(State or Country)

Boahtiful, Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

John J. Fisher
Offord, Ida.

15.

Filed

Dec - 10 - 1922

H. J. Hartigan
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

December - 8 - 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec - 3 - 1922, to Dec - 8 - 1922
that I last saw her alive on Dec - 6 - 1922,
and that death occurred on the date stated above, at 9:00 P.M.

The CAUSE OF DEATH* was as follows:

Anaemia Secondary.

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory (Secondary) Pneumonia 7 months

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) H. J. Hartigan, M. D.

(Address) Hailey, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Swan Lake, Ida. 2-11-1923

20. UNDERTAKER

ADDRESS

none

CERTIFICATE OF DEATH

40350

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Barnock
City of BlaineyRegistration District No. 83Primary Registration District No. 2160

JAN 8 1923

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

BUREAU OF VITAL

STATISTICAL

Full Name Anna Sophia Christensen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

F

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

widowed

(Write the word.)

6. DATE OF BIRTH

March 15 - 1840
(Month) (Day) (Year)

7. AGE

82 Yrs. 7 Mos. 10 ds.

IF LESS than 1 day

how many..... hrs.

or..... min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ilenmark

10. NAME OF FATHER

Hans Christensen

11. BIRTHPLACE OF FATHER

(State or Country)

Ilenmark

12. MAIDEN NAME OF MOTHER

Anna ?

13. BIRTHPLACE OF MOTHER

(State or Country)

Ilenmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Jerry Christensen
Blainey, Idaho

15.

Filed Oct - 28 - 1922

Local Registrar

16. DATE OF DEATH

Oct. 25, 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct - 24 - 1922, to Oct - 25 - 1922that I last saw her..... alive on Oct - 24 - 1922and that death occurred on the date stated above, at 9:20 P.M.

The CAUSE OF DEATH* was as follows:

Old age

(Duration) Yrs. mos. ds.

Contributory
(Secondary)none

(Duration) yrs. mos. ds.

(Signed)

H. Christensen M. D.10-27-1922 (Address) Blainey, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 3 yrs. 7 mos. days. In the State 3 yrs. 4 mos. days

Where was disease contracted if not at place of death?

Former or usual residence

Byrum, Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Byrum, Idaho 10-30-1922

20. UNDERTAKER

ADDRESS

C. E. Saylor Blainey, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH. Registration District No. 83
County of Bannock Summary Registration District No. 3160
City of Oxford (No. _____, _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 40351
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Owen E. Kendall Jr

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH December 17th 1905
(Month) (Day) (Year)

7. AGE 17 yrs. 10 mos. 11 ds. IF LESS than 1 day
how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farming & Labor
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Oxford Idaho

10. NAME OF FATHER Owen E. Kendall

11. BIRTHPLACE OF FATHER
(State or Country) Springville Utah

12. MAIDEN NAME OF MOTHER Susan Walker

13. BIRTHPLACE OF MOTHER
(State or Country) Oxford Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Owen E. Kendall
(Address) Oxford Idaho

15. Filed Oct-30-1922
L. J. Hastings
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH October 28 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept-28 1922, to Oct-28 1922
that I last saw him alive on Oct-26 1922
and that death occurred on the date stated above, at 6:15 M.
The CAUSE OF DEATH* was as follows:

Typhoid fever
(Duration) _____ yrs. _____ mos. 14 ds.
Contributory (Secondary) Meningitis (Poli)
(Duration) _____ yrs. _____ mos. 8 ds.
(Signed) G. W. Styles M. D.
Oct-26 1922 (Address) Creston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Oxford Idaho DATE OF BURIAL 10-30-1922

20. UNDERTAKER None ADDRESS _____

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

JAN 8 1923

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock
City of LawsonBUREAU OF
STATISTICSRegistration District No. 83
Registration District No. 2160
(No. _____, St.)File No. 40352
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ida Hyde Johnson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

F

4. COLOR OR RACE

White5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Married
(Write the word.)

6. DATE OF BIRTH

Jan 10 1883
(Month) (Day) (Year)

7. AGE

39 Yrs. 10 Mos. 3 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Housewife

9. BIRTHPLACE

(State or Country)

Hayville, Idaho

10. NAME OF FATHER

Israel Hyde

11. BIRTHPLACE OF FATHER

(State or Country)

New York State

12. MAIDEN NAME OF MOTHER

Hannah M. Simmons

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

George F. Hyde

(Address)

Lawson, Idaho

15.

Filed Nov 16 1922A. Stockman
Local Registrar

16. DATE OF DEATH

Nov 13 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Oct. 5, 1922, to Nov. 13, 1922, that I last saw her alive on Nov. 13, 1922, and that death occurred on the date stated above, at 7:55 P.M.

The CAUSE OF DEATH* was as follows:

Embolism of Pulmonary Artery.

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory (Secondary)

Arteriosclerosis

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

A. J. Eastwidge, M. D.11-16-1922 (Address) Lawson, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 20 yrs. _____ mos. _____ days. In the State 20 yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

Hayville Idaho

19. PLACE OF BURIAL OR REMOVAL

Lawson, Idaho

DATE OF BURIAL

11-16-1922

20. UNDERTAKER

C. E. Sayton

ADDRESS

Lawson.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 83County of BannockPrimary Registration District No. 2160City of Homony

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Byington

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Nov 13 1922
(Month) (Day) (Year)

7. AGE

— Yrs. 5 Mos. 5 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country) Homony, Ida

10. NAME OF FATHER

Ernest Byington

11. BIRTHPLACE OF FATHER

(State or Country) Homony, Ida

12. MAIDEN NAME OF MOTHER

Edith Stoner

13. BIRTHPLACE OF MOTHER

(State or Country) Mapleton, Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ernest Byington(Address) Homony, Ida

15.

Filed Nov. 22, 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 18 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

..... 19....., to 19.....

that I last saw him alive on 19.....

and that death occurred on the date stated above, at 1:00 P.M.

The CAUSE OF DEATH* was as follows:

6 1/2 mos gestation

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Mr. Holder

M. D.

11-20-1922 (Address) Homony, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Homony, Ida, R.F.H.11-20-1922

20. UNDERTAKER

ADDRESS

none

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **40354**

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Bannock
City of Swan Lake, Idaho

RECEIVED

Registration District No. 83Primary Registration District No. 2160

No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Marion F. Hadley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

12 - 3 - 1922
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many 2 hrs.
or — min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Swan Lake, Idaho

10. NAME OF FATHER

Rich Hadley

11. BIRTHPLACE OF FATHER

(State or Country)

Swan Lake

12. MAIDEN NAME OF MOTHER

Lillie Fisher

13. BIRTHPLACE OF MOTHER

(State or Country)

Bauntpine, Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Rich Hadley

(Address)

Swan Lake, Idaho

15.

Filed Dec - 2 - 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

December 3 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec - 2 - 1922, to Dec - 2 - 1922that I last saw him alive on Dec - 2 - 1922,and that death occurred on the date stated above, at 6:00 P.M.

The CAUSE OF DEATH* was as follows:

Seven month gestation

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) R. J. Hartigman M. D.12-2-1922 (Address) Lawson, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Swan Lake, Idaho 12-4-1922

20. UNDERTAKER

ADDRESS

None

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

1. PLACE OF DEATH.

County of Danvers Registration District No. 83
City of Downey Primary Registration District No. 2160
St. (No. _____) St. (_____)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Celia S Gehring

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 40355

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married

6. DATE OF BIRTH.

Aug 11 1852
(Month) (Day) (Year)

7. AGE

70 Yrs. 3 Mos. 21 ds.

IF LESS than 1 day
how many.....hrs. or
.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

House wife

9. BIRTHPLACE

(State or Country)

Salt Lake City, Ut.

10. NAME OF FATHER

John Hakley

11. BIRTHPLACE OF FATHER

(State or Country)

Michigan

12. MAIDEN NAME OF MOTHER

Polly Woodland

13. BIRTHPLACE OF MOTHER

(State or Country)

Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

John Bassett

(Address)

Downey, Cal.

15.

Filed Dec. 4, 1922

J. J. Hartig
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 2 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

10 - 31 - 1923, to 12 - 2 - 1923,

that I last saw her alive on 12 - 2 - 1923,

and that death occurred on the date stated above, at 2:30 AM.

The CAUSE OF DEATH* was as follows:

Old age

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory Acute Bronchitis
(Secondary)(Duration) _____ yrs. _____ mos. 21 ds.(Signed) J. J. Hartig M. D.#2-4-1923 (Address) Downey, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Woodland, Cal. Dec. 4, 1922

20. UNDERTAKER

ADDRESS

J. Guy Benson Malad, Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **40356**

Registered No. _____

1. PLACE OF DEATH

RECORD

Registration District No. **83**County of **Bannock**Primary Registration District No. **2160**City of **Payson**

(No. _____) (St. _____)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William Cottrell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

92

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

Oct 23 1879
(Month) (Day) (Year)

7. AGE

43 Yrs. Mos. 9 ds. 27IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)**Farmer**

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Charles Cottrell

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

May

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Wm. J. Cottrell

(Address)

Payson, Idaho

15.

Filed

Aug - 23 - 1922

Local Registrar

16. DATE OF DEATH

Aug 20 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug. 19, 1922 to Aug - 20 - 1922
that I last saw him alive on **Aug - 19 - 1922**
and that death occurred on the date stated above, at **7:00 P.M.**

The CAUSE OF DEATH* was as follows:

Severe Pneumonia.(Duration) Yrs. mos. **7** ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. H. Hartigan

M. D.

(Address) **Payson, Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Woodland Ida

DATE OF BURIAL

Aug - 22 - 1922

20. UNDERTAKER

B. E. Layton

ADDRESS

Payson

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40357**
Registered No. _____

1. PLACE OF DEATH

Registration District No. 83
County of Bannock Primary Registration District No. 2/60
City of Hawley St. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jana Ann Mortimer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH

Dec. 28, 1921
(Month) (Day) (Year)

7. AGE

1 Yrs. 10 Mos. 9 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Swan Lake, Ida.

10. NAME OF FATHER

John P. Mortimer

11. BIRTHPLACE OF FATHER

(State or Country) Beaver City, Utah

12. MAIDEN NAME OF MOTHER

Helen M. Nelson

13. BIRTHPLACE OF MOTHER

(State or Country) Bloomington, Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John P. Mortimer

(Address) Swan Lake

15.

Filed Dec-31-1922

H. J. Hartigan
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec. 28, 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec-26-1922, to Dec-28-1922, that I last saw him alive on Dec-28-1922, and that death occurred on the date stated above, at 10:30 P.M.

The CAUSE OF DEATH* was as follows:

Broncho - Pneumonia

(Duration) Yrs. mos. ds.
Contributory (Secondary) Infection - Tuberculosis

(Duration) yrs. mos. ds.
(Signed) H. J. Hartigan M. D.

(Address) Hawley, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Swan Lake, Ida

DATE OF BURIAL

12-31-1922

20. UNDERTAKER

ADDRESS

Mortimer

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bannock
 City of Swan Lake

Registration District No. 83
 Primary Registration District No. 2160
 (No. _____) (St. _____)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Resia Lavern Mae Kinsie

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 40358
 Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

m

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
 (Write the word.)

6. DATE OF BIRTH

Nov - 8 - 1922
 (Month) (Day) (Year)

7. AGE

7 Yrs. 17 Mos. 17 ds.

IF LESS than 1 day
 how many _____ hrs.
 or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

Infant

9. BIRTHPLACE

(State or Country)

Swan Lake, Ida.

10. NAME OF FATHER

Wm M Kinsie

11. BIRTHPLACE OF FATHER

(State or Country)

Smithfield, Wt.

12. MAIDEN NAME OF MOTHER

Mmie Wilson

13. BIRTHPLACE OF MOTHER

(State or Country)

Puerto

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Seth Gibbs

(Address)

Swan Lake Ida.

15.

Filed Dec - 27 - 1922

R. J. Hartigan
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec - 25 - 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____ 19____, to _____ 19____,
 that I last saw h. _____ alive on _____ 19____,
 and that death occurred on the date stated above, at 2:45 A.M.

The CAUSE OF DEATH* was as follows:

Broncho - Pneumonia

(Duration) _____ Yrs. _____ mos. _____ ds.
 Contributory (Secondary) Premature birth

(Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) R. J. Hartigan M. D.
 (Address) Lawney Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Swan Lake - Ida Dec - 27 - 1922

20. UNDERTAKER

ADDRESS

None

1. PLACE OF DEATH **RECEIVED** CERTIFICATE OF DEATH
 County of *Beauregard* Registration District No. *32*
 City of *Montpelier* Primary Registration District No. *2136*
 If death occurs away from usual residence, give facts called for under special information. (No. *10* St.)

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. *40359*
 Registered No. *10359*
 If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME *Isaac Peterson*

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH *79*

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED, *Married*
 (Write the word.)

6. DATE OF BIRTH. *Sept 26* 1872
 (Month) (Day) (Year)

7. AGE *49* Yrs. *11* Mos. *13* ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
 (a) Trade, profession or particular kind of work *Labour*
 (b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE
 (State or Country) *Finland*

10. NAME OF FATHER *Abraham Peterson*

11. BIRTHPLACE OF FATHER
 (State or Country) *Finland*

12. MAIDEN NAME OF MOTHER *Don't know*

13. BIRTHPLACE OF MOTHER
 (State or Country) *Finland*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) *Isaac Peterson*
 (Address) *Beauregard Idaho*

15. Filed *12-31* 1922 *N. K. Keeg*
 Local Registrar.

16. DATE OF DEATH *9* *8* 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *July 13* 1922 to *Sept 8* 1922
 that I last saw him alive on *Sept 8* 1922
 and that death occurred on the date stated above, at *4-10* P. M.

The CAUSE OF DEATH* was as follows:
Distention of the Heart
Myocarditis
Several months
 (Duration) Yrs. mos. ds.

Contributory (Secondary)
 (Duration) Yrs. mos. ds.

(Signed) *E. J. Surge* M. D.
 9/8/22 (Address) *Montpelier*

State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death? *Don't know*

Former or usual residence *Butte Montana*

19. PLACE OF BURIAL OR REMOVAL *Butte Montana* DATE OF BURIAL *Sept 11* 1922

20. UNDERTAKER *F. M. Williams* ADDRESS *Montpelier Idaho*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

gaertner 40360

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bear Lake Registration District No. 53
City of Montpelier Registration District No. 2136
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME Baby Bolmer

File No.
Registered No.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH. Nov 8th
(Month) (Day) (Year)

7. AGE Yrs. Mos. ds. IF LESS than 1 day how many . . . hrs. or . . . min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE Idaho
(State or Country)

10. NAME OF FATHER Roy Bolmer

11. BIRTHPLACE OF FATHER Idaho
(State or Country)

12. MAIDEN NAME OF MOTHER Pearl Mc Alexander

13. BIRTHPLACE OF MOTHER Kansas
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Roy Bolmer
(Address) Montpelier, Idaho

15. Filed 12-31-22 191...
Local Registrar. W. H. King

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 8 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-8-22 to 11-8-22
that I last saw her alive on 11-8-22 191...
and that death occurred on the date stated above, at 12:39 P.M.

The CAUSE OF DEATH* was as follows:
Premature infant
lived only one hour
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Signed) L. P. Gaertner M. D.
11-8-1922 (Address) Montpelier, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days, State yrs. mos. days
Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Montpelier, Idaho DATE OF BURIAL Nov 8 1922

20. UNDERTAKER W. H. Williams ADDRESS Montpelier, Idaho

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Blaine Registration District No. 52
City of Montpelier Primary Registration District No. 2136
St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Emily M. Hunter

File No. 40361

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH

Feb 26 1873
(Month) (Day) (Year)

7. AGE

49 Yrs. 8 Mos. 29 ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

House wife

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Geo. A. Bird

11. BIRTHPLACE OF FATHER

(State or Country)

Iowa

12. MAIDEN NAME OF MOTHER

Harriett George

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

G. A. Bird

(Address)

Pocatello, Idaho

15.

Filed 12-31-22 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 24 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 12 1922 to Nov 24 1922

that I last saw him alive on Nov 24 1922

and that death occurred on the date stated above, at 1045a M.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

(Duration) _____ Yrs. _____ mos. 14 ds.

Contributory
(Secondary)

(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed)

H. H. Schuy M. D.

(Address) Montpelier, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Montpelier Idaho Nov 26 1922

20. UNDERTAKER

ADDRESS

F. M. Williams Montpelier Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **40362**

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of *Bear Lake*City of *Ovid*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Anderson Lelesau

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widower
(Write the word.)

6. DATE OF BIRTH

June 21 1880
(Month) (Day) (Year)

7. AGE

72 5 27
Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Farmer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Denmark

10. NAME OF FATHER

Christian Petersen

11. BIRTHPLACE OF FATHER

(State or Country)

Denmark

12. MAIDEN NAME OF MOTHER

Martha Jensen

13. BIRTHPLACE OF MOTHER

(State or Country)

Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. A. P. Petersen

(Address)

Ovid Idaho

15.

Filed

*12-31-22**Attesting*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

18 18 22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 18 to Dec 17 1922
that I last saw him alive on *Dec 17 1922*
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Heart trouble

(Duration) Yrs. mos. ds.

Contributory (Secondary)

Old age

(Duration) Yrs. mos. ds.

(Signed)

Edw. C. Lusk M. D.*12-16-1922* (Address) *Marquette Id*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Ovid Idaho, Dec 21, 1922

20. UNDERTAKER

ADDRESS

Bishop J. J. Petersen Ovid Id

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **40363**
Registered No. _____

1. PLACE OF DEATH

County of Bear Lake Registration District No. _____
City of Montpelier Secondary Registration District No. 2136 St. _____

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Infant
(Write the word.)6. DATE OF BIRTH Oct 10 1922
(Month) (Day) (Year)7. AGE 2 yrs. 76 mos. 26 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15. Filed 12-31-22 1922 H. H. Kueg
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 26 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Dec 25 1922 to Dec 26 1922
that I last saw him alive on Dec 25 1922
and that death occurred on the date stated above, at _____ M.
The CAUSE OF DEATH* was as follows:
Pneumonia(Duration) Yrs. 5 mos. 5 ds.Contributory
(Secondary)(Duration) Yrs. 1 mos. 1 ds.(Signed) H. H. Kueg M. D.(Address) Montpelier

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Burial in Ida 12-27-22

20. UNDERTAKER ADDRESS

Bishop Hulme Banner

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bear Lake
City of Geneva Ida.Registration District No. 52Primary Registration District No. 2136

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 40364
Registered No. _____If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Edith LeissnerIf death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH

12 17 1850
(Month) (Day) (Year)

7. AGE

71 Yrs. 8 Mos. 19 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min. ? —

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)Farmer

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

Mr Leissner

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Not Known

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. H. Leissner
Geneva Ida.

(Address)

15.

Filed 12-31- 1922W. H. King

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 6 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
Aug 10 1922 to Sept 6 1922that I last saw him alive on Sept 20 1922
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory (Secondary) Pneumonia

(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed) E. H. Leissner M. D.Sept 6 1922 (Address) Geneva*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted
if not at place of death?Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Geneva IdaSept 8 1922

20. UNDERTAKER

ADDRESS

More
Bishop's Burial Co.Geneva Ida

CERTIFICATE OF DEATH

40365

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

Registration District No.

Primary Registration District No.

City of

(No.

St.)

If death occurs away from
usual residence, give facts
called for under special
information.

2. FULL NAME

Registered No.

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH.

7. AGE

IF LESS than 1 day
how many . . . hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of in-
dustry, business, or estab-
lishment in which em-
ployed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF
FATHER11. BIRTHPLACE
OF FATHER

(State or Country)

12. MAIDEN NAME
OF MOTHER13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed 12-28-1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on
and that death occurred on the date stated above, at 11:00 A.M.

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Signed)

Sept. 1, 1922 (Address)

State the Disease Causing Death; or in deaths from Violent
Causes, state (1) Means of Injury; and (2) whether Accidental,
Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place

In the

of death . . . yrs. . . . mos. . . . days, State . . . yrs. . . . mos. . . . days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

1. PLACE OF DEATH **RECEIVED**
Registration District No. 31
County of Bennett JAN 4 1923
Primary Registration District No. 100
City of Bennett St.)

File No. 2
Registered No. 26

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Joseph L. Abraham

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE Indian 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Infant
(Write the word.)

6. DATE OF BIRTH

Aug. 9 1922
(Month) (Day) (Year)

7. AGE

4 Yrs. 20 Mos. 20 ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Bennett Ida

10. NAME OF FATHER

Alexander Abraham

11. BIRTHPLACE OF FATHER

(State or Country) Bennett Ida

12. MAIDEN NAME OF MOTHER

Angeline Bedell

13. BIRTHPLACE OF MOTHER

(State or Country) Bennett Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Alex. Abraham

(Address)

Bennett

15.

Filed Jan 1st 1923

J. E. Bilan
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 29 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 26 1922, to Dec 29 1922,
that I last saw him alive on Dec 26 1922,
and that death occurred on the date stated above, at 5 A. M.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(Duration) _____ Yrs. _____ mos. 3 ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Frederick Bartman M. D.

Jan 1st 1923 (Address) Bennett

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bennett

Jan 1st 1923

20. UNDERTAKER

ADDRESS

J. E. Bilan

Bennett

1. PLACE OF DEATH

County of BennettRegistration District No. 31City of Bennett

Primary Registration District No. _____

File No. 2

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Thomas HenryRegistered No. 25

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

Indian5. SINGLE, MARRIED, WID-
OWED OR DIVORCED(Write the word.) Single

6. DATE OF BIRTH

June
(Month)

(Day)

1846
(Year)

7. AGE

76 Yrs. 6 Mos. _____ ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Montana10. NAME OF
FATHERThomas Henry11. BIRTHPLACE
OF FATHER

(State or Country)

Scotland12. MAIDEN NAME
OF MOTHERMary13. BIRTHPLACE
OF MOTHER

(State or Country)

Montana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Daniel Henry

(Address)

Tekoa Wash

15.

Filed Dec 18 1922Y. L. B. B. B.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

79

16. DATE OF DEATH

Dec 16
(Month)

(Day)

1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 10 1922, to Dec 16 1922that I last saw him alive on Dec 16 1922and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis(Duration) 5 Yrs. _____ mos. _____ ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Fred Barbeau M. D.12/18/1922 (Address) Bennett, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Bennett, Ida

DATE OF BURIAL

12/17 1922

20. UNDERTAKER

J. F. F. F.

ADDRESS

Bennett, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40368**
Registered No. **68**

1. PLACE OF DEATH. Registration District No. **32**
County of **Benedict** Primary Registration District No. **2049**
City of **St. Maries** No. **137** Third St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME

Ruth Kinsolving

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female **white** **single**
(Write the word.)

6. DATE OF BIRTH

January **5th** **1921**
(Month) (Day) (Year)

7. AGE

1 yrs. **11** mos. **13** ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country) **Virginia**

10. NAME OF FATHER

Charles J. Kinsolving

11. BIRTHPLACE OF FATHER

(State or Country) **Virginia**

12. MAIDEN NAME OF MOTHER

Julia Elizabeth Eanes

13. BIRTHPLACE OF MOTHER

(State or Country) **Virginia**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **C. J. Kinsolving**
(Address) **137 3rd St. St. Maries, Idaho**

15.

Filed **Dec 19** **1922** **O. S. Menger**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

December **18** **1922**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Dec 18** **1922**, to **Dec 18** **1922**

that I last saw her alive on **Dec 18** **1922**

and that death occurred on the date stated above, at **11:30 P.M.**

The CAUSE OF DEATH* was as follows:

Internal Hydrocephalus

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) **H. Bonnell** M. D.

12/21 **1922** (Address) **St. Maries**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Woodlawn

12-21 **1922**

20. UNDERTAKER

ADDRESS

Mitchell & Meraqu

St. Maries, Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **40369**
Registered No. **64**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Bennett Registration District No. 32
City of St. Mary Primary Registration District No. 2049
St. Mary Hospital (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

BUREAU OF
STATISTICSJohn Malnar

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDSingle
(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

(Year)

896

7. AGE

26 Yrs.

Mos.

ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Woodsman

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Hungary

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) St. Mary Hospital
(Address) St. Mary, Idaho

15.

Filed

Dec 6

19

22Osman

Local Registrar

MEDICAL CERTIFICATE OF DEATH

18

16. DATE OF DEATH

Dec
(Month)12
(Day)22
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 24 1922, to Dec 1 1922that I last saw him alive on Dec 1 1922and that death occurred on the date stated above, at 3:00 P. M.

The CAUSE OF DEATH* was as follows:

Basal Skull Fracture(Duration) Yrs. mos. 7 ds.Contributory Erysipelas
(Secondary)(Duration) yrs. mos. 4 ds.(Signed) P. A. Robins M. D.12/1 1922 (Address) St. Mary, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. 7 days. In the State yrs. mos. daysWhere was disease contracted if not at place of death? Abbe Clark & Shadone Co.

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Woodlan Cemetery

DATE OF BURIAL

12-7 1922

20. UNDERTAKER

Mitchell & Muray

ADDRESS

St. Mary, Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **40570**
Registered No. **6**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of **Benewah**
City of **St. Maries**Registration District No. **32**Primary Registration District No. **2049**(No. **St. Maries Hospital**)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Carl Braun

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white5. SINGLE, MARRIED, WIDOWED OR DIVORCED
married
(Write the word.)

6. DATE OF BIRTH

Sep. 16 1881
(Month) (Day) (Year)

7. AGE

41 Yrs. 2 Mos. 20 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

laborer

(b) General nature of industry, business or establishment in which employed (or employer).

Tramster

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

Jacob Braun

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

not known

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Mrs. E. Brown**(Address) **Plummer, Idaho**

15.

Filed **Nov 6 1922** **Conrager**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

December 6 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from **Dec 2" 1922** to **Dec 6" 1922**that I last saw him alive on **Dec 6" 1922**
and that death occurred on the date stated above, at **11:45 A.M.**

The CAUSE OF DEATH* was, as follows:

Lobar pneumonia(Duration) Yrs. mos. **7** ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Catobius M. D.**176 1922** (Address) **St. Maries, Ida**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. **5** In the State yrs. mos. daysWhere was disease contracted if not at place of death? **Plummer Idaho**Former or usual residence **Plummer Idaho**

19. PLACE OF BURIAL OR REMOVAL

Plummer Idaho

DATE OF BURIAL

12-8 1922

20. UNDERTAKER

Witchell & Muagn

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40371**
Registered No. **67**

1. PLACE OF DEATH

County of **Bernal**
City of **Osman**

Registration District No. **32**
Primary Registration District No. **2049**
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Thomas Blair

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

married
(Write the word.)

6. DATE OF BIRTH

Feb 4 1885
(Month) (Day) (Year)

7. AGE

37 Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

mill work

(b) General nature of industry, business or establishment in which employed (or employer)

Lumber grader

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

J. S. Blair

11. BIRTHPLACE OF FATHER

(State or Country)

not known

12. MAIDEN NAME OF MOTHER

not known

13. BIRTHPLACE OF MOTHER

(State or Country)

not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Mr. Katherine Blair**
(Address) **Osman Idaho**

15.

Filed **Dec 19 1922** **Osman**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec. 15 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Dec 10 1922** to **Dec 15 1922**

that I last saw him alive on **Dec 15 1922**

and that death occurred on the date stated above, at **9:30 P.M.**

The CAUSE OF DEATH* was as follows:

Lower pneumonia

(Duration) Yrs. mos. **5** ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) **Lebonville** M. D.
12/18 1922 (Address) **St. Maries Ida**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Portland Oregon

DATE OF BURIAL

married

20. UNDERTAKER

Medwell & Mesager

ADDRESS

St. Maries Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 40372

1. PLACE OF DEATH
County of Bingham
City of Blackfoot
Registration District No. 121
Primary Registration District No. 2194
(No. Idaho Idaho Idaho St.)
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME Bertha L. Burnett

Registered No. 178
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female
4. COLOR OR RACE Caucasian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)
6. DATE OF BIRTH May 13 1878
(Month) (Day) (Year)
7. AGE 44 Yrs. 6 Mos. 33 ds.
IF LESS than 1 day how many hrs. or min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business or establishment in which employed (or employer)
9. BIRTHPLACE (State or Country) Utah
10. NAME OF FATHER Charles A. Keene
11. BIRTHPLACE OF FATHER (State or Country) Utah
12. MAIDEN NAME OF MOTHER Harriet Mitchell
13. BIRTHPLACE OF MOTHER (State or Country) Utah
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Martha E. High - Bookkeeper
(Address) Idaho
15. Dec 4 1922
Filed Martha E. High
Local Registrar

16. DATE OF DEATH Dec 5 1922
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from November 9 1921 to Dec. 5 1922
that I last saw her alive on Dec. 5 1922
and that death occurred on the date stated above, at 4 P.M.
The CAUSE OF DEATH* was as follows:
manition of pernicious Anaemia
(Duration) Yrs. 4 mos. ds.
Contributory (Secondary) Pneumonia-specific
(Duration) 4 yrs. mos. ds.
(Signed) W. H. Cooper M. D.
12-5-1922 (Address) Blackfoot, Idaho
*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.
18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 1 yrs. 26 mos. 26 days In the State 40 yrs. mos. days
Where was disease contracted if not at place of death? Unknown
Former or usual residence Boise, Idaho
19. PLACE OF BURIAL OR REMOVAL Boise Idaho
DATE OF BURIAL 19
20. UNDERTAKER Ed Park
ADDRESS Blackfoot

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 121
County of Bingham Primary Registration District No. 1007
City of Blackfoot (W. T. F. & Co. St.)

If death occurs away from usual residence, give facts called for under special information.

File No. 40378
Registered No. 781

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Walter Fredrick Andersen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDmale white single
(Write the word.)

6. DATE OF BIRTH

July 22 1922
(Month) (Day) (Year)

7. AGE

4 Yrs. 20 Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

none

9. BIRTHPLACE

(State or Country)

Idaho, Bingham Co

10. NAME OF FATHER

Jens C Andersen

11. BIRTHPLACE OF FATHER

(State or Country)

Denmark

12. MAIDEN NAME OF MOTHER

Mayme L Carlson

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Jens C Andersen

(Address)

Blackfoot, Idaho

15.

Filed

Dec 12 1922 Mrs. Helen E. Pater

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 11 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 11 1922 to 1922

that I last saw him alive on Dec 11 1922

and that death occurred on the date stated above, at 4:20 PM.

The CAUSE OF DEATH* was as follows:

Encephalitis

(Duration) Yrs. mos. 4 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. C. Hurns M. D.

12/11/1922 (Address) Blackfoot, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Grove City Cemetery Dec 12 1922

20. UNDERTAKER

ADDRESS

J. C. Hurns Blackfoot, Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **40374**Registered No. **177**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Bingham Registration District No. 121
City of Blackfoot Primary Registration District No. 2194
(No. 1923 Idaho Idaho Idaho St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Peterson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDMale Caucasian unknown
(Write the word.)

6. DATE OF BIRTH

Jan. 6 1844
(Month) (Day) (Year)

7. AGE

78 Yrs. 10 Mos. 27 ds.IF LESS than 1 day
how many... hrs.
or... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Jeweler

9. BIRTHPLACE

(State or Country)

Norway

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Martha E. Peterson
High-School Bookkeeper
(Address) Idaho Idaho Idaho Idaho

15.

Filed Dec 5 1922 Mr. Matur E. Peterson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

December 4 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 12 1919 to Dec. 4 1922that I last saw him alive on Dec. 4 1922and that death occurred on the date stated above, at 4:00 P.M.

The CAUSE OF DEATH* was as follows:

Exhaustion of Senility(Duration) 4 Yrs. 1 mos. 3 ds.Contributory (Secondary) Senility(Duration) 4 Yrs. 1 mos. 3 ds.(Signed) Dr. J. H. Hager M. D.12.5 1922 (Address) Blackfoot, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 10 yrs. 16 mos. 16 days In the State 100 yrs. 16 mos. 16 daysWhere was disease contracted if not at place of death? UnknownFormer or usual residence Ada County

19. PLACE OF BURIAL OR REMOVAL

Asylum Cemetery 12/5 1922

20. UNDERTAKER

Frank Wilkerson

ADDRESS

Blackfoot, Ida

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of BinghamCity of BlackfootRegistration District No. 121Primary Registration District No. 1007(No. 508 No Stout St.)File No. 40375Registered No. 179

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Charles C Hurst

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married

6. DATE OF BIRTH

November 11 1872
(Month) (Day) (Year)

7. AGE

50 Yrs. X Mos. 25 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Day Laborer.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Logan Utah

10. NAME OF FATHER

Charles C Hurst

11. BIRTHPLACE OF FATHER

(State or Country)

W. S.

12. MAIDEN NAME OF MOTHER

Mary C. Holden

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs Charles C Hurst

(Address)

Blackfoot

15.

Filed

Dec 7 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 6 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 4 1922 to Dec 6 1922that I last saw him alive on Dec 6 1922and that death occurred on the date stated above, at 11:20 M.

The CAUSE OF DEATH* was as follows:

Influenza & pneumonia(Duration) Yrs. mos. 5 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. C. Harrison M. D.12/4 1922 (Address) Blackfoot Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Grove City Cem.

DATE OF BURIAL

19

20. UNDERTAKER

E. L. Ogli

ADDRESS

Blackfoot

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **40376**
Registered No. **180**

1. PLACE OF DEATH

County of *Blaine*City of *Morland*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No. *121*Primary Registration District No. *2194*

(Vital)

St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Oct 30
(Month)*1922*
(Day)*9*
(Year)

7. AGE

Yrs. *1*Mos. *10*

ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Brigham Co Idaho

10. NAME OF FATHER

Joseph E. Lay

11. BIRTHPLACE OF FATHER

(State or Country)

Mo

12. MAIDEN NAME OF MOTHER

Julia S. Jackson

13. BIRTHPLACE OF MOTHER

(State or Country)

Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Dec. 11 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec. 10
(Month)*1922*
(Day)*19*
(Year)17. I HEREBY CERTIFY, That I attended *Investigated* from *Death*

19 to 19

that I last saw him alive on 19

and that death occurred on the date stated above, at *6:30 P.M.*

The CAUSE OF DEATH* was as follows:

Pneumo-pneumonia

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

W. E. Patrie
Co. Clin.

M. D.

(Address)

Blanchfort, Mo

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morland Idaho Dec. 11 1922

20. UNDERTAKER

ADDRESS

Joseph L. Lay Blanchfort, Mo

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
JAN 3 1923

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Statistics

1. PLACE OF DEATH

County of Bingham Registration District No. 121
City of Blackfoot Registration District No. 2194
(No. Blackfoot St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Nora NetzlerFile No. 40377Registered No. 187

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

Caucasian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

March 18 1892
(Month) (Day) (Year)

7. AGE

29 yrs. 8 mos. 24 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)None

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Martha A. High - Bookkeeper
(Address) Idaho Avenue, Greyling, Blackfoot

15.

Filed Dec 13 1922 at Blackfoot by Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

December 13 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 12, 1919 to Dec. 13, 1922
that I last saw her alive on Dec. 12, 1922
and that death occurred on the date stated above, at 12:00 A.M.
The CAUSE OF DEATH* was as follows:Status Epilepticus(Duration) Yrs. 2 mos. 2 ds.Contributory (Secondary) Chronic Epilepsy(Duration) 20 yrs. 9 mos. 24 ds.(Signed) Car. J. Logan M.D.12-13-22 (Address) Blackfoot, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 4 yrs. 11 mos. 24 days In the State 29 yrs. 8 mos. 24 daysWhere was disease contracted if not at place of death? UnknownFormer or usual residence Grant, Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Regby Ida on arrival20. UNDERTAKER E. L. Egli

ADDRESS

Blackfoot

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH

JAN 3 1922

Registration District No. 121

County of

Bingham

BUREAU OF VITAL

Registration District No.

2194

City of

Blackfoot

STATISTICS

(No. 121) Idaho, Brane Canyon St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Arthur J. Johnson

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

40378

Registered No.

183

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Male

4. COLOR OR RACE

Caucasian

5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDSingle
(Write the word.)

6. DATE OF BIRTH

August 1, 1882
(Month) (Day) (Year)

7. AGE

40 Yrs. 4 Mos. 13 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Farmer

9. BIRTHPLACE

(State or Country)

Minnesota

10. NAME OF FATHER

Nels Johnson

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME OF MOTHER

Agusta Gunderson

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Martha E. Fitch - Bookkeeper

(Address) Idaho Insane Asylum - Belp.

15.

Filed

Dec 15 1922 Mrs. Helen E. Fitch

Local Registrar

16. DATE OF DEATH

Dec 14 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

November 29, 1921, to Dec 14, 1922

that I last saw him alive on Dec 14, 1922

and that death occurred on the date stated above, at 12:30 P.M.

The CAUSE OF DEATH* was as follows:

General St. Cerebral Paralysis

(Duration) Yrs. 1 mos. ds.

Contributory (Secondary)

Paralysis

(Duration) 2 yrs. 9 mos. ds.

(Signed)

G. A. Hays M. D.

12-14-1922 (Address) Blackfoot, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 1 yrs. 15 mos. 15 days. In the State 11 yrs. 11 mos. 15 days

Where was disease contracted if not at place of death?

Unknown

Former or usual residence

Fairfield

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Asylum Cemetery

12/16 1922

20. UNDERTAKER

ADDRESS

H. E. Wilkerson

Blackfoot, Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Bingham*City of *Blackfoot*

If death occurs away from usual residence, give facts called for under special information.

Registration District No. *121*Primary Registration District No. *2194*

CNo.

St.)

File No. *40379*Registered No. *184*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

LeWayne W. Monson

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

male

4. COLOR OR RACE

*White*5. SINGLE, MARRIED, WID-
OWED OR DIVORCED*(Widowed)*

6. DATE OF BIRTH

*Dec**20**1922*

(Month)

(Day)

(Year)

7. AGE

+ Yrs. *+* Mos. *18* ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

None

9. BIRTHPLACE

(State or Country)

Blackfoot

10. NAME OF FATHER

Vernon L Monson

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Clara Westover

13. BIRTHPLACE OF MOTHER

(State or Country)

Colo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

*V. L. Westover
Pch 1 Blackfoot*

15.

Filed

See to Mr. M. E. Peterson

Local Registrar

16. DATE OF DEATH

*December 20**1922*

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

12/14 1921 to *19*that I last saw him alive on *12/14* 1922and that death occurred on the date stated above, at *9 A.* M.

The CAUSE OF DEATH* was as follows:

pneumonia broncho(Duration) Yrs. mos. *3* ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *J. O. Hampton* M. D.*12/20/1922* (Address) *Blackfoot Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Preston Ida**On arrival*

20. UNDERTAKER

ADDRESS

*E. L. Egli**Blackfoot*

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bingham
City of DurhamRegistration District No. 121Primary Registration District No. 2194

(No. _____ St.)

File No. 40380Registered No. 185

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Alice Bernadine Gerratt

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Nov 8 1901
(Month) (Day) (Year)

7. AGE

1 Yrs. 14 Mos. 4 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

None

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Durham Bingham Co Idaho

10. NAME OF FATHER

Charles W. Gerratt

11. BIRTHPLACE OF FATHER

(State or Country)

Durham

12. MAIDEN NAME OF MOTHER

Mellie E. Parsons

13. BIRTHPLACE OF MOTHER

(State or Country)

Durham

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ed Gerratt

(Address)

Durham Idaho

15.

Filed Dec 20 1922 at Durham by M. E. Puterbaugh

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 20 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

death 19____ to 19____

that I last saw him _____ alive on _____ 19____

and that death occurred on the date stated above, at 1:30 M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia(Duration) _____ Yrs. _____ mos. 9 ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

M. E. Puterbaugh M. D.(Address) Durham Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or

usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Durham Idaho Dec 21 1922

20. UNDERTAKER

ADDRESS

Fanny Parsons Durham

RECEIVED CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bingham Registration District No. 121
City of Blackfoot Primary Registration District No. 2194
(No. CS St.)File No. 40381
Registered No. 186

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Garth K. Fjeldsted

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-OWED OR DIVORCED

Male WhiteSingle
(Write the word.)

6. DATE OF BIRTH

August 4 1917
(Month) (Day) (Year)

7. AGE

25 Yrs. 4 Mos. 18 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).None

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Edgar N. Fjeldsted

11. BIRTHPLACE OF FATHER

(State or Country)

Logan Utah

12. MAIDEN NAME OF MOTHER

Ella Roford

13. BIRTHPLACE OF MOTHER

(State or Country)

Trenton Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Edgar Fjeldsted

(Address)

Blackfoot R.R. 5

15.

Filed

Dec. 22 1922 Mr. H. C. F. Fjeldsted

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 22 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 22 1922 to Dec 22 1922
that I last saw him alive on Dec 22 1922
and that death occurred on the date stated above, at 2:10 P.M.

The CAUSE OF DEATH* was as follows:

Kicked in head by horse fracturing skull with loss of brain tissue
(Duration) 1 Yrs. 1 mos. 1 hourContributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. W. Beck

M. D.

12/22 1922 (Address) Blackfoot Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

W. W. BeckBlackfoot Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

40382

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Lamphong*City of *Blackfoot*Registration District No. *121*Primary Registration District No. *1007*(No. *14 North E. Main* St.)

File No. _____

Registered No. *187*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Francis Maria Kempsey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female*4. COLOR OR RACE *White*5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Married
(Write the word.)

6. DATE OF BIRTH

May 18 1849
(Month) (Day) (Year)

7. AGE

73 Yrs. *7* Mos. *7* ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)*Housekeeper*

9. BIRTHPLACE

(State or Country)

New York

10. NAME OF FATHER

Stephen Explorator

11. BIRTHPLACE OF FATHER

(State or Country)

New York

12. MAIDEN NAME OF MOTHER

Mary Ann Lawsey

13. BIRTHPLACE OF MOTHER

(State or Country)

New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

H. Hunter

(Address)

14 N. E. Main St. Blackfoot Idaho

15. Filed

Nov 26 1911

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 25 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 20 1922 to *Dec 25 1922*that I last saw him alive on *Dec 25 1922*and that death occurred on the date stated above, at *7:00 PM*

The CAUSE OF DEATH* was as follows:

Valvular disease heart-muscle(Duration) *3* Yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. *3* mos. _____ ds.

(Signed)

W. E. Puterbaugh

M. D.

12/26/22 (Address) *Blackfoot Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Helena Mont

19

20. UNDERTAKER

ADDRESS

E. J. Rusk Blackfoot

CERTIFICATE OF DEATH

40383

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Bingham*
City of *Groveland*Registration District No. *131*Primary Registration District No. *2194*

(No., St.)

File No.

Registered No. *188*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William Herbst

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

Nov. *12* *1858*
(Month) (Day) (Year)

7. AGE

64 Yrs. *1* Mos. *4* ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Farmer

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Pa.

10. NAME OF FATHER

John Herbst

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Anna Eva Bettmeyer

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Sarah G. Herbst

(Address)

Groveland, Ida.

15.

Filed *Dec 17* *1922* *Mrs. Sarah G. Herbst*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec. *16* *1922*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

*Oct 1, 1922, to Dec 16, 1922.*that I last saw him alive on *Nov 15, 1922*and that death occurred on the date stated above, at *12:05 A.M.*

The CAUSE OF DEATH* was as follows:

Diabetes mellitus(Duration) *7* Yrs. *1* mos. *1* ds.Contributory
(Secondary)(Duration) *7* yrs. *1* mos. *1* ds.

(Signed)

W. B. Beck M. D.*Dec 19, 1922* (Address) *Blackfoot, Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Groveland Cem.

DATE OF BURIAL

12/19, 1922

20. UNDERTAKER

C. L. Egli

ADDRESS

Blackfoot

CERTIFICATE OF DEATH

40384

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Bernham*
City of *Blacksfoot*

If death occurs away from usual residence, give facts called for under special information.

RECEIVED

Registration District No. *121*
Primary Registration District No. *2194*
(No. *1* St.)File No. *189*
Registered No. *189*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Zelma Rose Mitchell

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *Female* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *single*
(Write the word.)

6. DATE OF BIRTH

Oct 23 1922
(Month) (Day) (Year)

7. AGE

2 Yrs. *4* Mos. *4* ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work *none*
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) *Blacksfoot*

10. NAME OF FATHER

Erastus B. Mitchell

11. BIRTHPLACE OF FATHER

(State or Country) *Idaho*

12. MAIDEN NAME OF MOTHER

Emma Plant

13. BIRTHPLACE OF MOTHER

(State or Country) *Idaho*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Erastus B. Mitchell*
(Address) *Rt. 7 B. No. 1*

15.

Filed *Dec 28 1922**Mr. Hester E. Farnes*
Local Registrar

16. DATE OF DEATH

Dec 28 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *Dec 27 1922* to *Dec 28 1922*that I last saw *her* alive on *Dec 28 1922*
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

pneumonia - Broncho.
(Duration) _____ Yrs. _____ mos. *4* ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) *F. W. Mitchell* M. D.

19 _____ (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Funeral Home *Dec 28 1922*

20. UNDERTAKER

ADDRESS

Ed. H. Hark *Blacksfoot*

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 57

County of Blaine

Registration District No. 2022

City of Bellevue

St.)

File No. 40386

Registered No. 57

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Ann Jane Ashton

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

113
Wright.

16. DATE OF DEATH

Dec. 6 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov-10 1922 to Dec-5 1922

that I last saw her alive on Dec-5 1922

and that death occurred on the date stated above, at 59 M.

The CAUSE OF DEATH* was as follows:

Cirrhosis of liver

(Duration) 1 Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Robert H. Wright M. D.

1-3 1923 (Address) Stanley, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bellevue

Dec 9 1922

20. UNDERTAKER

ADDRESS

R. H. Harris

Stanley

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

married
(Write the word.)

6. DATE OF BIRTH

May 26 1848
(Month) (Day) (Year)

7. AGE

74 Yrs. 6 Mos. 10 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Housewife

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Wales

10. NAME OF FATHER

Edward Edwards

11. BIRTHPLACE OF FATHER

(State or Country)

Wales

12. MAIDEN NAME OF MOTHER

Mary Edwards

13. BIRTHPLACE OF MOTHER

(State or Country)

Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

R. H. Wright

(Address)

Bellevue Ida

15.

Filed 1-1 1923 R. H. Wright.

Local Registrar

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **40387**Registered No. **40**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Blaine
City of BellefleurRegistration District No. 57Primary Registration District No. 7022(No. 4 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Edward Ashton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED widowed
(Write the word.)

6. DATE OF BIRTH

Feb 7 1847
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day
how many.....hrs.
or.....min.?
Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Miner

9. BIRTHPLACE

(State or Country)

Wales

10. NAME OF FATHER

✓

11. BIRTHPLACE OF FATHER

(State or Country)

✓

12. MAIDEN NAME OF MOTHER

✓

13. BIRTHPLACE OF MOTHER

(State or Country)

✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ed Ashton
(Address) Bongnah Nevada15. Filed 1-1-23 19 23 R. H. Wright
Local Registrar

MEDICAL CERTIFICATE OF DEATH

94

16. DATE OF DEATH

Dec 27 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Dec-24 19 22 to Dec-27 19 22
that I last saw him alive on Dec-27 19 22
and that death occurred on the date stated above, at 11:30 P M.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema(Duration) Yrs. mos. ds. 7
Contributory (Secondary) Chronic Aschma(Duration) yrs. mos. ds. 1/3
(Signed) Robert H. Wright M. D.
(Address) Hailey Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Bellefleur, Ida. DATE OF BURIAL Dec 27, 192220. UNDERTAKER R. H. Harris ADDRESS Hailey

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
JAN 10 1923
CERTIFICATE OF DEATHState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **40388**Registered No. **41**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of *Blaine*City of *Hailey*Registration District No. *57*Primary Registration District No. *2022*

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

M. A. Humphrey

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

widowed
(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

1 (Year)

7. AGE

71

Yrs.

Mos.

ds.

IF LESS than 1 day

how many _____ hrs.

or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Miner.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

John A. Humphrey

11. BIRTHPLACE OF FATHER

(State or Country)

Kentucky

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

E. A. Humphrey
Hailey, Idaho

15.

Filed

1-1

19

*23**R. H. Wright*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

19

16. DATE OF DEATH

*Plummer**Dec*
(Month)*5*
(Day)*22*
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 _____ to 19 _____

that I last saw him alive on *Dec 3* 19*22*and that death occurred on the date stated above, at *7 A.M.*

The CAUSE OF DEATH* was as follows:

Heart Failure
(Died in sleep)

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

J. J. Plummer M. D.19*22* (Address) *Hailey, Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Hailey

DATE OF BURIAL

Dec 6 19*22*

20. UNDERTAKER

J. J. Plummer

ADDRESS

Hailey

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Blaine

City of Hailey

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 57

Primary Registration District No. 2022

(No. 57)

St.)

File No. 40389

Registered No. 42

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Clia Schaefer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

Wht.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

married
(Write the word.)

6. DATE OF BIRTH

June 29 1883
(Month) (Day) (Year)

7. AGE

39 Yrs. 5 Mos. 9 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

House wife

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

James T. Carothers

11. BIRTHPLACE OF FATHER

(State or Country)

Missouri

12. MAIDEN NAME OF MOTHER

Sarah Wooster

13. BIRTHPLACE OF MOTHER

(State or Country)

Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Louis B. Schaefer
Hailey Idaho

(Address)

15.

Filed 1-3 1923

R. H. Wright
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 8 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 2 1922, to Dec 8 1922, that I last saw him alive on Dec 8 1922, and that death occurred on the date stated above, at 5 P.M.
The CAUSE OF DEATH* was as follows:
Batulinus Poisoning

(Duration) Yrs. mos. 9 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) E. H. Reed M. D.

1922 (Address) Hailey Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Hailey Ida.

DATE OF BURIAL

Dec 10 1922

20. UNDERTAKER

J. D. Harris

ADDRESS

Hailey

FORM V. S. No. 5-A—25 M. 1-19.

1. PLACE OF DEATH

County of Blaine
City of Carey

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No. 57Primary Registration District No. 7075

(No. _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 40390Registered No. 40390

If death occurred in hospital, institution, or camp, give its NAME and street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

married
(Write the word.)

6. DATE OF BIRTH

Nov. 6 1916
(Month) (Day) (Year)

7. AGE

26 Yrs. 1 Mos. 24 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Housework

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

John Smith Park

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Martha M. Parker

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Elmo F. Howard

(Address)

Carey, Idaho

15.

Filed 1-819 23P. H. Wright

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec. 30
(Month) (Day)17. I HEREBY CERTIFY, That I attended deceased from Dec 30 19 22 to Dec 30 19 22that I last saw her alive on Dec 30 19 22
and that death occurred on the date stated above, at _____

The CAUSE OF DEATH* was as follows:

Mitral Stenosis(Duration) 5 Yrs. _____ mos.Contributory
(Secondary)Ascites(Duration) 2 yrs. _____ mos.

(Signed)

Houston E. Snyder12-30-19-22 (Address) Carey Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Carey, Idaho

DATE OF BURIAL

Jan. 1

20. UNDERTAKER

Mrs. Elmo F. Howard

ADDRESS

Carey

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Boise
City of Idaho

Registration District No. 12

Primary Registration District No. 12

File No. 40391

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Al Chow

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

dark

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

unknown

(Month)

(Day)

1

(Year)

7. AGE

about 75

Yrs.

Mos.

ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

minor

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

China

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Dec 16 1922 Mrs E. K. Hobson

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

found dead Dec 16th
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

..... 19....., to 19.....

that I last saw h..... alive on..... 19.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:-

Heart trouble

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)..... M. D.

19..... (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho City

..... 19.....

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **40392**
Registered No. **12**1. PLACE OF DEATH **RECEIVED**
County of **Baile** Registration District No. **12**
City of **Baile** Primary Registration District No. **12**
City of **Baile** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary Ann Woods

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WID-OWED OR DIVORCED
(Write the word.)6. DATE OF BIRTH **Oct 18**
(Month) (Day) (Year)7. AGE **2 days**
Yrs. Mos. **2 days**
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)9. BIRTHPLACE
(State or Country) **Baile**10. NAME OF FATHER **Elmer Woods**11. BIRTHPLACE OF FATHER
(State or Country) **Colorado**12. MAIDEN NAME OF MOTHER **Mary Tuller**13. BIRTHPLACE OF MOTHER
(State or Country) **Colorado**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Mrs E. E. Johnson**
(Address) **Baile**15. Filed **Dec 8 1922** **Mrs E. E. Johnson**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 12
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from **19** to **19**
that I last saw h..... alive on **19**
and that death occurred on the date stated above, at **M.**
The CAUSE OF DEATH* was as follows:
death know(Duration) Yrs. mos. ds.
Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) **M. D.****19** (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **Baile** DATE OF BURIAL **Oct 13 1922**

20. UNDERTAKER ADDRESS

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH *Idaho*
 County of *Boise* Registration District No. *12*
 Primary Registration District No.
 City of *Boise* (No.) St.

File No. *40393*
 Registered No. *12*

If death occurs away from
 usual residence, give facts
 called for under special in-
 formation.

2. FULL NAME

Richard Marion Woods.

If death occurred in a hos-
 pital, institution or camp,
 give its NAME instead of
 street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED
widower.
 (Write the word.)

6. DATE OF BIRTH
August *29* *1892*
 (Month) (Day) (Year)

7. AGE *85* Yrs. *1* Mos. *28* ds.
 IF LESS than 1 day
 how many..... hrs.
 or..... min.?

8. OCCUPATION

(a) Trade, profession or
 particular kind of work
 (b) General nature of in-
 dustry, business or estab-
 lishment in which employ-
 ed (or employer)

Farmer.

9. BIRTHPLACE

(State or Country)

Alabama.

10. NAME OF FATHER

Richard Woods.

11. BIRTHPLACE OF FATHER

(State or Country)

South Carolina.

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

North Carolina.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mrs Frank Thompson.*
 (Address) *Horseshoe Bend.*

15. *Filed* *Apr 5 1922* *Mrs Ed Robison*
 Local Registrar

16. DATE OF DEATH

Feb 30
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
 19....., to 19.....
 that I last saw h..... alive on 19.....
 and that death occurred on the date stated above, at M.
 The CAUSE OF DEATH* was as follows:

No Boats.

..... (Duration) Yrs. mos. ds.

Contributory
 (Secondary)

..... (Duration) yrs. mos. ds.

(Signed) M. D.

..... 19..... (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state
 (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted
 if not at place of death?

Former or
 usual residence

19. PLACE OF BURIAL OR REMOVAL *Horse Shod* DATE OF BURIAL *Feb 31, 1922*

20. UNDERTAKER ADDRESS

MARGIN RESERVED FOR BINDING
 WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
 N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Boise

City of _____

If death occurs away from usual residence, give facts called for under special information.

Registration District No. _____

Primary Registration District No. _____

(No. _____, _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 40394

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Frank Eel.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

single
(Write the word.)

6. DATE OF BIRTH

not known.

(Month)

(Day)

1922
(Year)

7. AGE

95

Yrs.

Mos.

ds.

IF LESS than 1 day

how many _____ hrs.

or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

miner.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Boston, Mass.

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Frank Thompson.(Address) Horseshoe Bend, Ida.

15.

Filed Dec 5 1922Mrs. E. P. Thom.

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 29

(Month)

(Day)

1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 19____, to _____ 19____.

that I last saw him _____ alive on _____ 19____.

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

old age.

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed) no doctor

M. D.

_____ 19____ (Address) _____

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs _____ mos _____ days. In the State _____ yrs _____ mos _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Horse Shoe Bend

DATE OF BURIAL

Sept 30, 1922

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **40395**Registered No. **72**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

Registration District No. _____
County of Boise Primary Registration District No. 12
City of Hase Shoebud (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Isabel Drake

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED divorced
(Write the word.)6. DATE OF BIRTH April 18th 1922
(Month) (Day) (Year)7. AGE 56 Yrs. _____ Mos. _____ ds. IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Housewife.
(b) General nature of industry, business or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country) Sioux City, Ia.

10. NAME OF FATHER

George Humphrey.

11. BIRTHPLACE OF FATHER

(State or Country) _____

12. MAIDEN NAME OF MOTHER

Pearlee Hall.

13. BIRTHPLACE OF MOTHER

(State or Country) _____

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Frank Thompson.
(Address) Hase Shoebud15. Filed Dec 5 1922 Mrs E. R. Brown
Local RegistrarMEDICAL CERTIFICATE OF DEATH 79

16. DATE OF DEATH

Nov 25 19_____
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 19_____, to _____ 19_____,

that I last saw him alive on _____ 19_____,

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Heart trouble stopped dead.

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

_____ 19_____. (Address) _____

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Hase Shoebud

DATE OF BURIAL

Nov 27, 1922

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of **Bonner**City of **Priest River**Registration District No. **85**Primary Registration District No. **2185**

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jacob HarmonState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **40396**

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

White5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Widower
(Write the word.)

6. DATE OF BIRTH

Sept. 15 1851
(Month) (Day) (Year)

7. AGE

71 Yrs. 3 Mos. 2 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Farmer

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Mo.

10. NAME OF FATHER

Jacob Harmon.

11. BIRTHPLACE OF FATHER

(State or Country)

Virg.

12. MAIDEN NAME OF MOTHER

Francis Powers.

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Mrs. H. R. Wilhelm**(Address) **Portland Ore 1600 Hodge St**

15.

Filed **Jan 1 1922**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 17 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
Dec 15 1922 to Dec 17 1922that I last saw him alive on **Dec 17 1922**
and that death occurred on the date stated above, at **3.10 P.M.**

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.(Duration) Yrs. mos. **2** ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Dec 17 1922 (Address) **Priest River, Ida.**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Newport. Wash.

DATE OF BURIAL

Dec 19, 22

20. UNDERTAKER

Wm Davis.

ADDRESS

Newport

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Bonner
City of Priest River, (No. St.)
Registration District No. 85
Primary Registration District No. 2185

File No. 40397
Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Henry J. Linton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH
Aug 11 1856
(Month) (Day) (Year)

7. AGE 66 Yrs. 4 Mos. 5 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Hotel Prop.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE
(State or Country) Ohio.

10. NAME OF FATHER
Tuomal O. Linton.

11. BIRTHPLACE OF FATHER
(State or Country) Maryland.

12. MAIDEN NAME OF MOTHER
Rosie Robinett

13. BIRTHPLACE OF MOTHER
(State or Country) Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William J. Linton
(Address) Priest River, Ida.

15. Filed Jan 1 1923

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 16 1922 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1922, to Dec 16 1922 19...
that I last saw within live on Dec 15 1922 19...
and that death occurred on the date stated above, at 2.35M.
The CAUSE OF DEATH* was as follows: A.M

Chronic valvular heart disease

(Duration) 1 Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) [Signature] M. D.Dec 17, 1922 (Address) Priest River

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL
Priest River,DATE OF BURIAL
Dec 23 192220. UNDERTAKER
Wm DavisADDRESS
Newport.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Bonner
City of Dover-Hospital

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jennie Lithgow

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WID-OWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

March 1 1885
(Month) (Day) (Year)

7. AGE

37 Yrs. 9 Mos. 26 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Dressmaking

9. BIRTHPLACE

(State or Country)

neb.

10. NAME OF FATHER

George Hazen

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Alice Woodard

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Roy L. Leonard
(Address) Sandpoint

15.

Filed Jan 3 1923Viola Allen
Deputy Local Registrar

SYNOPSIS CO. PRINTERS & BINDERS, BOISE 51088

Dr Jackson
RECEIVED
JAN 8 1923
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

JAN 8 1923

Registration District No. 78Registration District No. 2155

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 40398

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

December 27 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
Dec 19 1922, to Dec 27 1922
that I last saw her alive on Dec 27 1922
and that death occurred on the date stated above, at 5-a M.

The CAUSE OF DEATH* was as follows:

Rheumatic Endocarditis(Duration) _____ Yrs. 6 mos. 2 ds.Contributory Uremic Convulsions
(Secondary)(Duration) _____ yrs. _____ mos. 2 ds.(Signed) R. H. Jackson M. D.Dec 27, 1922 (Address) Dover, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. 6 days. In the 20 yrs. _____ mos. _____ daysWhere was disease contracted if not at place of death? Priest River, IdaFormer or usual residence Sandpoint, Ida

19. PLACE OF BURIAL OR REMOVAL

Sandpoint, Idaho

DATE OF BURIAL

12/30 1922

20. UNDERTAKER

MOON & DALE

ADDRESS

Sandpoint, Idaho

Dr Wendle

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 40399

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Conner Registration District No. 78
City of Sandpoint Registration District No. 2155 St.)

If death occurs away from usual residence, give facts called for under special information.

BUREAU OF VITAL STATISTICS

2. FULL NAME Alberto Luna

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH

Unknown
(Month) (Day) (Year)

7. AGE

23 Yrs. - Mos. - ds. IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Not Known.

9. BIRTHPLACE

(State or Country)

Unknown

10. NAME OF FATHER

Graybill Luna

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

"

13. BIRTHPLACE OF MOTHER

(State or Country)

"

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

L. S. Moon

(Address)

Sandpoint Idaho.

15.

Filed Jan 3 1923Viola Allen
Deputy Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec. 16 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec-15- 1922, to Dec-16 1922that I last saw him alive on Dec-15- 1922and that death occurred on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:

Accidental burning result of being overcome by gas in Mr. Refrigerator car
(Duration) Yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Floyd C. Wendle M. D.1-3 1923 (Address) Sandpoint, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lawrence Cemetery12/29/22

20. UNDERTAKER

ADDRESS

MOON & DALESandpoint, Idaho
L. S. Moon

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bonner
City of SandpointRegistration District No. 78Primary Registration District No. 2155File No. 40400

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William James McBride

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

MaleWhiteSingle (When the word.)

6. DATE OF BIRTH

May 21 1913
(Month) (Day) (Year)

7. AGE

9 Yrs. 6 Mos. 24 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Schoolboy.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

William McBride

11. BIRTHPLACE OF FATHER

(State or Country)

Wyo.

12. MAIDEN NAME OF MOTHER

Cora O'Raka

13. BIRTHPLACE OF MOTHER

(State or Country)

Wis.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

William McBride

(Address)

Sandpoint, Idaho.

15.

Filed Jan 3 1923Viola Allen
Deputy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec. 15 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Dec - 8 1922, to Dec - 15 1922, that I last saw him alive on Dec - 14 1922, and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Septicemia due to Auto-intoxication(Duration) _____ Yrs. _____ mos. 10 ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

John S. Wendt

M. D.

1-3 1923(Address) Sandpoint, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lakeview Cemetery12/18 1922

20. UNDERTAKER

MOON & DALE

ADDRESS

Sandpoint, Idaho.L. S. Moon

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **40401**

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of **Bonner**
City of **Sandpoint**Registration District No. **76**Primary Registration District No. **2153**

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

David James Williamson.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male**White****Widowed**

(Give the word.)

6. DATE OF BIRTH

October 6, 1846.

(Month)

(Day)

(Year)

7. AGE

76 Yrs. — **28** Mos. — ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Blacksmith

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

New York

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

"

12. MAIDEN NAME OF MOTHER

"

13. BIRTHPLACE OF MOTHER

(State or Country)

"

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Dr. Williamson

(Address)

Sandpoint, Idaho.

15.

Filed

Jan 3 1923

Local Registrar

Vivian Allen**Deputy**

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov. 4, 1922.

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov. 4 1922 to Nov. 4 1922that I last saw him alive on **Nov. 4 1922**and that death occurred on the date stated above, at **C.P.M.**

The CAUSE OF DEATH* was as follows:

Chronic Endo-renal disease with edema(Duration) **2** Yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

H. R. Waller M. D.**12-13-22** (Address) **Sandpoint Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Lakeview Cemetery

DATE OF BURIAL

11/6 22.

20. UNDERTAKER

MOON & DALE

ADDRESS

Sandpoint, Idaho.By **J. Moon**

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of BonnerCity of Sandpoint

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 78Primary Registration District No. 2155

(No.)

(St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 40402

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED
JAN 8 1923
BUREAU OF VITAL
STATISTICS

2. FULL NAME

Thomas McKay

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDSingle
(Write the word.)

6. DATE OF BIRTH

Not Known
(Month) (Day) (Year)

7. AGE

3
1/2 about
Yrs. Mos. da.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Woodman

9. BIRTHPLACE

(State or Country)

Unknown

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

City Hospital

(Address)

Sandpoint Idaho

15.

Filed Jan 3 1923Viola Allen
Deputy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

December 20 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Dec 17 1922 to Dec 20 1922
that I last saw him alive on Dec 19 1922
and that death occurred on the date stated above, at 4 A. M.

The CAUSE OF DEATH* was as follows:

Peritonitis due to
Attack of Peritonitis
Appendicitis(Duration) Yrs. mos. 6 ds.Contributory (Secondary) Appendicitis(Duration) yrs. mos. 6 ds.(Signed) O. J. Papp M. D.Dec 19 1922 (Address) Sandpoint Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lakewood Cemetery12/29 1922

20. UNDERTAKER

ADDRESS

MOON & DALESandpoint Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40403**
Registered No. _____

1. PLACE OF DEATH

County of Bonner Registration District No. 76
City of Sandpoint Primary Registration District No. 2155
(No. _____) (St.) _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Marrietta Woods Wendle

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widowed
(Write the word.)

6. DATE OF BIRTH

March 17 1891
(Month) (Day) (Year)

7. AGE

81 Yrs. 8 Mos. 26 ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Housewife retired

9. BIRTHPLACE

(State or Country)

Ogle County, Ill.

10. NAME OF FATHER

John Woods

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Henriette Barber

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Floyd G. Wendle

(Address) Sandpoint, Ida

15. Filed Jan 3 1923

Viola Allen
Deputy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

December 13 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1916, to Dec-13 1922, that I last saw her alive on Dec-13 1922, and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

General Debility resulting from accidental Fall

(Duration) Yrs. 1 1/2 mos. _____ ds.

Contributory (Secondary)

(Duration) yrs. _____ mos. _____ ds.

(Signed) Floyd G. Wendle M. D.

1-4-1923 (Address) Sandpoint, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hope, Idaho 12/16 1922

20. UNDERTAKER

ADDRESS

Thoon & Dale Sandpoint Ida
By L. Thoon

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Dr. Stackhouse

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40404**

1. PLACE OF DEATH

County of *Bonner*
City of *Glenary*

Registration District No. *78*
Primary Registration District No. *2155*
(No. St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William Dixon Cornagey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

Mar. 8 1851
(Month) (Day) (Year)

7. AGE

71 Yrs. Mos. ds.
IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Farmer.

9. BIRTHPLACE

(State or Country) *Tenn*

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country) *"*

12. MAIDEN NAME OF MOTHER

"

13. BIRTHPLACE OF MOTHER

(State or Country) *"*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *George Cornagey*
(Address) *Glenary, Tenn*

15. Filed *Jan 4 1923*

Viola Allen
Jan 4 1923
Deputy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov. 10 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *3-22-1921* to *Nov 10 1922*

that I last saw him alive on *Oct 27 1922*

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage, Left

(Duration) Yrs. mos. *17* ds.

Contributory (Secondary) *Myocarditis, Angina pectoris*

(Duration) Yrs. mos. *8* ds.

(Signed) *G. P. Stackhouse M. D.*

1/4 1923 (Address) *Sandpoint Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Boston, Idaho

DATE OF BURIAL

10/12 1922

20. UNDERTAKER

Wm. Dale
124 N. 1st

ADDRESS

Sandpoint, Idaho

Cornel Moore

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **40405**

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH RECORD
County of Bonner JAN 3 1923
City of Sandpoint (State) ID.
Registration District No. 78
Primary Registration District No. 2155

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ed John Young

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

175 a

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Word.)6. DATE OF BIRTH Unknown
(Month) (Day) (Year)7. AGE 45 about
Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Unknown
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Unknown

10. NAME OF FATHER

"

11. BIRTHPLACE OF FATHER

(State or Country) "

12. MAIDEN NAME OF MOTHER

"

13. BIRTHPLACE OF MOTHER

(State or Country) "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) L. B. Moon(Address) Sandpoint Ida.

15.

Filed Jan 3 19 23Viola Allen
Deputy Local Registrar

16. DATE OF DEATH

December 19 19 22
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from 19 to 19that I last saw him alive on 19and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Accidental - Struck by Train on R.R. Ry
(Duration) Yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

L. B. Moon M. D.
vi/19/22 (Address) Sandpoint

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Leeview Cemetery12/21 1922

20. UNDERTAKER

MOON & DALE

ADDRESS

Sandpoint, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Dr. Wendle

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **40406**

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH **RECEIVED**
Registration District No. **78**
County of *Bonner* JAN 8 1923
City of *Sandpoint* **BUREAU OF VITAL STATISTICS** Primary Registration District No. *2155* (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Charles Dixon*

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*
(Write the word.)6. DATE OF BIRTH *Unknown*
(Month) (Day) (Year)7. AGE *70* Yrs. Mos. ds. IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work *Farmer*
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) *Unknown*

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *City Hospital*
(Address) *Sandpoint Idaho*15. Filed *Jan 3* 1923 *Viola Allen*
Deputy Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

16. DATE OF DEATH *Dec. 20* 19 *22*
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *Dec-6* 19 *22* to *Dec-20* 19 *22*, that I last saw him alive on *Dec-19* 19 *22*, and that death occurred on the date stated above, at *2 P* M.

The CAUSE OF DEATH* was as follows:

Senility - General Debility

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *Floyd B Wendle* M. D.*1-3* 19 *23* (Address) *Sandpoint Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Lakeview Cemetery* DATE OF BURIAL *12/28* 19 *22*20. UNDERTAKER *MOON & DALE* ADDRESS *Sandpoint Idaho**E. B. Moon*

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **40407**

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Bonner
City of SandpointRegistration District No. 78January 1922
Registration District No. 2155

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

STATISTICS

Horace Lorenzo Bennett

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

Nov. 19, 1860
(Month) (Day) (Year)

7. AGE

62 Yrs. 14 Mos. 4 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Cook.

(b) General nature of industry, business or establishment in which employed (or employer).

Restaurant

9. BIRTHPLACE

(State or Country)

Minn.

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

"

12. MAIDEN NAME OF MOTHER

"

13. BIRTHPLACE OF MOTHER

(State or Country)

"

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. V. L. Bennett

(Address)

Sandpoint Ida.

15.

Filed

Jan 3 1922Viola Allen
Deputy Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec. 3, 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 1921 to Dec - 3 - 1922that I last saw him alive on Dec - 2 - 1922and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis(Duration) 2 Yrs. _____ mos. _____ ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Floyd B. Wendle M. D.Jan 3, 1922 (Address) Sandpoint Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lakeview12/6 1922

20. MOON'S DALE

ADDRESS

A. G. MoonSandpoint Ida.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of **Bonner**
City of **Sandpoint**

Registration District No. **76**Primary Registration District No. **2155**

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Arthur E. Polley

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40408**

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married

(Write the word.)

6. DATE OF BIRTH

Nov. 17 1855.
(Month) (Day) (Year)

7. AGE

67 Yrs. **0** Mos. **10** ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Engineer

(b) General nature of industry, business or establishment in which employed (or employer).

Stationery

9. BIRTHPLACE

(State or Country)

Wis.

10. NAME OF FATHER

Wm. C. Polley

11. BIRTHPLACE OF FATHER

(State or Country)

Wis.

12. MAIDEN NAME OF MOTHER

Clariessa Reynolds

13. BIRTHPLACE OF MOTHER

(State or Country)

N.Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. E. Polley

(Address)

Sandpoint, Idaho.

15.

Filed **Dec 8 1922**

Viola Allen
Deputy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec. 7, 1922.

(Month)

(Day)

19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 1922 to **Dec 1922**
that I last saw him alive on **Dec - 7 1922**
and that death occurred on the date stated above, at **2 P** M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) **2** Yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Floyd G. Wardle M. D.

Dec 8 1922 (Address) **Sandpoint, Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL
Thompson Falls, Mont.

DATE OF BURIAL
19 _____

20. UNDERTAKER

ADDRESS

Moore & Dale
4. M. Dale **Sandpoint, Idaho**

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Bonner
City of Sandpoint

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

~~James Moore~~

CERTIFICATE OF DEATH

JAN 8

78

Registration District No. _____
BUREAU
STATISTICAL
Registration District No. 2155
(No. _____) (St. _____)State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 40409

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

About
25 Yrs. _____ Mos. _____ ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Not Known

9. BIRTHPLACE

(State or Country)

Unknown

10. NAME OF FATHER

A. C. Bloomfield

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) L. B. Moore(Address) Sandpoint, Idaho

15.

Filed Jan 3 1923Viola Allen
Deputy Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51083

16. DATE OF DEATH

about Dec. 15, 1922
Not Known
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____ 19_____, to _____ 19_____,

that I last saw h. _____ alive on _____ 19_____,

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Burns

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) L. M. Moore Coroner M. D.1922 (Address) Sandpoint Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Kearney Nebraska 12/19 1922

20. UNDERTAKER

MOON & DALE Sandpoint IdahoAlston

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Banner
City of Sandpoint

If death occurs away from usual residence, give facts for under special information.

2. FULL NAME

Registration District No. 78Primary Registration District No. 2155(No. 472 Church St.) St.)

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 40410Registered No. 153

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Aug 5 1922
(Month) (Day) (Year)

7. AGE

Yrs. 4 Mos. 1 ds.
IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

None

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Clarence F. McKenzie

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Mildred Oliver

13. BIRTHPLACE OF MOTHER

(State or Country)

Ore

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Clarence F. McKenzie(Address) Sandpoint, Idaho

15.

Filed Dec 13 1922Viola Allen
Deputy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 11 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

.....19....., to19.....

that I last saw h..... alive on.....19.....

and that death occurred on the date stated above, at.....M.

The CAUSE OF DEATH* was as follows:

Accidental due to
suffocation in bed

(Duration)Yrs.....mos.....ds.

Contributory
(Secondary)

(Duration)yrs.....mos.....ds.

(Signed) Floyd R. Wendle M. D.Dec 13 (Address) Sandpoint, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

McArthur, Idaho

DATE OF BURIAL

12/14 19 22

20. UNDERTAKER

MOON & DALE

ADDRESS

Sandpoint, Idaho

CERTIFICATE OF DEATH

1. PLACE OF DEATH **RECEIVED**
 Registration District No. 73
 County of Bannock JAN 10
 Primary Registration District No. 214-0
 City of Idaho Falls (No. 1 St.)
 If death occurs away from usual residence, give facts called for under special information.

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 40411
 Registered No. 181

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jens Larsen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widowed
 (Write the word.)

6. DATE OF BIRTH

Oct 7 1845
 (Month) (Day) (Year)

7. AGE

77 Yrs. 2 Mos. 9 ds.

IF LESS than 1 day
 how many..... hrs.
 or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

Farming

9. BIRTHPLACE

(State or Country)

Denmark

10. NAME OF FATHER

Lars Jensen

11. BIRTHPLACE OF FATHER

(State or Country)

Denmark

12. MAIDEN NAME OF MOTHER

?

13. BIRTHPLACE OF MOTHER

(State or Country)

Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

B. E. Jensen

(Address)

Idaho Falls, Id.

15. Filed Dec 23 19 22 Wm. D. Soderquist
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 11 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 9th 1922 to Dec 11 1922

that I last saw him alive on Dec 9 1922
 and that death occurred on the date stated above, at 1 P M.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(Duration) Yrs. mos. ds.

Contributory
 (Secondary)

(Duration) yrs. mos. ds.

(Signed)

P. P. Soderquist M. D.

Idaho Falls, Id. 1922 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cirie, Ida 12/13 1922

20. UNDERTAKER

ADDRESS

E. E. Woodward Idaho Falls

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
40412
File No. 140
Registered No. 140

1. PLACE OF DEATH **RECEIVED**
Registration District No. 73
County of Bonneville
Primary Registration District No. 21V-0
City of Idaho Falls (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Sato (Yumi)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE Japanese 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Infant
(Write the word.)

6. DATE OF BIRTH Dec 4 1922
(Month) (Day) (Year)

7. AGE 0 Yrs. 0 Mos. 3 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE Idaho Falls
(State or Country)

10. NAME OF FATHER B. Sato

11. BIRTHPLACE OF FATHER Japan
(State or Country)

12. MAIDEN NAME OF MOTHER Y. Hanzawa

13. BIRTHPLACE OF MOTHER Japan
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. Sato
(Address)

15. Filed Dec 23 1922 W. H. H. H.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 7 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19
that I last saw him alive on 19
and that death occurred on the date stated above, at 9 P. M.
The CAUSE OF DEATH* was as follows: Unknown

No physician

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) W. H. H. H. M. D.
12/25/22 (Address) Idaho Falls, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Idaho Falls, Ida DATE OF BURIAL 12/11/1922

20. UNDERTAKER G. H. H. H. ADDRESS Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bannock Registration District No. 23
 City of Idaho Falls Primary Registration District No. 215-0
 (No. of Vital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED
 JAN 9 1923
 BUREAU OF VITAL STATISTICS

Bobby Sato (Trin)

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 40413
 Registered No. 179

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female Japanese

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Infant
 (Write the word.)

6. DATE OF BIRTH

Dec 4 1922
 (Month) (Day) (Year)

7. AGE

0 Yrs. 0 Mos. 5 ds.

IF LESS than 1 day
 how many..... hrs.
 or..... min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho Falls

10. NAME OF FATHER

B. Sato

11. BIRTHPLACE OF FATHER

(State or Country) Japan

12. MAIDEN NAME OF MOTHER

Y. Hanzawa

13. BIRTHPLACE OF MOTHER

(State or Country) Japan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. Sato

(Address) Idaho Falls

15.

Filed Dec 23 1922 C. Sato
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 9 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19..... to 19.....

that I last saw h..... alive on 19.....

and that death occurred on the date stated above, at 10 A M.

The CAUSE OF DEATH* was as follows: Unknown

No Physician

(Duration) Yrs. mos. ds.

Contributory
 (Secondary)

(Duration) yrs. mos. ds.

(Signed) C. Sato M. D.

12/25/22 (Address) Idaho Falls, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Idaho Falls, Ida

DATE OF BURIAL

12/11 1922

20. UNDERTAKER

B. B. Woodward

ADDRESS

Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 40414
Registered No. 177

1. PLACE OF DEATH
County of Bonanza
City of Idaho Falls
Registration District No. 3
Vital Registration District No. 214-0
St. Idaho

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Norma Aron

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
6. DATE OF BIRTH Nov 25 1922
7. AGE 0 Yrs. 0 Mos. 21 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE Idaho
(State or Country)

10. NAME OF FATHER Harold Aron

11. BIRTHPLACE OF FATHER Idaho
(State or Country)

12. MAIDEN NAME OF MOTHER Sarah Rasmussen

13. BIRTHPLACE OF MOTHER Idaho
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Adarve
(Address) Idaho Falls

15. Filed Dec 23 1922
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 16 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 24 1922, to Dec 16 1922 that I last saw him alive on Dec 15 1922 and that death occurred on the date stated above, at 7:30 P. M.

The CAUSE OF DEATH* was as follows:
Branches pneumonia

(Duration) Yrs. mos. ds.
Contributory (Secondary) Pneumonia infant - 7-f
(Duration) yrs. mos. ds.
(Signed) W. J. Fennell M. D.
12/23 1922 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Payson, Ida 12/17 1922
20. UNDERTAKER ADDRESS
B. B. Rasmussen, Idaho Falls

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Banner
City of Idaho FallsRegistration District No. 73Primary Registration District No. 215-0(No. 177)

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 40415Registered No. 177

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Hannah C. Safestrom

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widowed
(Write the word.)

6. DATE OF BIRTH

Dec 25 1863
(Month) (Day) (Year)

7. AGE

58 Yrs. 11 Mos. 10 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)at Home

9. BIRTHPLACE

(State or Country)

Sweden

10. NAME OF FATHER

Daniel Pohu

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME OF MOTHER

?

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

C. E. Duenow
Idaho Falls, Ida

Local Registrar

15.

Filed

Dec 23 1922 afternoon

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 5 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov. 1 1922 to Dec 5 1922that I last saw her alive on Dec 5 1922and that death occurred on the date stated above, at 8 P M.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus
and pelvic organs.(Duration) 2 Yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

A. P. Soderquist M. D.4/6 1922 (Address) Idaho Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

West Swedish Cem12/10 1922

20. UNDERTAKER

ADDRESS

C. E. Duenow Idaho Falls
A. P. Soderquist

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Blaine*City of *Idaho Falls,*Registration District No. *73*Primary Registration District No. *21V-0*(No. *19022*)

St.)

File No. *40416*Registered No. *76*

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME *Barbra M Bransa*

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *Female*4. COLOR OR RACE *white*5. SINGLE, MARRIED, WIDOWED OR DIVORCED *single*

(Write the word.)

6. DATE OF BIRTH

Oct 5 1922

(Month)

(Day)

(Year)

7. AGE

2 Yrs. *7* Mos. *2* ds.IF LESS than 1 day
how many *2* hrs.
or *2* min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work *none*

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) *Idaho Falls,*10. NAME OF FATHER *Ralph E Bransa*11. BIRTHPLACE OF FATHER *Idaho*

(State or Country)

12. MAIDEN NAME OF MOTHER *Mary J Cunningham*13. BIRTHPLACE OF MOTHER *Idaho*

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Ralph Bransa*(Address) *Idaho Falls*15. Filed *Dec 7 1922*19 *22*Local Registrar *W. M. Murphy*

16. DATE OF DEATH

December 6 1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 1 1922 to *Dec 6 1922*
that I last saw her alive on *Dec 6 1922*
and that death occurred on the date stated above, at *1:30 A.M.*

The CAUSE OF DEATH was as follows:

Pneumonia(Duration) *6* Yrs. *6* mos. *6* ds.Contributory
(Secondary)(Duration) *6* yrs. *6* mos. *6* ds.(Signed) *Geo. J. Ruppert*19 *22*(Address) *Idaho Falls, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death *6* yrs. *6* mos. *6* days. In the State *6* yrs. *6* mos. *6* days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Rose Hill Idaho Falls

DATE OF BURIAL

*Dec 7 1922*20. UNDERTAKER *W. M. Murphy*

ADDRESS

Idaho Falls

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Bonanza*
City of *Idaho Falls*Registration District No. *73*
Primary Registration District No. *21470*
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

File No. *40417*
Registered No. *179*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

James M. Berry

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*
(Write the word.)6. DATE OF BIRTH *?*
(Month) (Day) (Year)7. AGE *60*
Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work *Salesman*
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) *Don't know*

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country) *" "*

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country) *" "*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Walter Porter*(Address) *Idaho Falls, Idaho*15. *Dec 7 1922*
Filed *Dec 7 1922* Local Registrar

16. DATE OF DEATH

Dec 5 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *Dec 1 1922* to *Dec 5 1922*
that I last saw h. alive on *Dec 5 1922*
and that death occurred on the date stated above, at *19* M.

The CAUSE OF DEATH* was as follows:

Tuberculosis lungs(Duration) *1* Yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *W. C. Cline* M. D.*Dec 7 1922* (Address) *Idaho Falls, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Rose Hill, Idaho Falls, Idaho *Dec 7 1922*

20. UNDERTAKER

ADDRESS

Idaho Falls, Idaho

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Panhandle
 City of Ida Falls

Registration District No. 73
 Primary Registration District No. 214-0
 (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ragna Wilson

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 10418
 Registered No. 177

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widow
 (Write the word.)

6. DATE OF BIRTH

Oct 4 1896
 (Month) (Day) (Year)

7. AGE

86 Yrs. 3 Mos. 15 ds.

IF LESS than 1 day
 how many _____ hrs.
 or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

at Home

9. BIRTHPLACE

(State or Country)

Norway

10. NAME OF FATHER

Johansson

11. BIRTHPLACE OF FATHER

(State or Country)

Norway

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wils Wilson

(Address)

Ida Falls

15.

Filed

Dec 23 1922

19

W. R. Soderquist
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

94

16. DATE OF DEATH

Dec 20 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 10 1922 to Dec 20 1922

that I last saw her alive on Dec 19 1922 and that death occurred on the date stated above, at 5 a.m.

The CAUSE OF DEATH was as follows:

Myocardial Regeneration and Pulmonary Edema

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
 (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W. R. Soderquist M. D.

Dec 10 1922 (Address) Ida Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Ida Falls, Ida 12/22 1922

20. UNDERTAKER

ADDRESS

E. C. Woodward Ida Falls

W. R. Soderquist

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Boundary Registration District No. 79
 City of Bonners Ferry Primary Registration District No. 2156
 (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Louis P. Hill

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 40419
 Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
 (Write the word.)

6. DATE OF BIRTH

Apr 30 1860
 (Month) (Day) (Year)

7. AGE

62 Yrs. 7 Mos. 6 ds.

IF LESS than 1 day
 how many _____ hrs.
 or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

Farmer

9. BIRTHPLACE

(State or Country)

Norway

10. NAME OF FATHER

Paul Hill

11. BIRTHPLACE OF FATHER

(State or Country)

Norway

12. MAIDEN NAME OF MOTHER

Unknown Larson

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Emmer C. Linder

15.

Filed

Dec. 8 / 1922

SSJ
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 6 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 21 1922, to Dec. 6 1922
 that I last saw him alive on Dec. 5 1922,
 and that death occurred on the date stated above, at 10 A.M.
 The CAUSE OF DEATH* was as follows:

Periculous Aneurism

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
 (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

12/7/22 (Address) Bonners Ferry

*State the Disease Causing Death; or in deaths from Violent Cause, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Bonners Ferry

DATE OF BURIAL

12/10/1922

20. UNDERTAKER

O.R. Stoolley

ADDRESS

1. PLACE OF DEATH

County of Boundary
City of Bonners Ferry

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED CERTIFICATE OF DEATH

Registration District No. 79Primary Registration District No. 315-6

(No. _____)

(St. _____)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 40420

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

married
(Write the word.)

6. DATE OF BIRTH

Apr. 2nd. 1874
(Month) (Day) (Year)

7. AGE

48 Yrs. 8 Mos. 14 ds.

IF LESS than 1 day

how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

Logging Supt.

9. BIRTHPLACE

(State or Country)

Minnesota.

10. NAME OF FATHER

Do not know

11. BIRTHPLACE OF FATHER

(State or Country)

Do not know

12. MAIDEN NAME OF MOTHER

Do not know

13. BIRTHPLACE OF MOTHER

(State or Country)

Do not know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs Jno. Crowley

(Address) _____

15. Filed

Dec 18th 1933Local Registrar J. E. Fry

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec. 16th. 1933
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 1931 to Dec. 16 1933that I last saw him alive on Dec. 14 1933and that death occurred on the date stated above, at 3:30 PM

The CAUSE OF DEATH* was as follows:

Gallbladder Carcinoma
(Pseudo myxoma peritonei)

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

12/18 1933 (Address) Bonners Ferry, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Bonners Ferry

DATE OF BURIAL

12/30 1933

20. UNDERTAKER

O.R. Storkley

ADDRESS

Bonners Ferry

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED CERTIFICATE OF DEATH.

1. PLACE OF DEATH.

Registration District No. 79
County of Bonanza Primary Registration District No. 3156
City of Indian Village (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Alloysius Francis

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 40421

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE Red 5. SINGLE, MARRIED, WID-OWED OR DIVORCED. Single (Write the word.)

6. DATE OF BIRTH.

May 30 1922
(Month) (Day) (Year)

7. AGE

7 Yrs. 7 Mos. 10 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Simon Frances

11. BIRTHPLACE OF FATHER

(State or Country) Idaho

12. MAIDEN NAME OF MOTHER

Catherine Davis

13. BIRTHPLACE OF MOTHER

(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary F. Fisher(Address) Bonanza Ferry Id

15.

Filed Dec. 14 1922 M. F. FisherLocal Registrar E. J. Smith

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec. 10 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to 191,
that I last saw him alive on 191

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Inherent peritonitis.(Duration) Yrs. 3 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) E. J. Smith M. D.12/14 1922 (Address) Bonanza Ferry

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Indian cemetery

DATE OF BURIAL

Dec. 12 1922

20. UNDERTAKER

Indian

ADDRESS

Bonanza Ferry

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

1. PLACE OF DEATH.

Registration District No. 79
County of Bonneville Primary Registration District No. 2156
City of Indian Village (No. 1 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Andrew

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 40422

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE Red 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED. Single (See word.)

6. DATE OF BIRTH.

Aug 21 1922
(Month) (Day) (Year)

7. AGE

Yrs. 1 Mos. 25 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country) Idaho, U.S.A.

10. NAME OF FATHER

Andrew Purrie

11. BIRTHPLACE OF FATHER

(State or Country) Idaho, U.S.A.

12. MAIDEN NAME OF MOTHER

Magdalene Francis

13. BIRTHPLACE OF MOTHER

(State or Country) Idaho, U.S.A.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

W. J. Fisher
Bonneville Ferry, Idaho

15.

Filed

12/311922W. J. Fisher

Local Registrar

MEDICAL CERTIFICATE OF DEATH

42

16. DATE OF DEATH

Oct. 16 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191..... to 191.....
that I last saw him alive on 191.....
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Pneumonia(Duration) Yrs. mos. 4 ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed)

W. J. Fisher

19..... (Address)

Bonneville Ferry, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Indian cemeteryOct 17 19122

20. UNDERTAKER

ADDRESS

IndiansBonneville Ferry

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **40423**

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of

Registration District No.

Primary Registration District No.

(No.)

St.)

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

19. 30. to Dec. 15. 1922

that I last saw him alive on Nov. 15. 1922

and that death occurred on the date stated above, at 5:30 A.M.

The CAUSE OF DEATH* was as follows:

Myocardial Degeneration.
(Mitral stenosis? - Auricular fibrillation)

(Duration) 6 Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

12/17/1922. (Address) Bonners Ferry, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. In the days. State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 79
County of Boundary Primary Registration District No. 2156
City of Bonner Ferry (No. 1 St.)File No. 40424

Registered No. _____

If death occurs away from
usual residence, give facts
called for under special in-
formation.If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.2. FULL NAME Emma Huntington

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Widowed
(Write the word.)6. DATE OF BIRTH Dec. 2 1843
(Month) (Day) (Year)7. AGE 79 Yrs. 6 Mos. 6 ds. IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)Housewife

9. BIRTHPLACE

(State or Country)

England10. NAME OF
FATHERJ. J. Richardson11. BIRTHPLACE
OF FATHER

(State or Country)

England12. MAIDEN NAME
OF MOTHERWalshakett13. BIRTHPLACE
OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

P. H. Hall

(Address)

15.

Filed Dec. 10 1922P. H. Hall
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec. 8 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 1921 to Dec. 8 1922
that I last saw her alive on Sept. 1922
and that death occurred on the date stated above, at 4 A. M.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory Arterio-sclerosis-hypertension
(Secondary)(Duration) ? yrs. _____ mos. _____ ds.(Signed) R. M. Bowell M. D.Dec. 30 1922 (Address) Bonner Ferry Idaho*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted
if not at place of death?Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Bonner Ferry

DATE OF BURIAL

Dec. 11 1922

20. UNDERTAKER

O. R. Stork

ADDRESS

Bonner Ferry

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **40425**1. PLACE OF DEATH. **Butte** Registration District No. **59**
County of **Butte** Primary Registration District No. **59**
City of **Butte** St. **Butte**Registered No. **40425**
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Anna Neilson Farnum**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **F** 4. COLOR OR RACE **W** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Married**6. DATE OF BIRTH. **7-1-1873**

(Month) (Day) (Year)

7. AGE **49** Yrs. **5** Mos. **5** ds.IF LESS than 1 day
how many.....hrs. or
.....min.?8. OCCUPATION **Housewife**(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)9. BIRTHPLACE **Monroe Utah**

(State or Country)

10. NAME OF FATHER **Peter Neilson**11. BIRTHPLACE OF FATHER **Denmark**

(State or Country)

12. MAIDEN NAME OF MOTHER **Boletta Swenson**13. BIRTHPLACE OF MOTHER **Norway**

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) **Dr. Parley Neilson**
(Address) **Rexburg Ida**15. Filed **12/2/1914** **F.M. Cannon**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **12-10-1914**

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **11-26-1912** to **12-10-1914**that I last saw him alive on **12-10-1914**and that death occurred on the date stated above, at **4.9** M.

The CAUSE OF DEATH* was as follows:

Cardiac Decomensation(Duration) Yrs. Mos. ds.
Contributory (Secondary) **Thyroid Insufficiency**(Signature) **F.M. Cannon M.D.**
19. (Address) **Arco, Ida.**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted
if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **Monroe Utah** DATE OF BURIAL **12/14 1914**20. UNDERTAKER **E.P. Peck** ADDRESS **Blufffoot.**

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Camas County
City of ManardRegistration District No. 58dPrimary Registration District No. 2138

(No. _____)

St. _____

File No. 40426

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Barrel Nelson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

(Write the word.)

6. DATE OF BIRTH

Nov.

(Month)

4

(Day)

1922

(Year)

7. AGE

Yrs. _____

Mos. _____

28

ds. _____

IF LESS than 1 day

how many _____ hrs.

or _____ min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

None

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Camas County, Idaho

10. NAME OF FATHER

Oliver Charles Nelson

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Lepida Adeline Adams

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

O. C. Nelson by Dr. L. W.

(Address)

Fairfield, Idaho

15.

Filed

Dec. 19, 1922L. W. Wlenchek

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

December 2

(Month)

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov. 41922, toNov. 101922that I last saw her alive on Nov. 22 1922and that death occurred on the date stated above, at 5:00 AM

The CAUSE OF DEATH* was as follows:

Premature Birth - (Gestation8 mo - 1 week,

(Duration)

Yrs. _____

mos. _____

ds. _____

Contributory
(Secondary)

(Duration)

yrs. _____

mos. _____

ds. _____

(Signed)

L. W. Wlenchek

M. D.

12-13-1922

(Address)

Fairfield, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

yrs. _____

mos. _____

In the

days

State

yrs. _____

mos. _____

days _____

Where was disease contracted if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

Manard, Idaho

DATE OF BURIAL

Dec. 3, 1922

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Camas Registration District No. 58th
City of Soldier Primary Registration District No. 2138
(No. St.)File No. 40427

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

William Young Perkins

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH

March 8th 1850
(Month) (Day) (Year)

7. AGE

72 Yrs. 9 Mos. 4 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Farmer, Mill-Owner.

9. BIRTHPLACE

(State or Country)

Kentucky.

10. NAME OF FATHER

John H. Perkins

11. BIRTHPLACE OF FATHER

(State or Country)

Virginia

12. MAIDEN NAME OF MOTHER

Lucy Young

13. BIRTHPLACE OF MOTHER

(State or Country)

Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. W. Perkins (by L. W. Llencheck)
(Address) Soldier, Idaho

15.

Filed 1-8 1923L. W. Llencheck
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

December 12th 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
December 11th 1922, to December 12th 1922
that I last saw h. live alive on December 11th 1922
and that death occurred on the date stated above, at 5³⁰ A.M.
The CAUSE OF DEATH* was as follows:Senility and Renal Calc(Duration) Yrs. mos. 2 ds.Contributory
(Secondary)Renal Calc(Duration) yrs. mos. 2 ds.

(Signed)

L. W. Llencheck

M. D.

1-8 1923 (Address) Fairfield, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Soldier, Idaho19

20. UNDERTAKER

ADDRESS

JAN 1922
CERTIFICATE OF DEATHState of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of CanyonCity of Nampa

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7Primary Registration District No. 1056(No. State Sanitarium St.)File No. 40428

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lewis Shipley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

1859
(Year)

7. AGE

71

Yrs.

Mos.

ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Laborer

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

West Virginia

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Don Byrnes

(Address)

Nampa, Idaho

15.

Filed Dec. 30 1922 Pearle Dadds

Local Registrar

MEDICAL CERTIFICATE OF DEATH

68

16. DATE OF DEATH

Dec
(Month)3
(Day)1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 9 1918, to Dec 3 1922that I last saw him alive on Dec 3 1922and that death occurred on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Senile dementia(Duration) 32 Yrs. mos. ds.Contributory
(Secondary)Senile decay

(Duration) yrs. mos. ds.

(Signed)

Don Byrnes

M. D.

12/3 1922(Address) Don Byrnes

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 4 yrs. 5 mos. 10 days. In the State yrs. mos. daysWhere was disease contracted if not at place of death? MT. PEAKS, IDAHOFormer or usual residence MT. PEAKS, IDAHO

19. PLACE OF BURIAL OR REMOVAL

Nampa, Idaho

DATE OF BURIAL

12/8 1922

20. UNDERTAKER

Fred K. Robinson

ADDRESS

Nampa

1. PLACE OF DEATH

County of CalaverasCity of Mariposa

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No. 7Primary Registration District No. 1006State (No.)

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 40429Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many hrs.or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Signed)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

1. PLACE OF DEATH

County of CamdenCity of Nampa

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elizabeth Johnson

RECEIVED CERTIFICATE OF DEATH

Registration District No. 7Primary Registration District No. 1806St. IdahoState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 40430

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH

7. AGE

63 Yrs. _____ Mos. _____ ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country) Idaho10. NAME OF FATHER Davis Thompson

11. BIRTHPLACE OF FATHER

(State or Country) Idaho

12. MAIDEN NAME OF MOTHER _____

13. BIRTHPLACE OF MOTHER _____

(State or Country) _____

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) But Johnson(Address) Nampa Idaho

15.

Filed Dec. 30 1922Pearl Dodds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

2 (Month) 10 (Day) 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec. 6th 1922, to Dec. 9th 1922.that I last saw him alive on Dec. 9th 1922.

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia(Duration) _____ Yrs. _____ mos. 4 ds.Contributory
(Secondary) _____

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Geo. P. Proctor M. D.12/14/1922 (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Nampa Idaho

DATE OF BURIAL

12/14 1922

20. UNDERTAKER

W. H. Robinson

ADDRESS

Nampa

1. PLACE OF DEATH

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsCounty of Carson

JAN 5 1923

Registration District No. 7City of Nampa

BUREAU

Registration District No. 1006File No. 40431Registered No. 40431

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Margaret E. Haragan

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

90

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDFemale WhiteWidowed
(Write the word.)

6. DATE OF BIRTH

Dec 23 1845
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day

how many hrs.

or min.?

77 Yrs. 13 Mos. 3 ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

Housewife

9. BIRTHPLACE

(State or Country)

Ireland

10. NAME OF FATHER

Pat Keating

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Roach

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs L. Maloney

(Address)

Nampa Ida

15.

Filed Dec. 30 1922Pearle Dodds

Local Registrar

16. DATE OF DEATH

Dec 10 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 1905 to Dec 9 1922that I last saw her alive on Dec 9 1922and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis
and Mitral Heart Lesion(Duration) 20? Yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) H.P. Ross M. D.12/2/22 (Address) Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Catholic Cem12/12/22

20. UNDERTAKER

ADDRESS

F.K. RobertsNampa Ida

Bms

1. PLACE OF DEATH

County of Canyon
City of Nampa

If death occurs away from usual residence, give facts relied for under special information.

RECEIVED

JAN 5 1923
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 7
Primary Registration District No. 1086
St.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 40432
Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Adelle Edwards

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widowed
(Write the word.)

6. DATE OF BIRTH Oct 30 1922
(Month) (Day) (Year)

7. AGE 2 yrs 2 mos 28 ds
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE Idaho
(State or Country)

10. NAME OF FATHER W E Edwards

11. BIRTHPLACE OF FATHER Colo
(State or Country)

12. MAIDEN NAME OF MOTHER Gertrud Barky

13. BIRTHPLACE OF MOTHER Ida
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W E Edwards
(Address) Nampa Ida

15. Filed Dec 30 1922 Pearl Dodd
Local Registrar

MEDICAL CERTIFICATE OF DEATH

91

16. DATE OF DEATH Dec 11 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 10 1922 to Dec 10 1922
that I last saw her alive on Dec 10 1922
and that death occurred on the date stated above, at 9 a.m.
The CAUSE OF DEATH* was as follows:

Branches Pneumonia Acute

(Duration) 7 yrs. 7 mos. 7 ds.
Contributory (Secondary)

(Duration) 12/11/1922 yrs. 7 mos. 7 ds.
(Signed) Leo N Clifton M. D.
(Address) Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 7 yrs. 7 mos. 7 days. In the State 7 yrs. 7 mos. 7 days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Nampa Ida DATE OF BURIAL 12/12/1922

20. UNDERTAKER R K Arken ADDRESS Nampa Ida

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Lemmon Registration District No. 7
City of Nampa Primary Registration District No. 1006
(No. 1006 St.)

File No. 40433
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles E. Hamilton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH July 7 1904
(Month) (Day) (Year)

7. AGE 18 Yrs. 5 Mos. 15 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION In School
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE Nebraska
(State or Country)

10. NAME OF FATHER R.E. Hamilton

11. BIRTHPLACE OF FATHER Idaho
(State or Country)

12. MAIDEN NAME OF MOTHER Ella Rucky

13. BIRTHPLACE OF MOTHER Ohio
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R.E. Hamilton
(Address) Nampa Idaho

15. Filled Dec. 30 1922 Pearle Dodds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 22 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1921 to Dec. 17th 1922.
that I last saw him alive on Dec. 17th 1922
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:
Chronic valvular heart disease

(Duration) Long Yrs. _____ mos. _____ ds.
Contributory (Secondary) Chronic pyelitis
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) Geo. R. Proctor M. D.
12/22 1922 (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.
Where was disease contracted if not at place of death? _____
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Nampa Idaho DATE OF BURIAL 12/24 1922

20. UNDERTAKER J.K. Robinson ADDRESS Nampa Idaho

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH JAN 5 1923
 County of Canyon Registration District No. 7
 City of Naupaka Primary Registration District No. 1006
 (No. _____ St.) Registered No. 40435

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mike H. Harmon

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
 (Write the words)

6. DATE OF BIRTH July 13 1848
 (Month) (Day) (Year)

7. AGE 74 Yrs. Mos. ds. IF LESS than 1 day
 how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Justice of Peace
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) N. Y.

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country) —

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ms M. H. Harmon
 (Address) Naupaka Idaho

15.

Filed Dec 30 1922 Pearle Dodds
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 22 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19....., to 19.....
 that I last saw him alive on 19.....
 and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Myo Carditis.

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Paul L. Caldwell M.D.

12/20-22 (Address) Caldwell Idaho
 Coroner.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Naupaka Idaho

DATE OF BURIAL

12/24/1922

20. UNDERTAKER

P. H. Johnson

ADDRESS

Naupaka

1. PLACE OF DEATH

County of Campan

City of Nampa

If death occurs away from usual residence, give facts called for under special information.

Given name on birth certificate Sarah Jane
Doris Mae Chamberlain

2. FULL NAME

CERTIFICATE OF DEATH

JAN 1923 Registration District No. 7

Primary Registration District No. 1006

STAT 1/18 10 am 71 St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 40436

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female White (Write the word.)

6. DATE OF BIRTH

Sept 7 1922
(Month) (Day) (Year)

7. AGE

3 Yrs 0 Mos 0 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. ✓
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

F. A. Chamberlain

11. BIRTHPLACE OF FATHER

(State or Country) Iowa

12. MAIDEN NAME OF MOTHER

Ruby Slusher

13. BIRTHPLACE OF MOTHER

(State or Country) Nebr

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) F. A. Chamberlain

(Address) Nampa Ida

15. Filed Dec. 30. 1922 Pearle Dodds

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 24 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19... to 19...

that I last saw h... alive on... 19...

and that death occurred on the date stated above, at... M.

The CAUSE OF DEATH was as follows:

Exhaustion

(Duration) Yrs... mos... ds.

Contributory (Secondary)

(Duration) yrs... mos... ds.

(Signed) Paul L. Bess M.D.

12/28/22 (Address) Calvinell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs... mos... days. In the State yrs... mos... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Chamberlain Ida 12/26/1922

20. UNDERTAKER

ADDRESS

(Coroner)

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 7
 County of Canyon Primary Registration District No. 1006
 City of North (No. 409-924 St.)

File No. 40437

Registered No. _____

If death occurs away from
usual residence, give facts
called for under special in-
formation.

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

2. FULL NAME

Mary J. Jones

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Married

6. DATE OF BIRTH

Dec 1 1862
 (Month) (Day) (Year)

7. AGE

60 Yrs. Mos. ds.
 IF LESS than 1 day
 how many hrs. or min.?

8. OCCUPATION

a) Trade, profession or
particular kind of work
b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Maine

10. NAME OF FATHER

Amos Williams

11. BIRTHPLACE OF FATHER

(State or Country)

Wales

12. MAIDEN NAME OF MOTHER

Williams

13. BIRTHPLACE OF MOTHER

(State or Country)

Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Dr. Jones
Naupaka, I. H.

15.

Filed Dec 30 1922

Pearle Dodds
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 24 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 1 1922 to Dec 23 1922
 that I last saw her alive on Dec 23 1922
 and that death occurred on the date stated above, at 89 A. M.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease(Duration) Yrs. 67 mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

H. P. Rose

M. D.

12/26/22 (Address) Naupaka, I. H.

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Brownsville, I. H.12 1922

20. UNDERTAKER

ADDRESS

F. H. RobinsonNaupaka, I. H.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40438**

1. PLACE OF DEATH

County of LanyonCity of Nampa

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No. 7Primary Registration District No. 1086(No. Mercy Hospital St.)

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Female White Married

6. DATE OF BIRTH

Dec 11 1903
(Month) (Day) (Year)

7. AGE

19 Yrs. 26 Mos. 26 ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Tenn

10. NAME OF FATHER

James B. Charles

11. BIRTHPLACE OF FATHER

(State or Country)

Tenn

12. MAIDEN NAME OF MOTHER

Ella M. Loney

13. BIRTHPLACE OF MOTHER

(State or Country)

Tenn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

G. L. Loney
Boise, Idaho

(Address)

15.

Filed Dec. 30 1922

Pearle Dodd
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 29 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

5 P.M. 12/29/1922 to 6:30 P.M. 12/29/1922
that I last saw her alive on Dec 29 1922
and that death occurred on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:

Suicide

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Les W. Chittus M. D.

12/29/1922 (Address) Nampa, Id.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Ontario Oregon

.....19.....

20. UNDERTAKER

ADDRESS

F. K. Robinson

Nampa

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40439**
Registered No. _____

1. PLACE OF DEATH

County of CanyonCity of HampanaRegistration District No. 7Primary Registration District No. 2006

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Sylvia B. Parks

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F.

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

June291910
(Month) (Day) (Year)

7. AGE

11

Yrs.

Mos.

ds.

IF LESS than 1 day

how many _____ hrs.

or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

In school

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

C. A. Parks

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

C. A. Parks

(Address)

Hampana, Ida

15.

Filed Dec. 30 1922Pearle Dodd

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec51922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 2 1922 to Dec 5 1922that I last saw him alive on Dec 4 1922and that death occurred on the date stated above, at 9:4 A.M.

The CAUSE OF DEATH* was as follows:

Diphtheria(Duration) _____ Yrs. _____ mos. 6 ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

C. M. Kelly

M. D.

12/5 1922 (Address) Pearle Dodd

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hampana, Ida12/6 1922

20. UNDERTAKER

ADDRESS

Frank A. RobinsonHampana, Ida

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon
City of ManupiaRegistration District No. 7
Primary Registration District No. 2006
(No. _____ St.)File No. 40440
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jim C. Tobor

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH

Nov 20 1920
(Month) (Day) (Year)

7. AGE

2 Yrs. _____ Mos. _____ ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

D.M. Tobor

11. BIRTHPLACE OF FATHER

(State or Country) Mo.

12. MAIDEN NAME OF MOTHER

Bula Shryack

13. BIRTHPLACE OF MOTHER

(State or Country) Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) D.M. Tobor(Address) Manupia Id.

15.

Filed Dec. 30 1922 Pearl Dodds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec. 5 - 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec. 1 1922 to Dec. 5 1922
that I last saw her alive on Dec. 4 1922
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Acute Bronchopneumonia

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory (Secondary) Flu

(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed) C. L. Dutton M. D.12/16/22 (Address) Overland Bldg.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Robertson 12/6/22

20. UNDERTAKER

ADDRESS

F. J. Robinson Manupia Id.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **40441**

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of **Canyon** Registration District No. **7**
City of **Malheur** Primary Registration District No. **2006**
St. **Idaho**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Martin Welch

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Single**

(Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

73 Yrs. - Mos. - ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Dec. 30 1922**Pearle Dodd**

Local Registrar

16. DATE OF DEATH

Dec. 11 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from **Dec. 10 1922** to **Dec. 11 1922** that I last saw him alive on **Dec. 11 1922** and that death occurred on the date stated above, at **12 M.** The CAUSE OF DEATH* was as follows:
Acute Alcoholism(Duration) Yrs. mos. **5** ds.
Contributory (Secondary) **Cardiac Decompensation**(Duration) yrs. mos. **1** ds.
(Signed) **Daniel B. Swaine** M. D.
Dec. 11 1922 (Address) **Malheur, Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Malheur Idaho**12-12-1922**

20. UNDERTAKER

ADDRESS

H. H. Robinson**Malheur**

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

PLACE OF DEATH

Registration District No. 7

File No. 40442

County of Canyon

Primary Registration District No. 2006

Registered No.

City of Nampa

(No. St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts for under special information.

Given name on Birth certificate - Fern M

2. FULL NAME Norma Gregg

PERSONAL AND STATISTICAL PARTICULARS

SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

White (Write the word.)

6. DATE OF BIRTH

Nov 4 1922 (Month) (Day) (Year)

7. AGE

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Informant

(Address)

15.

Filed Dec 30 1922

Pearl Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 12 1922 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

12-12-1922 to 12-12-1922

that I last saw him alive on 12-12-1922

and that death occurred on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

MRS. D. E. & SUSIE V. STANDARD

(Duration) Yrs. mos. ds.

201-2-3 Waddell Bldg Nampa Idaho

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) M. D.

12/19/22 (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

1. PLACE OF DEATH

County of Idaho Registration District No. 7
 City of Nampa Primary Registration District No. 2006
 State (No. _____) St. _____

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 40443

Registered No. _____

If death occurs away from
 usual residence, give facts
 called for under special in-
 formation.

2. FULL NAME

Infant Fairless

If death occurred in a hos-
 pital, institution or camp,
 give its NAME instead of
 street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED _____
 (Write the word.)

6. DATE OF BIRTH

Dec 1 1922
 (Month) (Day) (Year)

7. AGE

12
 Yrs. Mos. ds.

IF LESS than 1 day
 how many _____ hrs.
 or _____ min.?

8. OCCUPATION

(a) Trade, profession or
 particular kind of work
 (b) General nature of in-
 dustry, business or estab-
 lishment in which employ-
 ed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

John W Fairless

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Emma Herin

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Fairless(Address) Nampa Idaho

15.

Filed Dec 30 1922 Pearle Dodds
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 12 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
12-12-1922 to 12-12-1922
 that I last saw him alive on 12-12-1922
 and that death occurred on the date stated above, at 8 P. M.
 The CAUSE OF DEATH was as follows:

Broncho Pneumonia

(Duration) Yrs. _____ mos. 5 ds.
 DRS. D. E. & SUSIE V. STANDART
 Contributory
 (Secondary)
 201-2-3 Waddell Bldg. Nampa Idaho
 (Duration) Yrs. _____ mos. _____ ds.

(Signed) D. E. Standart M. D.12/12 1922 (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state
 (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted
 if not at place of death?

Former or
 usual residence

19. PLACE OF BURIAL OR REMOVAL

Nampa Idaho 12-30 1922

20. UNDERTAKER

ADDRESS

JAN 3 1923

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

BURIAL

Registration District No.

County of Canyon

Primary Registration District No.

City of

(No. St.)

File No: 40444

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Lusana Fogler

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

166

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

16. DATE OF DEATH

7. AGE

IF LESS than 1 day

how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (for employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed Dec 30 1922

Pearle Dodd
Local Registrar

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Burned to death. Accidental.

Contributory
(Secondary)

(Signed)

12/17/22 (Address) Caldwell, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Nampa, Ida 12/17 1922

20. UNDERTAKER

ADDRESS

Fred K. Robinson Nampa, Ida

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Canyon Registration District No. 7
City of Naupha Primary Registration District No. 2006
(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Moore

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 40445

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED single
(Write the word.)

6. DATE OF BIRTH

Dec 21 1922
(Month) (Day) (Year)

7. AGE

Yrs. _____ Mos. _____ ds. _____

IF LESS than 1 day
how many 3 hrs.
or 30 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Infant
(b) General nature of industry, business or establishment in which employed (or employer). Infant

9. BIRTHPLACE

(State or Country) Canyon Co. Idaho

10. NAME OF FATHER

C. M. Moore

11. BIRTHPLACE OF FATHER

(State or Country) Ohio

12. MAIDEN NAME OF MOTHER

Millie Richardson

13. BIRTHPLACE OF MOTHER

(State or Country) Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. M. Moore
(Address) Naupha Ida - RR No 4

15.

Filed Dec 30 1922 Pearle Dodd
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 21 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 21 1922 to Dec 21 1922

that I last saw him alive on Dec 21 1922

and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Premature birth

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. H. Murray M. D.

12/22/22 (Address) Naupha Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? ✓

Former or usual residence ✓

19. PLACE OF BURIAL OR REMOVAL

Kohlertown Cemetery

DATE OF BURIAL

12-22 1922

20. UNDERTAKER

none

ADDRESS

PLACE OF DEATH

RECEIVED
CERTIFICATE OF DEATHState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsCounty of Canyon Registration District No. 2006
City of Burley Primary Registration District No. 2006
(No. 2006 St.)File No. 40446Registered No. 40446

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Oliver Hansen

PERSONAL AND STATISTICAL PARTICULARS

SEX M 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)6. DATE OF BIRTH Feb 16 1913
(Month) (Day) (Year)7. AGE 7 Yrs. 7 Mos. 7 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)In School

9. BIRTHPLACE

(State or Country)

Alaska

10. NAME OF FATHER

Olaf Hansen

11. BIRTHPLACE OF FATHER

(State or Country)

Norway

12. MAIDEN NAME OF MOTHER

Jeanette Skelstad

13. BIRTHPLACE OF MOTHER

(State or Country)

Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Olaf Hansen(Address) Nampa Ida15. Filed Dec 30 1922 Pearle Dodds

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 23 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Dec 23 1 P.M. 1922, to Dec 23 8 P.M. 1922that I last saw him alive on Dec 23 1922 and that death occurred on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Acute Meningitis (Secondary)(Duration) 7 Yrs. 7 Mos. 7 ds.Contributory (Secondary) Acute Endocarditis
Acute Streptococcal Throat(Duration) 7 Yrs. 7 Mos. 7 ds.(Signed) Leo W Chilton M. D.12/28 1922 (Address) Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 7 yrs. 7 mos. 7 days. In the State 7 yrs. 7 mos. 7 days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Nampa Ida 12/26/22

20. UNDERTAKER

ADDRESS

Frank W. Chilton Nampa Ida

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 7
County of Canyon Primary Registration District No. 2006
City of Nampa (No. Murphy Hospital St.)File No. 40447

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wm B. Firebaugh

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married

6. DATE OF BIRTH

Oct 10 1896
(Month) (Day) (Year)

7. AGE

76 Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Vir

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country) Virginia

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country) Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Della Firebaugh
(Address) Shoshone Idaho15. Filed Dec. 30 1922 Pearle Dodds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec. 7th 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Nov. 24th 1922, to Dec. 6th 1922, that I last saw him alive on Dec. 6th 1922, and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Myocarditis(Duration) Yrs. mos. 15 ds.
Contributory (Secondary) Arterio sclerosis(Duration) Yrs. mos. ds.
(Signed) Geo. R. Proctor M. D.
19. (Address) Nampa, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Shoshone Idaho 19

20. UNDERTAKER

ADDRESS

H. K. Robinson Nampa

FORM V. S. No. 5-A—25 M. 1-15

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **40448**

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of *Canyon*City of *Nampa*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Charles Heath

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

*Oct**2**1899*

(Month)

(Day)

(Year)

7. AGE

84

Yrs.

Mos.

ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Farmer.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

England.

10. NAME OF FATHER

Unknown.

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mrs. Frank Rodgers*(Address) *22 Ave 3rd & 308 - Nampa Ida*

15.

Filed *Dec 27* 19*22**Pearle Dodd*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

*Nov.**22**1922*

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 16 19*22* to *Nov 22* 19*22*that I last saw him alive on *Nov 22* 19*22*and that death occurred on the date stated above, at *10.35 P.M.*

The CAUSE OF DEATH was as follows:

Cerebral embolism

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)*Lobar Pneumonia*

(Duration)

Yrs.

mos.

ds.

(Signed)

Marion D. Jones

M. D.

Dec 14 19*22* (Address) *Nampa Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Glenns Berry**Dec 26 1922*

20. UNDERTAKER

ADDRESS

*W. H. Berry**Glenns Berry*

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 7
 County of Canyon Primary Registration District No. 2006
 City of Melba (Name) _____ (St.) _____

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Marcellus (Seth) Peirsol

File No. 40449

Registered No. _____

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Single
(Write the word.)

16. DATE OF DEATH

Nov 12 1922
(Month) (Day) (Year)

6. DATE OF BIRTH

Nov 1922
(Month) (Day) (Year)

7. AGE

0 Yrs. 0 Mos. 0 ds.

IF LESS than 1 day
how many ✓ hrs.
or 20 min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work none
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer) _____

9. BIRTHPLACE

(State or Country) Canyon Co., Idaho

10. NAME OF FATHER

James Bryan Peirsol

11. BIRTHPLACE OF FATHER

(State or Country) Nebraska

12. MAIDEN NAME OF MOTHER

Nettie Olive Doramus

13. BIRTHPLACE OF MOTHER

(State or Country) Oklahoma

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James Bryan Peirsol
(Address) Melba, Ida

15.

Filed Dec 1 1922 Pearle Dodds
Local Registrar

17. I HEREBY CERTIFY, That I attended deceased from
Nov 12 1922, to Nov 12 1922,
that I last saw him alive on Nov 12 1922,
and that death occurred on the date stated above, at 10:45 A.M.

The CAUSE OF DEATH was as follows:

Intra Cranial injuries at birth

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Samuel W. Wayne M. D.

11-12-1922 (Address) Melba, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted
if not at place of death? _____

Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hohlerdown Cemetery at Nampa Nov 13 1922

20. UNDERTAKER

ADDRESS

none

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH
in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH

County of CampanCity of Hampton

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No. 7Primary Registration District No. 1006(No. 1006 St.)State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 40450Registered No. 40450

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Married

(Write the word.)

6. DATE OF BIRTH

June 30 1864
(Month) (Day) (Year)

7. AGE

58 Yrs. 3 Mos. 17 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Talbot, Campan(Address) 323. 16th St. Hampton

15. Filed

Nov. 13 1922Pearle J. Dadds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 17 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

7-18-1922 to 10-17-1922that I last saw him alive on 10-17-1922and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Paralysis(Duration) Yrs. 3 mos. ds.

Drs. D. E. & SUSIE V. STANDARD

Contributory Heart Valve leakage

201-2-3 Wadden Bldg. Nampa Idaho

(Duration) Yrs. 3 mos. ds.(Signed) D. E. Standard M. D.19. (Address) 201-2-3 Wadden Bldg. Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Phylis Loun Cam 10-20-1922

20. UNDERTAKER

ADDRESS

Mrs. H. Robinson Hampton

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Camp Registration District No. 7
City of Nampa Primary Registration District No. 1004
(No. _____ St.)File No. 40451

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William Holladay

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED _____

(Write the word.)

6. DATE OF BIRTH _____

(Month) (Day) (Year)

7. AGE 74

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)Farmer

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

Holliday

11. BIRTHPLACE OF FATHER

(State or Country)

Indiana

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. S. Holladay
Nampa Idaho

15.

Filed Dec 4 1922Pearle Dodd
Local Registrar

16. DATE OF DEATH

Nov 27 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 8 1922 to Nov 27 1922
that I last saw him alive on Nov 27 1922
and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Coronary on next
arteries
arteries
arteries
(Duration) yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. S. R. Proctor M. D.19. (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Council Grove, Iowa 1922

20. UNDERTAKER

ADDRESS

F. H. Robinson Nampa

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Canyon*
City of *Nampa*

Registration District No. *7*
Primary Registration District No. *1006*
(No. St.)

File No. *40452*
Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Virgil Elmer Helt*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

male *White* *Single*
(Write the word.)

6. DATE OF BIRTH

Oct 16 1922
(Month) (Day) (Year)

7. AGE

Yrs. *13* Mos. *Nov.* IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) *Nampa Ida*

10. NAME OF FATHER

Charles A Helt.

11. BIRTHPLACE OF FATHER

(State or Country) *Latah Co. Idaho*

12. MAIDEN NAME OF MOTHER

Josephine Keith

13. BIRTHPLACE OF MOTHER

(State or Country) *Nevada*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mr Chas A Helt.
(Address) *Nampa Ida*

15.

Filled *Dec 4 1922* *Pearl Dodd*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 16 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

10-16-1922 to *10-16-1922*
that I last saw him alive on *10-16-1922*
and that death occurred on the date stated above, at *12* M.

The CAUSE OF DEATH* was as follows:

Died at 11 PM. born at 11 AM. Breach presentation & never breathed properly
(Duration) Yrs. mos. ds.

Contributory
(Secondary)

DRS. D. E & SUSIE V. STANDARD
(Duration) Yrs. mos. ds.

201-2-3 Waddell Bldg Nampa Idaho
(Signed) *D. E. Standard* M. D.

19. (Address) *Nampa*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Kokkilaun Cemetery Nampa, Idaho DATE OF BURIAL *10-17-1922*

20. UNDERTAKER

ADDRESS

none

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon District No. 7
City of Melba Registration District No. 2006
~~City of~~ Melba (No. 1) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby HaasFile No. 40453
Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)6. DATE OF BIRTH Nov 30 1922
(Month) (Day) (Year)7. AGE 0 Yrs. 0 Mos. 0 ds. IF LESS than 1 day how many 3 hrs. or # min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work none
(b) General nature of industry, business or establishment in which employed (or employer)9. BIRTHPLACE Melba, Idaho
(State or Country)10. NAME OF FATHER Ernest Frederick Haas11. BIRTHPLACE OF FATHER Nebraska
(State or Country)12. MAIDEN NAME OF MOTHER Helen Marie Hattenburg13. BIRTHPLACE OF MOTHER Wisconsin
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ernest Haas
(Address) _____15. Filed Dec 4 1922 Pearl Dodge
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 30 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Nov 30 1922, to Nov 30 1922, that I last saw him alive on Nov 30 1922, and that death occurred on the date stated above, at 9 P.M. The CAUSE OF DEATH* was as follows:Prematurity
six 1/2 mo intra uterine
gestation
(Duration) 1 Yrs. 2 mos. 1 ds.
Contributory (Secondary) none
(Duration) 1 yrs. 1 mos. 1 ds.
Nov (Signed) Samuel A. Gwynne M. D.
30.19.22 (Address) Melba, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Melba Cemetery DATE OF BURIAL Dec 30 1922
20. UNDERTAKER none ADDRESS _____

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40454**
Registered No. _____

1. PLACE OF DEATH
County of **Canyon**
City of **Naupaka**
Registration District No. **7**
Primary Registration District No. **1806**
(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Robert H. Loures

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Single**
(Write the word.)

6. DATE OF BIRTH **Aug 22 1913**
(Month) (Day) (Year)

7. AGE **9** Yrs. _____ Mos. _____ ds. _____
IF LESS than 1 day how many _____ hrs. or _____ min. ?

8. OCCUPATION **In School**
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE **Ill**
(State or Country)

10. NAME OF FATHER **W H Loures**

11. BIRTHPLACE OF FATHER **Canada**
(State or Country)

12. MAIDEN NAME OF MOTHER **Mabel A Reynolds**

13. BIRTHPLACE OF MOTHER **Mich**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) **Mabel Reynolds**
(Address) **Naupaka Ida**

15. Filed **Dec 4 1922** **Pearle Golda**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **Nov 25 1922**
(Month) (Day) (Year)

17. I HEREBY CERTIFY That I attended deceased from **a few hours before death**
19 _____ to 19 _____
that I last saw him alive on **Nov 24 1922**
and that death occurred on the date stated above, at **7 A.** M.

The CAUSE OF DEATH* was as follows:
suspected diphtheria -
was treated by 'Sciencet'

(Duration) _____ Yrs. _____ mos. **7** ds.
Contributory (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) **J. H. Murray** M. D.
11/25 1922 (Address) **Naupaka Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.
Where was disease contracted if not at place of death? _____
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL **Chicago Ill** DATE OF BURIAL _____ 19 _____

20. UNDERTAKER **J. H. Robinson** ADDRESS **Naupaka Ida**

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 7
County of Benewah Primary Registration District No. 1006
City of Hampton (Name) St.

File No. 40455

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Julia D. Cartow

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widow

(Write the word.)

6. DATE OF BIRTH

Nov 16 1842
(Month) (Day) (Year)

7. AGE

78 Yrs. 10 Mos. 4 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

House wife

9. BIRTHPLACE

(State or Country)

Ill.

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

James Paskington

Mass.

12. MAIDEN NAME OF MOTHER

unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

John C. Cartow
Box 1000, Waco, Tex.

15.

Filed Nov. 13 1922

Pearl Dodds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 20 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

10-12-1922 to 10-20-1922
that I last saw him alive on 10-20-1922
and that death occurred on the date stated above, at _____ M.
The CAUSE OF DEATH* was as follows:

Bronchial Anthrax

(Duration) 1 Yrs. mos. ds.
Contributory (Secondary) Myocardial Valvular leakage

DRS. D. E. & SUSIE V. STANDARD

(Signed) _____ M. D.
201-2-3 Waddell Bldg. Nampa, Id.
19 _____ (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. mos. days. In the _____ State _____ yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF

Sec. City Iowa 10-24-1922

20. UNDERTAKER

ADDRESS

Thos. J. Robinson Nampa

1. PLACE OF DEATH

County of *Benewah*City of *Hammond*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No. *7*Primary Registration District No. *1086*(No. *1086*)

(St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **40456**

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

*Male**white**single*
(Write the word.)

6. DATE OF BIRTH

Aug. 27 1906
(Month) (Day) (Year)

7. AGE

16 Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).*In school*

9. BIRTHPLACE

(State or Country)

Calif.

10. NAME OF FATHER

F. M. Littlejohn

11. BIRTHPLACE OF FATHER

(State or Country)

Iowa

12. MAIDEN NAME OF MOTHER

Frankie Wellman

13. BIRTHPLACE OF MOTHER

(State or Country)

Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

F. M. Littlejohn

(Address)

Hammond Ill.

15.

Filed *Nov. 13 1922**Pearle Dodds*
Local Registrar

CERTIFICATE OF DEATH

Lewis M. Littlejohn

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct. 13 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *10-11-1922* to *11-12-1922*that I last saw him alive on *11-12-1922*and that death occurred on the date stated above, at *2:4* M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia(Duration) Yrs. mos. *3* ds.Contributory
(Secondary)

(Duration) Yrs. mos. ds.

DRS. D. E. & SUSIE V. STANDARD

(Signed)

201-2-3 Waddell Bldg. Nampa Idaho
19 (Address)

*State the Disease Causing Death; or, in Deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Anthony's C. 10-16-1922

20. UNDERTAKER

ADDRESS

Fred T. P. P. Nampa

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 7
County of Campan Primary Registration District No. 1006
City of Nampa St.)File No. 40457

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Marjory A. Schwalbe

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Single
(Write the word.)6. DATE OF BIRTH Aug 1 1917
(Month) (Day) (Year)7. AGE 5 Yrs. 4 Mos. 1 ds. IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)In school

9. BIRTHPLACE

(State or Country)

Wyoming

10. NAME OF FATHER

Blie Schwalbe

11. BIRTHPLACE OF FATHER

(State or Country)

Texas

12. MAIDEN NAME OF MOTHER

Carrie Blackfield

13. BIRTHPLACE OF MOTHER

(State or Country)

Wyoming

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Blie Schwalbe

(Address)

Nampa

15.

Filed Dec 4 1922Pearle Dodd
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 30 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
10-25-1922 to 11-30-1922
that I last saw her alive on 11-30-1922
and that death occurred on the date stated above, at 2:30 PMThe CAUSE OF DEATH was as follows:
Acute Nephritis

DRS. D. E. & SUSIE V. STANDARD

201-2-3 Wadsworth Bldg Nampa Idaho

(Duration) Yrs. Mos. Ds.

Contributory
(Secondary)

(Duration) Yrs. Mos. Ds.

(Signed)

M. D.

12-1-1922 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. Mos. Days. In the State Yrs. Mos. Days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Kohlerdown 12-7-1922

20. INTERMENT

ADDRESS

M. A. Robinson Nampa

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of CanyonCity of CaldwellRegistration District No. 3Primary Registration District No. 1009

(No. _____ St.)

File No. 40458Registered No. 124

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Stanley Gheen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

(Write the word.)

6. DATE OF BIRTH

Nov. 171922

(Month)

(Day)

(Year)

7. AGE

Yrs. Mos. ds.IF LESS than 1 day
how many 12 hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Caldwell Idaho

10. NAME OF FATHER

Evan Pennock Gheen

11. BIRTHPLACE OF FATHER

(State or Country)

Penn.

12. MAIDEN NAME OF MOTHER

Ruby Aileen Skinner

13. BIRTHPLACE OF MOTHER

(State or Country)

Caldwell Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Evan B. Gheen

(Address)

Caldwell Idaho

15.

Filed Nov. 20 - 1922John H. Ingers
Local Registrar

16. DATE OF DEATH

Nov. 18-22

(Month)

(Day)

19

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 17 1922 to Nov 18 1922that I last saw him alive on Nov 18 1922and that death occurred on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral malformation of heart.(Duration) Yrs. mos. 1 1/2 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

M. D.11/18/22 (Address) Caldwell, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Canyon Hill

DATE OF BURIAL

Nov. 20, 22

20. UNDERTAKER

Paul L. Case

ADDRESS

Caldwell Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of CanyonCity of Caldwell

If death occurs away from usual residence, give facts called for under special information.

RECEIVED

Registration District No. 3Primary Registration District No. 1045

BUREAU

STATION

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 40459Registered No. 123

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Clyde Scott Rees

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

single

6. DATE OF BIRTH

Feb 3 1904
(Month) (Day) (Year)

7. AGE

18 Yrs. 9 Mos. 12 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Student

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

N. E. Rees

11. BIRTHPLACE OF FATHER

(State or Country)

Missouri

12. MAIDEN NAME OF MOTHER

Mary Missouri Scott

13. BIRTHPLACE OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

N. E. Rees (Per Thorplog)

(Address)

Caldwell Idaho

15.

Filed Nov. 18 - 1922 John V. Meyer

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 18 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 4th 1922 to Nov 15 1922that I last saw him alive on Nov 14 1922and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Spleno-myelogenous Leukemia(Duration) Yrs. 1 mos. _____ ds.Contributory
(Secondary)

(Duration) yrs. _____ mos. _____ ds.

(Signed)

H. Montgomery

M. D.

Nov 16 1922 (Address) Caldwell Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. _____ mos. _____ days. In the State yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Canyon Hill

DATE OF BURIAL

11-18-1922

20. UNDERTAKER

ADDRESS

E. V. Beckham Caldwell

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40460**
Registered No. **122**

1. PLACE OF DEATH

County of **Canyon** Registration District No. **3**
City of **Caldwell** Primary Registration District No. **2005**
(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Eugene D. Witt Post

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **male** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED **widower**

6. DATE OF BIRTH

May 7 1891
(Month) (Day) (Year)

7. AGE

91 Yrs. 6 Mos. 10 ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Rancher.

9. BIRTHPLACE

(State or Country) **Ohio**

10. NAME OF FATHER

Joshua Post

11. BIRTHPLACE OF FATHER

(State or Country) **Connecticut**

12. MAIDEN NAME OF MOTHER

Martha Fletcher

13. BIRTHPLACE OF MOTHER

(State or Country) **Connecticut**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Eugene Post
Caldwell, Ida.

15. Filed

Nov. 18 - 1922

John H. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov. 17 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 7 1922 to Nov 8 1922
that I last saw him alive on **Nov 7 1922**
and that death occurred on the date stated above, at **7-10 A.M.**

The CAUSE OF DEATH* was as follows:

Asthma

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory **old age**
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) **G. B. Dudley** M. D.

11-18-22 (Address) **Caldwell Ida**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Parma Cem. **11-19-22**

20. UNDERTAKER

ADDRESS

V. Beckham Caldwell

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40461**
Registered No. **716**

1. PLACE OF DEATH

County of **Caldwell**
City of **Canyon**

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME **Mary Louise Paynter**

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED **Single**
(Write the word.)

6. DATE OF BIRTH

Sept 7 - 1914
(Month) (Day) (Year)

7. AGE

8 Yrs. **1** Mos. **8** ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed. (or Employer)

9. BIRTHPLACE

(State or Country) **Idaho**

10. NAME OF FATHER

Chas S. Paynter

11. BIRTHPLACE OF FATHER

(State or Country) **Idaho**

12. MAIDEN NAME OF MOTHER

Hattie J. Mott

13. BIRTHPLACE OF MOTHER

(State or Country) **Idaho**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Chas S Paynter**

(Address) **Caldwell Idaho R F D**

15.

Filed **Oct - 16 - 1922**

John L. Mayes
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct. 15 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Oct 9 1922 to **Oct 15 1922**
that I last saw her alive on **Oct 15 1922**
and that death occurred on the date stated above, at **8 P. M.**
The CAUSE OF DEATH* was as follows:

Septic. paralysis

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Canyon Hill

DATE OF BURIAL

10-17-22

20. UNDERTAKER

Paul L. Case

ADDRESS

Caldwell Ida

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Canyon* Registration District No. *3*
City of *Caldwell* Registration District No. *2005*
St. *Idaho*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Wm*File No. *40462*
Registered No. *729*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *married*
(Write the word.)

6. DATE OF BIRTH

Dec. 20 1869
(Month) (Day) (Year)

7. AGE

*52 yrs 11 Mos 14 ds*IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)*Rancher*

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Thomas Henry

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Mary Ann Ramsey

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *W.A. Smart*
(Address) *Caldwell, Ida*15. Filed *Dec-7-1922* *John H. Meyer*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 4 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *Nov. 28 1922* to *Dec 4 1922*that I last saw him alive on *Dec 3 1922*and that death occurred on the date stated above, at *5:50 A.M.*

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) Yrs. Mos. Ds.

Contributory (Secondary) *Ch. Nephritis*

(Duration) Yrs. Mos. Ds.

(Signed) *W.A. Smart* M. D.*12-5-22* (Address) *Caldwell, Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. Mos. Ds. In the State Yrs. Mos. Ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Canyon Hill* DATE OF BURIAL *12-7-1922*20. UNDERTAKER *C. V. Peckham* ADDRESS *Caldwell, Ida*

MARGIN RESERVED FOR BINDING Nov 28 -

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **40463**Registered No. **128**If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

1. PLACE OF DEATH **RECEIVED**
County of **Canyon** Registration District No. **3**
City of **Caldwell** Registration District No. **2005**
(St.)

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME **Frederick Houston**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED **Married**
(Write the word.)

6. DATE OF BIRTH

April 1 1860
(Month) (Day) (Year)

7. AGE

62 Yrs. **8** Mos. **1** ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work **Rancher**
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country) **Wisconsin**

10. NAME OF
FATHER**Samuel Houston**11. BIRTHPLACE
OF FATHER

(State or Country) **Indiana**

12. MAIDEN NAME
OF MOTHER**Elizabeth Waughtel**13. BIRTHPLACE
OF MOTHER

(State or Country) **Ills**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Robert Houston

(Address) **R4 Caldwell Idaho**

15.

Filed

Dec. 3rd 1922 **John V. Meyer**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec. 2 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 27 1922 to **Nov 2 1922**

that I last saw him alive on **Nov 1st 1922**

and that death occurred on the date stated above, at **6 A.M.**

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(Duration) Yrs. **6** mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

M. D.

(Address) **Caldwell Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Canyon Hill

DATE OF BURIAL

12-3-22

20. UNDERTAKER

Paul L. Case

ADDRESS

Caldwell Ida

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada
City of BoiseRegistration District No. 3Primary Registration District No. 2005(No. 3)

St.)

File No. 40464Registered No. 127

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Clara Louise Dutcher

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDFemale white widowed

6. DATE OF BIRTH

Jan 11 1866
(Month) (Day) (Year)

7. AGE

56 Yrs. 10 Mos. 16 ds.IF LESS than 1 day
how many.....hrs.
or.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)House keeping

9. BIRTHPLACE

(State or Country)

Wisconsin

10. NAME OF FATHER

Henry Fynola

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Carina

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

John Dutcher
Caldwell, Ida

15.

Filed Nov 29 1922John Dutcher
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 27 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct. 14 1922 to Nov 26 1922
that I last saw him alive on Nov 26 1922
and that death occurred on the date stated above, at 4:35 P.M.

The CAUSE OF DEATH* was as follows:

Probably a tumor of brain.
Had a rapid nervous breakdown

(Duration) Yrs. mos. ds.

Contributory Cancer of breast May 11/1922
(Secondary)this may have been contributory
(Duration) yrs. mos. ds.(Signed) L. P. McCall M. D.14-28-1922 (Address) Caldwell, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Canyon Hill 11-29-1922

20. UNDERTAKER

ADDRESS

E. V. Beckman Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

July 22 - 22

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Canyon Registration District No. 3
 City of Caldwell Primary Registration District No. 2005
 (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Almeda Medda Libben

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 40465
 Registered No. 126

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

female white married

6. DATE OF BIRTH

July 21 1872
 (Month) (Day) (Year)

7. AGE

50 Yrs. 4 Mos. 4 ds.
 IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. House wife
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Missouri

10. NAME OF FATHER

Albert Stoddard

11. BIRTHPLACE OF FATHER

(State or Country) Illinois

12. MAIDEN NAME OF MOTHER

Almeda Carter

13. BIRTHPLACE OF MOTHER

(State or Country) New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. E. Libben
 (Address) Caldwell, Ida.

15.

Filled Nov. 27 - 1922 John V. Meyer
 Local Registrar

16. DATE OF DEATH

Nov. 25th 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 22 1922 to Nov. 28 1922

that I last saw him _____ alive on _____ 19____
 and that death occurred on the date stated above, at 6:45 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of intestines
 (Duration) Yrs. 8 mos. _____ ds.

Contributory (Secondary)

(Duration) yrs. _____ mos. _____ ds.

(Signed) M. D.
 11-27-22 (Address) Caldwell, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Canyon Hill DATE OF BURIAL 11-28 1922

20. UNDERTAKER

W. Beckham ADDRESS Caldwell

RECEIVED
DEC 20 1922

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Canyon
City of CaldwellRegistration District No. 3Primary Registration District No. 2005

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Joseph B. JonesState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 40466Registered No. 725

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widower

(Write the word.)

6. DATE OF BIRTH

June 8 1837
(Month) (Day) (Year)

7. AGE

85 Yrs. 5 Mos. 16 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Stage Driver.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Maine

10. NAME OF FATHER

Joseph Jones

11. BIRTHPLACE OF FATHER

(State or Country) Maine

12. MAIDEN NAME OF MOTHER

Sarah Dunham

13. BIRTHPLACE OF MOTHER

(State or Country) Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Paul L. Case(Address) Caldwell Idaho

15.

Filed Nov. 26 1922John H. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov. 24 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 12 1922 to Nov 24 1922that I last saw him alive on Nov 24 1922and that death occurred on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach(Duration) _____ Yrs. 6 mos. _____ ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. H. Meyer11/24 1922 (Address) Caldwell Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Canyon Hill

DATE OF BURIAL

Nov. 26-22

20. UNDERTAKER

Paul L. Case

ADDRESS

Caldwell Ida

1. PLACE OF DEATH

County of CanyonCity of Wilder

If death occurs away from usual residence, give facts called for under special information.

RECEIVED CERTIFICATE OF DEATH

Registration District No. 3Primary Registration District No. 2005

(No. _____)

(St. _____)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 40467Registered No. 121

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Henry Baker Bitner

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many _____ hrs.

or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Nov. 20 - 1922John H. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from Nov 14 1922 to Nov 15 1922that I last saw him alive on Nov. 15 1922 and that death occurred on the date stated above, at 6:35 P.M.

The CAUSE OF DEATH* was as follows:

Peritonitis due to accident

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

J. L. Newell

M. D.

11/20/1922 (Address) Wilder, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wilder, Idaho11-20-1922

20. UNDERTAKER

ADDRESS

C. V. Beckham Caldwell

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Canyon
City of Caldwell Ida

If death occurs away from usual residence, give facts called for under special information.

CERTIFICATE OF DEATH

RECEIVED
DEC 24 1922
BUREAU OF VITAL STATISTICSRegistration District No. 3Registration District No. 1005

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 40468Registered No. 120

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Henry Tracy West

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Male

White

Widower

(Write the word.)

6. DATE OF BIRTH

Oct. 171824

1

(Month)

(Day)

(Year)

7. AGE

98

Yrs.

--

Mos.

29

ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Banker

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

New York

10. NAME OF FATHER

Pelatiah West

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Hulda Green

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Caldwell Idaho

15.

Filed Nov. 17 - 1922John H. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov. 16-22

(Month)

(Day)

19

(Year)

17. I HEREBY CERTIFY, That I deceased fromSenility 1922 to Oct 17 1922that I last saw him alive on Nov 16 1922and that death occurred on the date stated above, at 3:30 P.M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration)

98

Yrs.

mos.

29 ds.Contributory
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

J. H. Gue

M. D.

11/17/22 (Address) Caldwell Id

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Canyon Hill

DATE OF BURIAL

Nov. 19-22

20. UNDERTAKER

Paul L. Case

ADDRESS

Caldwell Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon Registration District No. 3
City of Caldwell Registration District No. 2005 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Moses Reed PedersenFile No. 40469
Registered No. 117

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-OWED OR DIVORCED

male white married

6. DATE OF BIRTH

Jan 9 1848
(Month) (Day) (Year)

7. AGE

74 Yrs. 10 Mos. 5 ds.
IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Rancher (retired)

9. BIRTHPLACE

(State or Country)

Kentucky

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

Andrew Pedersen
not known

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Ray V. Pedersen
Caldwell Idaho

15.

Filed

Nov. 16 1922 John B. Meyer
Local Registrar

16. DATE OF DEATH

Nov 14 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 14 1922 to Nov 14 1922
that I last saw him alive on Nov 14 1922
and that death occurred on the date stated above, at 9:30 P.

The CAUSE OF DEATH* was as follows:

Uremic poisoning(Duration) 5 Yrs. mos. ds.

Contributory (Secondary)

Enlarged prostate(Duration) 5 yrs. mos. ds.

(Signed)

W. D. MontgomeryNov 15 1922 (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Canyon Hill 11-17-1922

20. UNDERTAKER

ADDRESS

E. V. Beckham Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECORDED

DEC 10 1922

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Canyon Registration District No. 3
City of Caldwell (No. 2005 St.)

File No. 40470
Registered No. 118

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lyslin Pike Miller

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married

6. DATE OF BIRTH Jan 6 1894
(Month) (Day) (Year)

7. AGE 76 Yrs. 10 Mos. 6 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Home Keeping
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE Indiana
(State or Country)

10. NAME OF FATHER Jacob Meliza

11. BIRTHPLACE OF FATHER Pennsylvania
(State or Country)

12. MAIDEN NAME OF MOTHER Louise Shively

13. BIRTHPLACE OF MOTHER Germany
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. H. Miller
(Address) Caldwell, Idaho

15. Filed Nov 14 - 1922 John H. Meyer
Local Registrar

16. DATE OF DEATH Nov 12 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 14 1922 to Nov 12 1922
that I last saw him alive on Nov 10 1922
and that death occurred on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH* was as follows:

Stroke
(Duration) 2 yrs. 0 mos. 0 ds.
Contributory (Secondary)
(Duration) 0 yrs. 0 mos. 0 ds.
(Signed) Miller M. D.
11/31 1922 (Address) Caldwell, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 0 yrs. 0 mos. 0 days. In the State 0 yrs. 0 mos. 0 days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Canyon Hill DATE OF BURIAL 11-14-1922

20. UNDERTAKER C. J. Beckham ADDRESS Caldwell

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many.....hrs.
or.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him.....alive on.....

and that death occurred on the date stated above, at.....M.

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Signed)

g.....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40472**
Registered No. **132**

1. PLACE OF DEATH

Registration District No. **3**
County of **Canyon** Primary Registration District No. **1005**
City of **Caldwell** (No. **1** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ruth Maude Felt

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WID-OWED OR DIVORCED **married**
(Write the word.)

6. DATE OF BIRTH

Aug 26 1891
(Month) (Day) (Year)

7. AGE

31 Yrs. **3** Mos. **13** ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

housewife

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

Geo. L. Rhodes

11. BIRTHPLACE OF FATHER

(State or Country)

Tenn.

12. MAIDEN NAME OF MOTHER

Lydia Johnson

13. BIRTHPLACE OF MOTHER

(State or Country)

Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Fred. H. Felt

(Address)

Waltman, Wyo.

15.

Filed

Dec. 6 1922

John H. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec. 9 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Sept. 20 1922** to **Dec. 9 1922**

that I last saw her alive on **Dec. 9 1922** and that death occurred on the date stated above, at **7:30 A.M.**

The CAUSE OF DEATH* was as follows:

Permeious anemia

(Duration) Yrs. **two** mos. **ads.**

Contributory (Secondary)

Chronic/alveolar heart disease

(Duration) yrs. mos. ds.

(Signed)

C. R. Whittenberger D.O.

Dec. 9 1922 (Address) **Caldwell, Ida.**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Waltman, Wyo.

19

20. UNBERTAKER

ADDRESS

C. V. Pechham

Caldwell, Ida.

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH

JAN 9 1923

District No. 3

County of

HOMEDALE

Registration District No. 2002-

City of

Homedale

(No.)

St.)

Registered No. 109

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Albert Benson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Dec. 12- 1922

John V. Meyer

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 8 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 30 1922, to Dec 8 1922

that I last saw him alive on Dec 7 1922

and that death occurred on the date stated above, at 1:24 P.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) Yrs. mos. 8 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) C. J. M. D.

Dec 1922 (Address) Wilkes Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Greenleaf Cem

12-9 1922

20. UNDERTAKER

ADDRESS

C. J. M. D.

Caldwell

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Quincy
City of HomedaleRegistration District No. 3
Primary Registration District No. 2005
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ruth Evelyn PegramState of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 40474
Registered No. 130

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH

Aug 30 1917
(Month) (Day) (Year)

7. AGE

5 Yrs. 2 Mos. 28 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work at home
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

J. A. Pegram

11. BIRTHPLACE OF FATHER

(State or Country) Kansas

12. MAIDEN NAME OF MOTHER

Pearl E. McDowell

13. BIRTHPLACE OF MOTHER

(State or Country) Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) R. A. McDowell(Address) Homedale, Idaho

15.

Filed Dec. 1 1922 John B. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 28 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 27 1922, to Nov 28 1922
that I last saw him alive on Nov 28 1922
and that death occurred on the date stated above, at 9:15 A.M.

The CAUSE OF DEATH* was as follows:

pneumonia(Duration) Yrs. mos. 4 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) W. B. Rankin M. D.Nov 19 1922 (Address) Wilder, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Canyon Hill 12-1 1922

20. UNDERTAKER

ADDRESS

W. B. Rankin Calderwell

JAN 5 1923
BUREAU OF VITAL STATISTICSState of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon
City of CaldwellRegistration District No. 3Primary Registration District No. 2005

(No. _____, _____ St.)

File No. 49475

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

George W. Robbins

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

male white single
(Write the word.)

6. DATE OF BIRTH

Feb. 22 1885
(Month) (Day) (Year)

7. AGE

37 Yrs. 10 Mos. 7 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Labor

9. BIRTHPLACE

(State or Country)

Michigan

10. NAME OF FATHER

Charles Robinson

11. BIRTHPLACE OF FATHER

(State or Country)

Michigan

12. MAIDEN NAME OF MOTHER

Brown

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Minnie Horning
(Address) Caldwell

15.

Filed Jan. 14 1923, John H. Meyer,
Local Registrar

MEDICAL CERTIFICATE OF DEATH

19

16. DATE OF DEATH

Dec. 29 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from _____ 19____ to Dec 29 1922that I last saw him alive on Dec 29 1922and that death occurred on the date stated above, at 8:30 PM.

The CAUSE OF DEATH* was as follows:

Heart Failure due to
myocarditis(Duration) 6+ Yrs. _____ mos. _____ ds.Contributory. Exposure - Habits
(Secondary)(Duration) 20+ yrs. _____ mos. _____ ds.(Signed) D. B. Dudley, M. D._____ 19____ (Address) Caldwell Id

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Canyon Hill

DATE OF BURIAL

1-1-1923

20. UNDERTAKER

C. V. Pickham

ADDRESS

Caldwell

1. PLACE OF DEATH

County of *Canyon*City of *Middleton*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED CERTIFICATE OF DEATH

Registration District No. *3*Primary Registration District No. *2005*

(No.)

St.)

File No.

40476

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-OWED OR DIVORCED

*male**white**married*
(Write the word.)

6. DATE OF BIRTH

Nov
(Month)*9*
(Day)*1829*
(Year)

7. AGE

93 yrs.*1* mos.*19* ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).*rancher.*

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

Wm. Heavin

11. BIRTHPLACE OF FATHER

(State or Country)

Not known

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Pa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Maro A. Heavin

(Address)

Middleton, Idaho

15.

Filed

*Dec. 31 - 1922**John H. Ingers*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec. 28
(Month) (Day)*1922*
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 11 19*22*, to *Dec 22* 19*22*that I last saw him alive on *Dec 22* 19*22*and that death occurred on the date stated above, at *11 P.M.*

The CAUSE OF DEATH* was as follows:

Sunstroke

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

L. E. Hurst

M. D.

12/26 1922

(Address)

Caldwell, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Middleton

DATE OF BURIAL

12-31-1922

20. UNDERTAKER

C. V. Peckham

ADDRESS

Caldwell, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40477**
Registered No. **139**

1. PLACE OF DEATH

Registration District No. **3**
County of **Canyon**
Primary Registration District No. **2005**
City of **Wilder** (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Rueh Alma M^e Nutt

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female white married
(Write the word.)

6. DATE OF BIRTH

Aug 2 1857
(Month) (Day) (Year)

7. AGE

65 Yrs 4 Mos 26 ds.
IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Housewife

9. BIRTHPLACE

(State or Country) **Iowa**

10. NAME OF FATHER

Dr. Wonder

11. BIRTHPLACE OF FATHER

(State or Country) **Not known**

12. MAIDEN NAME OF MOTHER

" "

13. BIRTHPLACE OF MOTHER

(State or Country) **" "**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Charles C. McHurt**

(Address) **Wilder Idaho R.R. 1.**

15.

Filed **Dec. 30- 1922** **John H. Meyer**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec. 28 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 1922 to Dec 1922
that I last saw him alive on **Oct 12 1922**

and that death occurred on the date stated above, at **1:30 PM.**

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory.
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Benton O. Clark M. D.
Dec 30 1922 (Address) **Emmett Ida**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Wilder Idaho

DATE OF BURIAL

12-30-1922

20. UNDERTAKER

C. V. Beckham

ADDRESS

Caldwell, Ida

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of CanyonCity of CaldwellRegistration District No. 3Primary Registration District No. 2005

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME August JohnsonState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 40478Registered No. 138

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

(Write the word.)

6. DATE OF BIRTH

June 6 1871

(Month)

(Day)

(Year)

7. AGE

51

Yrs.

6

Mos.

21

ds.

IF LESS than 1 day

how many _____ hrs.

or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Miner

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Finland Russia

10. NAME OF FATHER

John Johnson

11. BIRTHPLACE OF FATHER

(State or Country)

Finland Russia

12. MAIDEN NAME OF MOTHER

Not Known

13. BIRTHPLACE OF MOTHER

(State or Country)

Finland Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Sarah J. Driscoll

(Address)

Caldwell Idaho

15.

Filed

Dec. 27 - 1922John H. Meyers
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec. 27-22

(Month)

(Day)

19____ (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19____

to

19____

that I last saw h. _____ alive on _____ 19____

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Cardiac Asthma

(Duration) Several Years. ds.Contributory Flu
(Secondary)(Duration) _____ yrs. _____ mos. 5 ds.(Signed) J. H. Meyers

M. D.

12/27-22 (Address) Caldwell Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Hailey Ida

DATE OF BURIAL

Dec. 28 1922

20. UNDERTAKER

Paul L. Case

ADDRESS

Caldwell Ida

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Jersey
City of HomesteadRegistration District No. 3Primary Registration District No. 2005-

(No. _____ St.)

File No. 40479Registered No. 137

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lucinda Baldridge

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

married

6. DATE OF BIRTH

Dec 21 1867
(Month) (Day) (Year)

7. AGE

54 Yrs. 11 Mos. 27 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)House wife

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

Campbell

11. BIRTHPLACE OF FATHER

(State or Country)

Virginia

12. MAIDEN NAME OF MOTHER

not known

13. BIRTHPLACE OF MOTHER

(State or Country)

Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Berdie Veta Reynolds

(Address)

Homestead Ida

15.

Filed Dec. 20 - 1922John V. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

qv

16. DATE OF DEATH

Dec 18 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 4 1922 to Dec 17 1922that I last saw her alive on Dec 17 1922and that death occurred on the date stated above, at 5:23 P.

The CAUSE OF DEATH* was as follows:

Pneumonia(Duration) _____ Yrs. _____ mos. 4 ds.

Contributory (Secondary)

Apoplexy(Duration) _____ yrs. _____ mos. 13 ds.(Signed) W. B. Bouch M. D.Dec 19 22 (Address) Wilder Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Denver Colo 19 _____

20. UNDERTAKER

ADDRESS

C. V. Beckham Caldwell
Ida

July 28 -

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 3
County of Canyon Primary Registration District No. 2005
City of Caldwell (No. 100) St. File No. 40480
Registered No. 136

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Thomas Allen Randolph

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married

6. DATE OF BIRTH

Sept 2 1884
(Month) (Day) (Year)

7. AGE

58 Yrs. 3 Mos. 14 ds.IF LESS than 1 day
how many..... hrs
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Rancher

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

Wm R. Randolph

11. BIRTHPLACE OF FATHER

(State or Country)

Tenn.

12. MAIDEN NAME OF MOTHER

Mary Hyle

13. BIRTHPLACE OF MOTHER

(State or Country)

Tenn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Interpretor) Arthur Randolph
(Address) Caldwell Ida #115. Filed Dec. 17 1922 John H. Mayes
Local Registrar

16. DATE OF DEATH

Dec 15 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 28 1922 to Dec 16 1922
that I last saw him alive on Dec 14 1922
and that death occurred on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH* was as follows:

embolism(Duration) 6 mos. 0 ds.

Contributory (Secondary)

Chronic Nephritis(Duration) 4 yrs. 0 mos. 0 ds.

(Signed)

12-17-22 (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Canyon Hill 12-17 1922

20. UNDERTAKER

ADDRESS

V. Beckham Caldwell

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Canyon
City of CaldwellRegistration District No. 3Primary Registration District No. 1005

(No. _____) (St. _____)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mark Petty MilesState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 40482Registered No. 134

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married

6. DATE OF BIRTH

May 5 1884
(Month) (Day) (Year)

7. AGE

68 Yrs. 7 Mos. 7 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Blacksmith

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

Henry J. Miles

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Rebecca Pemberton

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Wilder, Ida

15.

Filed

Dec. 14 - 1922John H. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 12 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 7 - 1922 to Dec - 11 1922
that I last saw him alive on Dec 10 8 PM 1922
and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia(Duration) _____ Yrs. _____ mos. _____ ds.
Contributory (Secondary) Heart disease (myocard)(Duration) 3 Yrs. _____ mos. _____ ds.(Signed) J. B. Dudley M. D.19. (Address) Caldwell, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ Yrs. _____ mos. _____ days. In the State _____ Yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Canyon Hill 12-14 1922

20. UNDERTAKER

ADDRESS

J. P. Beckham Caldwell

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Canyon Registration District No. 3
 City of Caldwell Primary Registration District No. 2005
 (No. _____) (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Chas Edwin Eddis

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 40483
 Registered No. 133

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
 (Write the word.)

6. DATE OF BIRTH

July 24 1868
 (Month) (Day) (Year)

7. AGE

54 Yrs. 4 Mos. 16 ds.

IF LESS than 1 day
 how many _____ hrs.
 or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

Rancher

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

Wm Eddis

11. BIRTHPLACE OF FATHER

(State or Country)

Canada

12. MAIDEN NAME OF MOTHER

Janet House

13. BIRTHPLACE OF MOTHER

(State or Country)

not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mary Eddis

(Address)

Caldwell, Ida.

15.

Filed

Dec. 14 1922 John V. Meyer
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 10 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 15 1922 to Dec 10 1922

that I last saw him alive on Dec 10 1922
 and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) 4 Yrs. _____ mos. _____ ds.

Contributory (Secondary)

Influenza

(Duration) _____ yrs. 1 mos. _____ ds.

(Signed)

G. D. Montgomery D.

Dec 11 1922 (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Rigby, Idaho

DATE OF BURIAL

12-11 1922

20. UNDERTAKER

C. V. Peckham

ADDRESS

Caldwell, Ida

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Benewah Registration District No. 82
City of Soda Springs Primary Registration District No. 2159
(No. VITAL St.)

File No. 40484Registered No. 18

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Harry Sherman Maloney

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single

(Write the word.)

6. DATE OF BIRTH.

March 4

(Month)

(Day)

1884
(Year)

7. AGE

38 Yrs. 9 Mos. 24 ds.

If LESS than 1 day
how many.....hrs. or
.....min.2]

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

Machinist

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Peter A. Maloney

11. BIRTHPLACE OF FATHER

(State or Country)

Scotland

12. MAIDEN NAME OF MOTHER

Bessie White

13. BIRTHPLACE OF MOTHER

(State or Country)

Cheio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Harry Maloney

(Address)

Soda Springs, W.

15.

Filed Dec 30 19122Ernie Karsley

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

December

(Month)

29

(Day)

1912

(Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 9 1912 to Dec 29 1912, that I last saw him alive on Dec 29 1912, and that death occurred on the date stated above, at 2:35 P. M.

The CAUSE OF DEATH* was as follows:

Phlegm's Pneumonia

(Duration)

Yrs. 2 mos. ds.

Contributory (Secondary)

None

(Duration)

yrs. mos. ds.

(Signed)

Ernie Karsley

M. D.

19 (Address)

Soda Springs, W.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death.....yrs.....mos.....days

In the

State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Soda Springs, W.Dec 31 19122

20. UNDERTAKER

Ed Whelan

ADDRESS

Soda Spr

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

1. PLACE OF DEATH

County of Laramie Registration District No. 82
City of Indian Spring Primary Registration District No. 2159 (Station) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jonas Harris

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 40485Registered No. 17

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Child

(Write the word.)

6. DATE OF BIRTH

Feb 16, 1914
(Month) (Day) (Year)

7. AGE

8 Yrs. 7 Mos. 16 ds.

IF LESS than 1 day
how many hrs. or
..... min.?)

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

None

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Jon Harris

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Louise Larsen

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Jon Harris

(Address)

Cleveland, Idaho

15.

Filed

Oct 2, 1912

E. J. Kinsley

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 2, 1912
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1st 1912, to Oct 2nd 1912, that I last saw him alive on Oct 1st 1912, and that death occurred on the date stated above, at 59 M.

The CAUSE OF DEATH* was as follows:

Pertussis

(Duration) Yrs. mos. 2 ds.

Contributory (Secondary)

Respiratory

(Duration) Yrs. mos. 4 ds.

(Signed)

E. J. Kinsley M. D.

Oct 2, 1912 (Address) Indian Spring, Wyo.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Perry Idaho

Oct 4th 1912

20. UNDERTAKER

ADDRESS

None

✓

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

R.E. Rich.
State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 40486
Registered No. 647

1. PLACE OF DEATH

County of Cassia
City of Burley

Registration District No. 117
Primary Registration District No. 2196
(No. 2196 21. Burley Ave. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ada S. Harper.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female White Married (Write the word.)

6. DATE OF BIRTH

Aug. 22, 1888
(Month) (Day) (Year)

7. AGE

34 Yrs. 4 Mos. 7 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Housewife

9. BIRTHPLACE

(State or Country) Plano Idaho.

10. NAME OF FATHER

William Oren Pratt.

11. BIRTHPLACE OF FATHER

(State or Country) Franklin, Ida.

12. MAIDEN NAME OF MOTHER

Sophia Keller.

13. BIRTHPLACE OF MOTHER

(State or Country) Brigham City Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Albert Harper

(Address) Gemel del. Burley, Ida.

15.

Filed Dec 31, 1922 Dr. J. C. Patterson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec. 29, 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 22, 1922, to Dec. 29, 1922, that I last saw her alive on Dec. 29, 1922, and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Streptococcus infection of throat (quinsy) or peritonsillar abscess

(Duration) Yrs. mos. 10 ds.

Contributory (Secondary) Hemorrhage

(Duration) Yrs. mos. ds. Almost instantaneous

(Signed) C. F. Rich M. D.

1-2 1923 (Address) Burley Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Burley Ida.

DATE OF BURIAL

Dec. 31, 1922

20. UNDERTAKER

H. B. Gallagher.

ADDRESS

Burley Ida.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40487**
Registered No. **646**

1. PLACE OF DEATH

County of Cassia
City of Burley

Registration District No. 117
Primary Registration District No. 2196
(No. 102 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Joseph Lee Wadsworth

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male White Single (Write the word.)

6. DATE OF BIRTH

April 22 = 1921
(Month) (Day) (Year)

7. AGE

1 Yrs. 8 Mos. 6 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

At Home

9. BIRTHPLACE

(State or Country) Ogden Utah

10. NAME OF FATHER

Claude Wadsworth

11. BIRTHPLACE OF FATHER

(State or Country) Kooper Utah

12. MAIDEN NAME OF MOTHER

Beatrice Howles

13. BIRTHPLACE OF MOTHER

(State or Country) Kooper, Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. H. Fowles

(Address) Burley, Ida.

15.

Filed 12-31-22 19

Dr. J. C. Patterson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec. 20 = 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec. 20 1922 to Dec. 30 1922
that I last saw him alive on Dec. 30 1922
and that death occurred on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) Yrs. mos. 2 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. C. Patterson M. D.

12-31-1922 (Address) Burley, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Ogden Utah

DATE OF BURIAL

Jan. 1 = 1923

20. UNDERTAKER

R. B. Gallogly

ADDRESS

Burley, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

OVER

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Cassia*
City of *Burley*

Registration District No. *111*
Primary Registration District No. *2196*
(No. St.)

File No. *40488*
Registered No. *641*

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

James Mortenson Sanders

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male *White* *Single* (Write the word.)

6. DATE OF BIRTH

Sept. 5 19*22*
(Month) (Day) (Year)

7. AGE

Yrs *3* Mos *2* ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work *At Home*
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) *Idaho* *Ida.*

10. NAME OF FATHER

Lee W. Sanders

11. BIRTHPLACE OF FATHER

(State or Country) *Oregon*

12. MAIDEN NAME OF MOTHER

Jetta Fern Mortenson

13. BIRTHPLACE OF MOTHER

(State or Country) *Old Mexico*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *L. W. Sanders*

(Address) *Burley Ida.*

15.

Filed *Dec. 31* 19*22* *Ph. J. C. Patterson*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec. 7 19*22*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

..... 19..... to 19.....
that I last saw him alive on 19.....
and that death occurred on the date stated above, at *4:30* A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

..... (Duration) Yrs. mos. ds.

Contributory (Secondary)

..... (Duration) yrs. mos. ds.

(Signed) *L. B. Gregory (Coroner)* M. D.

12/8/22 (Address) *Burley Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Burley Ida.

DATE OF BURIAL

12/8/1922

20. UNDERTAKER

Bishop L. W. Drake

ADDRESS

Burley Ida.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of CassiaCity of Burley

If death occurs away from usual residence, give facts called for under special information.

Registered District No. 117Primary Registration District No. 2196(No. 117, St.)State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 40489Registered No. 643

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elvina Luginbuhl

PERSONAL AND STATISTICAL PARTICULARS

3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female | White | Single (Write the word.)

6. DATE OF BIRTH

April 9 1922
(Month) (Day) (Year)

7. AGE

8 Yrs. 8 Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

at home

9. BIRTHPLACE

(State or Country)

Burley Idaho.

10. NAME OF FATHER

Alva Luginbuhl

11. BIRTHPLACE OF FATHER

(State or Country)

Denver Colorado.

12. MAIDEN NAME OF MOTHER

Jina Smith

13. BIRTHPLACE OF MOTHER

(State or Country)

Shelley Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Alva Luginbuhl

(Address)

Burley Idaho.

15.

Filed

Dec 31 1922Mr J.C. Patterson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov. 29 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 9, 1922 to Nov. 29, 1922
that I last saw him alive on Nov. 28, 1922and that death occurred on the date stated above, at 3 a. M.

The CAUSE OF DEATH* was as follows:

Malnutrition(Duration) 8 Yrs. 8 mos. ds.Contributory
(Secondary)(Duration) Yrs. mos. ds.

(Signed)

J. C. Patterson

M. D.

Nov. 29, 1922(Address) Burley, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Burley Idaho.

DATE OF BURIAL

11/29/1922

20. UNDERTAKER

L. B. Gellough

ADDRESS

Burley Ida.

FORM V. S. No. 5-25 M. 1-19.

123 CERTIFICATE OF DEATH

Cooper.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Cassia
City of BurleyRegistration District No. 111Primary Registration District No. 2196(No. 1 St.)File No. 40490Registered No. 643

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Joseph H. Hewellyn Nielsen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male White Single (Write the word.)

6. DATE OF BIRTH

May 2 (Month) 2 (Day) 1922 (Year)

7. AGE

9 Yrs. 1 Mos. 25 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).In School.

9. BIRTHPLACE

(State or Country)

Spanishfork Utah

10. NAME OF FATHER

J. Gilbert Nielsen

11. BIRTHPLACE OF FATHER

(State or Country)

Spanishfork, Utah

12. MAIDEN NAME OF MOTHER

Jennie Thomas

13. BIRTHPLACE OF MOTHER

(State or Country)

Spanishfork Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. T. Nielsen

(Address)

Burley, Ida. R.F.D. #3

15.

Filed Dec 31 19 22 P. J. C. Patterson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec. 27 19 22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec. 26 - 1922 to Dec. 27 19 22that I last saw him alive on Dec. 27 19 22
and that death occurred on the date stated above, at 8:30 P.M.

The CAUSE OF DEATH* was as follows:

myocarditis(Duration) Yrs. — mos. 10 ds.Contributory
(Secondary)(Duration) yrs. — mos. 10 ds.

(Signed)

W. H. Cooper

M. D.

19

(Address)

Burley, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. — mos. — days. In the State yrs. — mos. — days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Burley, Ida.

DATE OF BURIAL

Dec. 30, 1922

20. UNDERTAKER

L. B. Gallagher

ADDRESS

Burley, Ida.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of IdahoCity of Burley

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 117
Primary Registration District No. 2196
(Name) W. B. Burton St.)

2. FULL NAME

Norma J. GibsonState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 40491Registered No. 644

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female White Single (Write the word.)

6. DATE OF BIRTH

Nov. 21 = 1922
(Month) (Day) (Year)

7. AGE

1 Yrs. 7 Mos. 7 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).None.

9. BIRTHPLACE

(State or Country)

Burley, Ida.

10. NAME OF FATHER

Francis Russell Gibson

11. BIRTHPLACE OF FATHER

(State or Country)

Ogden Utah.

12. MAIDEN NAME OF MOTHER

Ora J. Brower

13. BIRTHPLACE OF MOTHER

(State or Country)

Ora, Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) F. R. Gibson(Address) 422 N. Burton, Burley, Ida.15. Filed Dec. 31 1922 W. J. C. Patterson

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec. 27 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov. 26, 1922 to Dec. 27, 1922that I last saw him alive on Nov. 26, 1922and that death occurred on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia(Duration) Yrs. mos. 1 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. C. Patterson M. D.
Burley, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Burley Ida.

DATE OF BURIAL

Dec. 29 = 1922

20. UNDERTAKER

L. B. Gallagher

ADDRESS

Burley, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

40492

State of Idaho

BOARD OF HEALTH

Bureau of Vital Statistics

File No.
 Registered No. **645**
 If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of *Mu*

Registration District No. *117*

Registration District No. *2196*

City of *Blackfoot*
 If death occurs away from usual residence, give facts called for under special information.
 Wilford Lewis Rogers

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
 (Write the word.)

6. DATE OF BIRTH.

Oct 24 19*06*
 (Month) (Day) (Year)

7. AGE

61 Yrs. *3* Mos. *6* ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business, or establishment in which employed (or employer)

Rancher

9. BIRTHPLACE

(State or Country)

Ida

10. NAME OF FATHER

Edwin Rogers

11. BIRTHPLACE OF FATHER

(State or Country)

Don't know

12. MAIDEN NAME OF MOTHER

Edwina Blandens

13. BIRTHPLACE OF MOTHER

(State or Country)

N.Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mrs. W. D. Rogers*

(Address)

Blackfoot, Ida.

15.

Filed

Dec. 31 19*22*

H. J. C. Patterson
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 31 19*22*
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw h. alive on *Jan 1* 19*23*
 and that death occurred on the date stated above, at *191* M.

The CAUSE OF DEATH* was as follows:

Broken neck
 (Dead when found)

(Duration) Yrs. mos. ds.

Contributory (Secondary)

Accident

(Duration) Yrs. mos. ds.

(Signed)

H. J. C. Patterson

Jan 1 19*23* (Address) *Barley, Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
 of death yrs. mos. days, State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Blackfoot, Ida

DATE OF BURIAL

on arrival

20. UNDERTAKER

Wm. H. Huddles

ADDRESS

Barley, Ida

RECEIVED CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics.

1. PLACE OF DEATH

County of Clark Registration District No. 125
 City of Dubois Primary Registration District No. 2263
 (No. TICS) (St.)

File No. 40493

Registered No. _____

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Norma Kingsford

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Infant
(Write the word.)

6. DATE OF BIRTH

Nov 5 1922
(Month) (Day) (Year)

7. AGE

Yrs. 1 Mos. 19 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

Infant

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Edward L Kingsford

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Ethel Dowdle

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edward L Kingsford
(Address) Dubois Idaho

15. Filed Dec 24 1922 W E Jones M.D.
Local Registrar

16. DATE OF DEATH

Dec 24 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19
that I last saw h. alive on 19
and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Probably
Bronchopneumonia(Duration) Yrs. mos. 5 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

W E Jones M. D.
12/24/1922 (Address) Dubois Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Dubois Idaho

DATE OF BURIAL

12/25 1922

20. UNDERTAKER

None

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 125

County of Clark

Primary Registration District No. 2203

City of Dubois

(No.)

(St.)

File No.

40494

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lucy B Curtis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

135

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDFemale White married
(write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

35 Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Housewife

9. BIRTHPLACE

(State or Country)

Nebraska

10. NAME OF FATHER

Smith

11. BIRTHPLACE OF FATHER

(State or Country)

Smith

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

W E Curtis
Dubois Idaho

15.

Filed

Dec 13 1922 W E Jones M D
Local Registrar

16. DATE OF DEATH

Dec 13 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
Dec 13, 10 AM 1922, to Dec 13, 4 AM 1922,that I last saw her alive on Dec 13 1922
and that death occurred on the date stated above, at 4 AM.

The CAUSE OF DEATH* was as follows:

Child birth complications
Hemorrhage - heart failure
(Duration) Yrs. mos. 5 ds.Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

12/13/22

(Address)

W E Jones M. D.
Dubois Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Roberts Idaho Dec 14 1922

20. UNDERTAKER

ADDRESS

C C Haynes Dubois Idaho

MARGIN RESERVE FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH

County of Clearwater
City of Profino

Registration District No. 90
Primary Registration District No. 2168
(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Iver Theodore Oberg

File No. 40496
Registered No. 60

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH About 1874
(Month) (Day) (Year)

7. AGE 48 about IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Tailor
(b) General nature of industry, business or establishment in which employed (or employer) Making & Repairing of Suits, Garments, etc.

9. BIRTHPLACE

(State or Country) Sweden

10. NAME OF FATHER

Oberg

11. BIRTHPLACE OF FATHER

(State or Country) Sweden

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. W. Attaberry
(Address) Profino - Idaho

15. Filed Jan 6 1923

J. McFarley
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

December Ninth 19 22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 28th 19 22, to December 9th 19 22 that I last saw him alive on December 9th 19 22 and that death occurred on the date stated above, at 6:50 P.M.

The CAUSE OF DEATH* was as follows:

Epilepsy

(Duration) 9 Yrs. _____ mos. _____ ds.

Contributory (Secondary) Insanity

(Duration) ? yrs. _____ mos. _____ ds.

(Signed) John W. Attaberry M. D.

12/10 19 22 (Address) Profino - Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 3 yrs. 12 mos. 15 days. In the State 15 yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence Moscow, Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Moscow Ida Dec 12 - 1922

20. UNDERTAKER

ADDRESS

W. A. Shaver Profino

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40497**
Registered No. **61**

1. PLACE OF DEATH

County of Clearwater Registration District No. 90
City of Profino, Idaho Primary Registration District No. 2168
(No. _____) (St. _____)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Nicholas Herres

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Unknown
(Write the word.)

6. DATE OF BIRTH

About

(Month)

(Day)

1874
(Year)

7. AGE

48 about

Yrs.

Mos.

ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Farmer

(b) General nature of industry, business or establishment in which employed (or employer)

General Farm Work

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

Herres

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. W. Atteberry
Profino, Idaho.

15.

Filed

Jan 6 1923

Miss Emily
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

December 24th 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from February 12th 1922 to December 24th 1922, that I last saw him alive on December 23rd 1922, and that death occurred on the date stated above, at 4:00 A.M.
The CAUSE OF DEATH* was as follows:

Epilepsy

(Duration) Unknown Yrs. _____ mos. _____ ds.

Contributory (Secondary)

Insanity

(Duration) Unknown yrs. _____ mos. _____ ds.

(Signed)

Dec 25 1922

(Address)

Profino - Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place 4 yrs. 10 mos. 13 days. In the State 13 yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lewiston, Ida Dec 27 1922

20. UNDERTAKER

ADDRESS

W. A. Spaul Profino

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Clearwater
 City of Aksakha

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 90
 Primary Registration District No. 2168
 (N. St.)

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 40498
 Registered No. 58

2. FULL NAME

RECEIVED
 DEC 30 1922
 BUREAU OF VITAL STATISTICS

Edward Davis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE Indian 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
 (Write the word.)

6. DATE OF BIRTH

Nov 24 1899
 (Month) (Day) (Year)

7. AGE

68 Yrs. 00 Mos. 00 da.

IF LESS than 1 day
 how many _____ hrs.
 or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

Farmer

9. BIRTHPLACE

(State or Country)

Ida

10. NAME OF FATHER

Edward Davis

11. BIRTHPLACE OF FATHER

(State or Country)

Ida

12. MAIDEN NAME OF MOTHER

Apenagahlpaw

13. BIRTHPLACE OF MOTHER

(State or Country)

Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. E. Davis

(Address)

Hamish, Ida

15.

Filled

Dec 9 1922

J. M. Gentry
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 27 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

11/23 1922 to Abang 1922
 that I last saw him alive on 11/25 1922
 and that death occurred on the date stated above, at 11:00 M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) Yrs. 00 mos. 7 ds.

Contributory
 (Secondary)

(Duration) Yrs. 00 mos. 00 ds.

(Signed)

[Signature]

M. D.

11/28 1922 (Address) Hamish, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. 00 mos. 00 days. In the State Yrs. 00 mos. 00 days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Hamish

DATE OF BURIAL

11/15 1922

20. UNDERTAKER

V. A. Shaw

ADDRESS

Orfer

RECEIVED
DEC 30 1922
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 40499

Registered No. 57

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of

City of

Registration District No. 90

Registration District No. 2168

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Beverly Patrick Edmonson

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female

White

(Write the word.)

6. DATE OF BIRTH.

Apr

23

1922

(Month)

(Day)

(Year)

7. AGE

Yrs. 6 Mos. 28 ds.

IF LESS than 1 day
how many hrs. or min.

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

None

9. BIRTHPLACE

(State or Country)

Ida

10. NAME OF FATHER

Harry Edmonson

11. BIRTHPLACE OF FATHER

(State or Country)

Virginia

12. MAIDEN NAME OF MOTHER

Hattie Jordan

13. BIRTHPLACE OF MOTHER

(State or Country)

Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Harry Jordan

(Address)

Fraser

15.

Filed

Dec 9 1922

1922

J. M. Fairley

Local Registrar

16. DATE OF DEATH

Nov

21

1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 20 1922 to Nov 21 1922 that I last saw him alive on Nov 21 1922 and that death occurred on the date stated above, at 70 M.

The CAUSE OF DEATH* was as follows:

Autumnusception

(Duration)

Yrs.

mos.

5 ds.

Contributory (Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

E. H. Howell

M. D.

11/22/22 (Address)

Oxford, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death....yrs....mos....days State....yrs....mos....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Fraser Ida

11/22 1922

20. UNDERTAKER

ADDRESS

W. A. Shaw,

Oxford

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

Registration District No.

Prima Registration District No.

St.)

File No.

Registered No.

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF
FATHER11. BIRTHPLACE
OF FATHER

(State or Country)

12. MAIDEN NAME
OF MOTHER13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw her alive on

The CAUSE OF DEATH* was as follows:

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) M. D.

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH
in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH
County of Elmore Primary Registrar District No. 2020 File No. 40561
City of Mont Home Ida. (Not a City) (St.) Registered No. 31
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Boyer Bach

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH Nov. 18 1922
(Month) (Day) (Year)

7. AGE _____ Yrs. _____ Mos. _____ ds. IF LESS than 1 day how many 9 hrs. or _____ min.?

8. OCCUPATION None
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE Mont Home Ida.
(State or Country)

10. NAME OF FATHER Jayette Bach

11. BIRTHPLACE OF FATHER Idaho
(State or Country)

12. MAIDEN NAME OF MOTHER Edna Boyer

13. BIRTHPLACE OF MOTHER Idaho
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) B.S. Parker
(Address) Mont Home Ida.

15. Filed 12-1-22 J.E. Evans Local Registrar

MEDICAL CERTIFICATE OF DEATH 1526

16. DATE OF DEATH Nov. 18 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-18-1922 to 11-18-1922 that I last saw him alive on 11-18-1922 and that death occurred on the date stated above, at 10 P.M. The CAUSE OF DEATH* was as follows:

(Duration) _____ Yrs. _____ mos. _____ ds.
Contributory (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) J.E. Evans M. D.
19 (Address) Mont Home Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days
Where was disease contracted if not at place of death? _____
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Mont Home Cemetery DATE OF BURIAL 11/19/22
20. UNDERTAKER Wm McBratney ADDRESS _____

1. PLACE OF DEATH

County of Elmore
City of Mt. Home

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

W. F. Ferguson

CERTIFICATE OF DEATH

Registration District No. 34
Primary Registration District No. 2020
(No. _____ St.)State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 110502
Registered No. 32

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Single
(Write the word.)

6. DATE OF BIRTH

(Month) _____ (Day) 1 (Year) _____

7. AGE

75 Yrs. _____ Mos. _____ ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Trapper.

9. BIRTHPLACE

(State or Country)

Tenn.

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed 11-22-1922J. E. Coons
Local Registrar

16. DATE OF DEATH

Nov. 20 22
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from 11-17-1922 to 11-20-1922that I last saw him alive on 11-19-1922
and that death occurred on the date stated above, at 3 1/2 M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia(Duration) _____ Yrs. 7 mos. _____ ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

M. D.

11-22-1922

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mt. Home Cemetery11/22-1922

20. UNDERTAKER

ADDRESS

Wm McBratneyBorerside

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Elmore Registration District No. 2020
City of Mountain Home (State) IdahoFile No. 40508
Registered No. 33

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Seth Heath

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Divorced
(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from
12-1-1922 to 12-9-1922that I last saw him alive on 12-6-1922
and that death occurred on the date stated above, at 12/9/22

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) J E Evans M. D.12-9-1922 (Address) Mt Home Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

City Cemetery, Mt. Home 12/13/1922

20. UNDERTAKER

ADDRESS

Wm D Talley Mt Home, Ida

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Elmore*
City of *Mt. Home*Registration District No. *34*
Primary Registration District No. *20 20*
(No. _____ St.)File No. *40504*
Registered No. *34*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Wilbert Doty

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*
(Write the word.)6. DATE OF BIRTH *Dec. 14* 19*22*
(Month) (Day) (Year)7. AGE _____ Yrs. _____ Mos. *2* ds. IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).9. BIRTHPLACE *Mt. Home*
(State or Country) *Ida.*10. NAME OF FATHER *Henry Doty*11. BIRTHPLACE OF FATHER *Calif.*
(State or Country)12. MAIDEN NAME OF MOTHER *Irene Hunt*13. BIRTHPLACE OF MOTHER *Neb.*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Henry Doty*
(Address) _____15. Filed *12-17-19* *J. E. Evans*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec. 16 19*22*
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *12-14-19* to *12-16-19* that I last saw h. *alive* on *12-16-19* and that death occurred on the date stated above, at *11:30 A.* The CAUSE OF DEATH* was as follows:*Premature Birth - 6 1/2 mos*(Duration) _____ Yrs. _____ mos. _____ ds.
Contributory (Secondary) _____(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) *J. E. Evans* M. D.*12-17-19* (Address) *Mt. Home Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL *Mt. Home* DATE OF BURIAL *Dec 17* 19*22*20. UNDERTAKER *Wm D. Talley* ADDRESS *Mt. Home*

FORM V. S. No. 5-A—25 M. 1-19

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **40505**
Registered No. **3**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH **Elmore** Registration District No. **84**
County of **Elmore** Primary Registration District No. **2020**
City of **Mtn Home** (No. **1513**) St.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Walter Doty**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **single**
(Write the word.)6. DATE OF BIRTH **Dec. 14** **1922**
(Month) (Day) (Year)7. AGE _____ If LESS than 1 day how many _____ hrs. or _____ min.?
Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).9. BIRTHPLACE **Mtn Home Ida.**
(State or Country)10. NAME OF FATHER **Henry Doty**11. BIRTHPLACE OF FATHER **Calif.**
(State or Country)12. MAIDEN NAME OF MOTHER **Irene Hunt**13. BIRTHPLACE OF MOTHER **Nebr.**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Henry Doty**
(Address) **Mtn Home**15. Filed **12-20-1922****J. E. Evans**
Local RegistrarMEDICAL CERTIFICATE OF DEATH **1515**16. DATE OF DEATH **Dec 16** **1922**
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from _____ 19 _____ to _____ 19 _____
that I last saw him alive on _____ 19 _____
and that death occurred on the date stated above, **12:15 P.M.**
The CAUSE OF DEATH* was as follows:**Premature Birth - 6 1/2 mos**

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) **J. E. Evans** M. D.19. (Address) **Mtn Home Ida**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL **Mtn Home Ida** DATE OF BURIAL **Dec 17** **1922**20. UNDERTAKER **Wm D. Talley** ADDRESS **Mtn Home**

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **40506**
Registered No. **36**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

Registration District No. _____
County of Elmore Primary Registration District No. _____
City of Pine (No. _____) St. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Francis M. Riordan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single6. DATE OF BIRTH Idaho City, Idaho
July 22 1895
(Month) (Day) (Year)7. AGE 47 Yrs. 5 Mos. 4 ds.
IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Clerk
(b) General nature of industry, business or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country) Unknown

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country) ✓

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country) ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. S. Parker(Address) 207 7th & Ida

15.

Filed 12-26- 1922J. E. Evans
Local RegistrarMEDICAL CERTIFICATE OF DEATH qV

16. DATE OF DEATH

December 26 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Dec 19, 1922 to Dec 26, 1922that I last saw him alive on 26th Dec. 1922and that death occurred on the date stated above, at 6:45 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia (Right Lobe)(Duration) _____ Yrs. _____ mos. 21 ds.Contributory (Secondary) Uræmia(Duration) _____ Yrs. _____ mos. 24 hrs.(Signed) C. S. Allen M. D.Dec 26 1922 (Address) 318-19 McCarty Bldg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Bowl Idaho

DATE OF BURIAL

19

20. UNDERTAKER

Wm McBratney

ADDRESS

Bowl Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40508**

Registered No. _____

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH. **Elmore** Registration District No. **35**
County of **Elmore** Primary Registration District No. **2021**
City of **King Hill** (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

North Franklin Bullash

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **male** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **single**
(Write the word.)

6. DATE OF BIRTH

July 30 1922
(Month) (Day) (Year)

7. AGE

2 yrs. 2 mos. 27 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work **none**
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

King Hill Idaho

10. NAME OF FATHER

Mark A. Bullash

11. BIRTHPLACE OF FATHER

(State or Country)

S Dakota

12. MAIDEN NAME OF MOTHER

Alice Bobbi

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

M. A. Bullash

(Address)

King Hill Idaho

15.

Filed

Dec 15 1922**J. W. Davis**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct. 26 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct. 26 1922 to **Oct. 26 1922**

that I last saw him alive on **Oct. 26 1922**, and that death occurred on the date stated above, at **5 P. M.**

The CAUSE OF DEATH* was as follows:

Tubercular Meningitis(Duration) **2** yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. W. Davis M. D.
Oct. 26 1922 (Address) **Elmore's Ferry Idaho**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted.

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Gooding Idaho**Oct. 28 1922**

20. UNDERTAKER

ADDRESS

Mr Thompson**Gooding Idaho**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40509**

1. PLACE OF DEATH.

RECEIVED
JAN 3
BUREAU
VITAL

Registration District No. **35**County of **Elmore**Primary Registration District No. **2021**City of **Glenn's Ferry**

St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Martha Tracy

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female**Black****Widow**
(Write the word.)

6. DATE OF BIRTH

August 20 1866
(Month) (Day) (Year)

7. AGE

56 yrs. 3 mos. 22 ds.

IF LESS than 1 day
how many.....hrs. or
.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Garrett Co. Kentucky

10. NAME OF FATHER

Cloris Lowell

11. BIRTHPLACE OF FATHER

(State or Country)

Kentucky

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Jennie Mize

(Address)

Glenn's Ferry

15.

Filed **Dec. 15 1922****J. W. Dorris**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

40

16. DATE OF DEATH

Dec. 13 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct. 18 1922 to **Dec. 13 1922**

that I last saw him alive on **Dec. 13 1922**,
and that death occurred on the date stated above, at **12:10 P. M.**

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

(Duration) **5** yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) **J. W. Dorris** M. D.**Dec. 14 1922** (Address) **Glenn's Ferry Idaho**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Glenn's Ferry**12/14 1922**

20. UNDERTAKER

ADDRESS

J. W. Dorris **Glenn's Ferry**

1. PLACE OF DEATH

County of ElmoreCity of 47m West Glenmore

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lucy Larina Green

CERTIFICATE OF DEATH

Registration District No. 35Registration District No. 2021

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 40540

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F. 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widow
(Write the word.)

6. DATE OF BIRTH

May 19th 1842
(Month) (Day) (Year)

7. AGE

80 Yrs. 7 Mos. 4 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)none

9. BIRTHPLACE

(State or Country)

Tenn.

10. NAME OF FATHER

John Davis Green

11. BIRTHPLACE OF FATHER

(State or Country)

New York

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Morton A. Green(Address) Glenmore, Tenn.

15.

Filed Dec. 24 1922J. W. Davis
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec. 23 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Dec. 17 1922, to Dec. 23 1922, that I last saw her alive on Dec. 17 1922, and that death occurred on the date stated above, at 12 P.M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. W. Davis M. D.Dec 23 1922 (Address) Glenmore, Tenn.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

S.W. Irons Ranch.12/25 1922

20. UNDERTAKER

ADDRESS

Wm Mc BratneyBoise Ida.

V. S. No. 5. 10M. 6-20-11.

PLACE OF DEATH.

County of *Elmore*City of *Glenn's Ferry*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED
CERTIFICATE OF DEATHRegistration District No. *35*Primary Registration District No. *2021*

(No. _____, _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *4054*

Registered No. _____

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.*Male White**married*
(Write the word.)

6. DATE OF BIRTH

Mar 3 1864
(Month) (Day) (Year)

7. AGE

*58 yrs. 9 mos. 14 ds.*IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work*Housewife*(b) General nature of industry
business or establishment in
which employed (or employer)

9. BIRTHPLACE

(State or Country)

*Missouri*10. NAME OF
FATHER*William Baker*11. BIRTHPLACE
OF FATHER

(State or Country)

*Missouri*12. MAIDEN NAME
OF MOTHER13. BIRTHPLACE
OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

R L Gregory

(Address)

Glenn's Ferry

15.

Filed

*Mar 19 1922**1922**J. W. Davis*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec. 16 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

*Jan. 2nd 1922, to Dec. 16 1922*that I last saw her alive on *Dec. 16 1922*,
and that death occurred on the date stated above, at *9 P M.*

The CAUSE OF DEATH* was as follows:

Carcinoma Uteri(Duration) *2* yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *J. W. Davis* M. D.*Dec. 18 1922* (Address) *Glenn's Ferry Idaho*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Glenn's Ferry Idaho**Dec. 19 1922*

20. UNDERTAKER

ADDRESS

*J. W. Dickson**Glenn's Ferry Idaho*

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of FranklinCity of Preston

If death occurs away from usual residence, give facts called for under special information.

CERTIFICATE OF DEATH

Registration District No. 27Primary Registration District No. 2119(No. 1108)

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 40512Registered No. 75

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Samuel Henry Lucherini

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married (use the word.)

6. DATE OF BIRTH

September 9, 1897.

(Month)

(Day)

(Year)

7. AGE

25 Yrs. 2 Mos. 28 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

clerk

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Salt Lake City, Utah.

10. NAME OF FATHER

Henry Lucherini,

11. BIRTHPLACE OF FATHER

(State or Country) Italy.

12. MAIDEN NAME OF MOTHER

Millie Walker

13. BIRTHPLACE OF MOTHER

(State or Country) Manchester, England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henry Lucherini(Address) Logan Utah

15.

Filed Jan 8 1923Mrs. M. L. Lucherini
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

December 7, 1922.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov. 28 1922 to Dec 7 1922that I last saw him alive on Dec 7 1922and that death occurred on the date stated above, at 10:35 P.

The CAUSE OF DEATH* was as follows:

Operated for Ruptured Appendix Nov.
29, 1922. The immediate cause of death
was heart failure. (Duration) Yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Currie Bland M. D.Dec. 9, 1922 (Address) Preston, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 0 yrs. mos. days. In the State 15 yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence Blackfoot, Idaho.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Preston City CemeteryDec. 11, 1922.20. UNDERTAKER
W. O. EricksonADDRESS
Preston, Idaho.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED CERTIFICATE OF DEATH

Registration District No. 27

Primary Registration District No. 2119

BUREAU OF VITAL STATISTICS

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

40513

Registered No.

73

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WID-OWED OR DIVORCED

married

6. DATE OF BIRTH

April 25 1882
(Month) (Day) (Year)

7. AGE

40 Yrs. 8 Mos. 4 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Farming

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Andrew G. Larson

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Caroline Eppson

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. R. Larson

(Address)

Preston, Ida.

15.

Filed

12-29 1922 J. R. Cutler

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 29 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 1 1922 to Dec 29 1922
that I last saw him alive on Dec 22 1922
and that death occurred on the date stated above, at 12:00 A.M.

The CAUSE OF DEATH* was as follows:

Malignant Endocarditis

(Duration) Yrs. 3 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. R. Cutler M. D.

12-29-1922 (Address) Preston, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mimbicreek Idaho 12-29 1922

20. UNDERTAKER

ADDRESS

W. A. Skidmore Preston, Ida.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of FranklinCity of Weston

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 27Primary Registration District No. 2119(No. 2119)

St.)

2. FULL NAME Stephen Larsen RoseState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 40514Registered No. 74

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single (Write the word.)

6. DATE OF BIRTH

August 6, 1922

(Month)

(Day)

(Year)

7. AGE

4 Mos. 25 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

At Home

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Weston, Idaho.

10. NAME OF FATHER

Thomas J. Rose.

11. BIRTHPLACE OF FATHER

(State or Country)

Weston, Idaho.

12. MAIDEN NAME OF MOTHER

Irene Esther Larsen.

13. BIRTHPLACE OF MOTHER

(State or Country)

Cove, Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thomas J. Rose(Address) Weston, Idaho.

15.

Filed Jan 8 19 23Mrs. Ida Lippert
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 31 19 32
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec-30 1932, to Dec-31 1932,
that I last saw him alive on Dec 30 1932,
and that death occurred on the date stated above, at 9:45 P.M.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia(Duration) ✓ Yrs. ✓ mos. 4 ds.Contributory
(Secondary)(Duration) ✓ yrs. ✓ mos. ✓ ds.

(Signed)

F. W. States M. D.Dec 31 1932 (Address) Preston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 0 yrs. 4 mos. 25 ds. In the State 0 yrs. 4 mos. 25 days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Weston, Idaho

DATE OF BURIAL

January 12, 1923

20. UNDERTAKER

W. O. Erickson,

ADDRESS

Preston, Idah o.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **4051**
Registered No. **71**

1. PLACE OF DEATH

County of Franklin Registration District No. 27
City of Layton Registration District No. 2119 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

BUREAU OF VITAL STATISTICS

If death occurred in a hospital, institution, or nursing home, give its NAME, number of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

M. W. (Write the word.)

6. DATE OF BIRTH

Oct. 31 1922
(Month) (Day) (Year)

7. AGE

1 yr. 24 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or occupation of work.
(b) General nature of business, occupation or profession in which engaged.
(c) (for employer)

9. BIRTHPLACE

(State or Country) Layton, Ida

10. NAME OF FATHER

Alma L. Jensen

11. BIRTHPLACE OF FATHER

(State or Country) Mendon, Utah

12. MARRIAGE NAME OF MOTHER

Catherine Georgeon

13. BIRTHPLACE OF MOTHER

(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Alma L. Jensen

(Address) Layton, Ida

15. Filed Jan 8 1923 Mrs. H. L. Jensen

Local Registrar

16. DATE OF DEATH

Dec 24 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 23 1922 to Dec 24 1922

that I last saw him alive on Dec 24 1922

and that death occurred on the date stated above, at 6 PM.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) Yrs. mos. 3 ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) R. R. Vetter M. D.

19 (Address) Layton, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Manner of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Clarkston, Utah

20. UNDERTAKER

DATE OF BURIAL Dec 16 1922

ADDRESS 2

MARGIN REMOVED FOR READING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B. - Every item of information should be carefully checked. All should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Better statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Franklin
City of WhitneyRegistration District No. 27
Primary Registration District No. 2119
(No. _____ St.)File No. 40516
Registered No. 72

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jennie Woodward Rallison

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-OWED OR DIVORCED Married
(Write the word.)

16. DATE OF DEATH

December 26th 1922
(Month) (Day) (Year)

6. DATE OF BIRTH

May 21st 1873
(Month) (Day) (Year)

7. AGE

49 Yrs. 7 Mos. 5 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min. ?17. I HEREBY CERTIFY, That I attended deceased from June 29, 1923 to Dec 26, 1922,
that I last saw her alive on Dec - 23, 1922
and that death occurred on the date stated above, at 1 30 A.M.
The CAUSE OF DEATH* was as follows:

8. OCCUPATION

(a) Trade, profession or particular kind of work At Home
(b) General nature of industry, business or establishment in which employed (or employer)Nephritis -

9. BIRTHPLACE

Franklin, Idaho?
(State or Country)(Duration) 3 Yrs. 5 mos. 4 ds.

10. NAME OF FATHER

William Woodward,Contributory
(Secondary)Chronic (Duration) 4 yrs. 4 mos. 4 ds.

11. BIRTHPLACE OF FATHER

England.
(State or Country)(Signed) E. W. States M. D.Dec. 26, 1922 (Address) Preston, Idaho.

12. MAIDEN NAME OF MOTHER

Rebecca Wright,

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

13. BIRTHPLACE OF MOTHER

Scotland.
(State or Country)

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place 20 In the 49 yrs. 7 mos. 5 days
of death _____ yrs. _____ mos. _____ days. State _____ yrs. _____ mos. _____ days

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Where was disease contracted if not at place of death?

(Informant)

(Address)

Former or usual residence Franklin, Idaho.

15.

Filed Jan 8 1923 Mrs. G. L. Lippert
Local Registrar

19. PLACE OF BURIAL OR REMOVAL

Whitney, Idaho.

DATE OF BURIAL

December 28, 1922

20. UNDERTAKER

Wm?O. Erickson,

ADDRESS

Preston, Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of FranklinCity of Glendale

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Dominicus CarterRegistration District No. 27Primary Registration District No. 2119

(No. _____ St.)

File No. 40517Registered No. 74

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widowed (Write the word.)

6. DATE OF BIRTH

June 15, 1852
(Month) (Day) (Year)

7. AGE

70 Yrs. 5 Mos. 22 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Provo, Utah.

10. NAME OF FATHER

Dominicus Carter.

11. BIRTHPLACE OF FATHER

(State or Country) England.

12. MAIDEN NAME OF MOTHER

Mary Duffy.

13. BIRTHPLACE OF MOTHER

(State or Country) England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. O. Erickson(Address) Provo, Idaho.

15.

Filed Jan 8 1923 Mrs. Ida Lippert
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

December 7, 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 14, 1922 to Dec 7, 1922
that I last saw him alive on Dec 30, 1922and that death occurred on the date stated above, at 4:30 P. M.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis
and Argent's Valvular Heart
Disease(Duration) 8 Yrs. — mos. — ds.Contributory
(Secondary)

(Duration) _____ yrs. — mos. — ds.

(Signed) W. O. Erickson

M. D.

Dec. 8, 1922 (Address) Provo, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 0 yrs. 5 mos. _____ days. In the State 4 yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence Provo, Idaho.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Provo Cemetery Dec. 9, 1922

20. UNDERTAKER

ADDRESS

Wm. O. EricksonProvo, Idaho.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
40519
File No. _____
Registered No. 17

1. PLACE OF DEATH

County of *Freemont*City of *St. Anthony Idaho*Registration District No. *99*Primary Registration District No. *2177*

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Poulk Ruland Hansen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

(Write the word.)

6. DATE OF BIRTH

August 9th

(Month)

(Day)

1916
(Year)

7. AGE

6 Yrs. *4* Mos. *21* ds.

IF LESS than 1 day

how many _____ hrs.

or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

None

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Wilford Idaho

10. NAME OF FATHER

James Hansen

11. BIRTHPLACE OF FATHER

(State or Country)

Denmark

12. MAIDEN NAME OF MOTHER

Cathrine Poulk

13. BIRTHPLACE OF MOTHER

(State or Country)

Beaver Canyon Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

James Hansen

(Address)

15.

Filed *Jan 1st* 19*22**W. M. Hansen*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

December 30th

(Month)

(Day)

1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec. 30 19*22*, to *Dec. 31* 19*22*that I last saw *him* alive on *Dec. 30* 19*22*and that death occurred on the date stated above, at *9 P. M.*

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia(Duration) _____ Yrs. _____ mos. *1* ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) *J. E. Melton* M. D.*1-1-1923* (Address) *St. Anthony*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

*Wilford**Jan 2nd* 19*23*

20. UNDERTAKER

W. M. Hansen

ADDRESS

St. Anthony Ida

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Freemont Registration District No. 99
City of Parker Primary Registration District No. 2177
(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Roland Humphries

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 40522
Registered No. 14

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH

December 25 1916
(Month) (Day) (Year)

7. AGE

5 Yrs. 11 Mos. 28 ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

None

9. BIRTHPLACE

(State or Country)

Parker

10. NAME OF FATHER

William R. Humphries

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Ethel Claire Miller

13. BIRTHPLACE OF MOTHER

(State or Country)

Freemont Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. R. Humphries

(Address)

Parker Idaho

15.

Filled

Dec. 24th 1922

W. M. Hansen

Local Registrar

MEDICAL CERTIFICATE OF DEATH

19

16. DATE OF DEATH

December 23rd 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 22 1922, to Dec. 23 1922.

that I last saw him alive on Dec. 23 1922 and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Malignant Endocarditis

(Duration) Yrs. _____ mos. 7 ds.

Contributory (Secondary)

Insults

(Duration) yrs. _____ mos. 7 ds.

(Signed)

J. E. Metton

M. D.

12-24-1922 (Address) Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. _____ mos. _____ days. In the State yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Parker

DATE OF BURIAL

Dec 24th 1922

20. UNDERTAKER

None

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics1. PLACE OF DEATH *Idaho*
County of *Franklin*
City of *St Anthony*Registration District No. *99*
Primary Registration District No. *2177*
(No. St.)File No. *40523*
Registered No. *93*

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME *Betty Ross*

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *female* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *single*
(Write the word.)6. DATE OF BIRTH *Nov 12 1920*
(Month) (Day) (Year)7. AGE *2 Yrs. 2 Mos. 11 ds.* IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15. Filed *Dec 24 1922* *St. Anthony Idaho*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 23 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *Dec 22 1922* to *Dec 23 1922*
that I last saw him alive on *Dec 23 1922*
and that death occurred on the date stated above, at *9:40* M.

The CAUSE OF DEATH* was as follows:

double
Broncho Pneumonia(Duration) Yrs. mos. *3* ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

M. D.

19. (Address) *St Anthony Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Welford
*None**12/25 1922*

20. UNDERTAKER

ADDRESS

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Fremont* JANCity of *St. Anthony*Registration District No. *99*Primary Registration District No. *2177*

(No. _____ St.)

File No. *40524*Registered No. *12*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

David Daniels Davis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married

(Write the word.)

6. DATE OF BIRTH

December 15th 1869
(Month) (Day) (Year)

7. AGE

53

Yrs. — Mos. — ds.

IF LESS than 1 day

how many _____ hrs.

or _____ min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Merchant

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Penn.

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. G. B. Davis

(Address)

St. Anthony Idaho

15.

Filed

*Dec 16th 1922**1922**W. M. Hansen*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

December 15th 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 14, 1922 to *1922*that I last saw him alive on *Dec 14, 1922*and that death occurred on the date stated above, at *1:30 P.M.*

The CAUSE OF DEATH* was as follows:

*Cerebral hemorrhage**4 hrs* (Duration) _____ Yrs. _____ mos. _____ ds.Contributory
(Secondary)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

*R. L. Maxwell M.D.**12-15-22*

(Address)

St. Anthony

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

St. Anthony Idaho

DATE OF BURIAL

Dec. 17, 1922

20. UNDERTAKER

W. M. Hansen

ADDRESS

St. Anthony Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 40525

Registered No. 10

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

1. PLACE OF DEATH
County of Fremont
City of St. Anthony, Idaho
Registration District No. 99
Primary Registration District No. 2177
(No.) St.)

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME George Washington Patton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Widower
(Write the word.)

6. DATE OF BIRTH
September Third 1842
(Month) (Day) (Year)

7. AGE 80 Yrs. 3 Mos. 3 ds.
IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work Retired
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country) Illinois

10. NAME OF
FATHER

Samuel F. Patton

11. BIRTHPLACE
OF FATHER

(State or Country) Virginia

12. MAIDEN NAME
OF MOTHER

Mary Deatherage

13. BIRTHPLACE
OF MOTHER

(State or Country) North Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. H. Patton
(Address) St. Anthony, Idaho

15. Filed December 6-1922
Local Registrar

SYMS-TORE CO., PRINTERS & BINDERS, 501 E. 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

December 6th, 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
9 Nov. 1922 to Dec 6 1922
that I last saw him alive on Dec 6 1922
and that death occurred on the date stated above, at 6 A. M.
The CAUSE OF DEATH* was as follows:

Senility

(Duration) Yrs. 3 mos. ds.

Contributory (Secondary) none

(Duration) yrs. 3 mos. ds.

(Signed) John H. Gray, M. D.

Dec. 6th 1922 (Address) St. Anthony, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL
Warrensburg, Missouri

DATE OF BURIAL
Dec. 10th, 22

20. UNDERTAKER

W. H. Patton

ADDRESS

St. Anthony, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
 County of **FREMONT.**
 City of **ASHTON**
 Registration District No. **103**
 Primary Registration District No. **6**
 (No. _____) St.)

File No. **40526**
 Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME **LEVI. BERT. REYNOLDS.**

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX **MALE** 4. COLOR OR RACE **WHITE** 5. SINGLE, MARRIED, WID-OWED OR DIVORCED
MARRIED.
 (Write the word.)

16. DATE OF DEATH

DECEMBER. 23th 22
 (Month) (Day) (Year)

6. DATE OF BIRTH

FEB. 2TH 1859
 (Month) (Day) (Year)

7. AGE

63 Yrs. **10** Mos. **15** ds.

IF LESS than 1 day
 how many _____ hrs.
 or _____ min.?

17. I HEREBY CERTIFY, That I attended deceased from

his date 19 _____, to *his date* 19 _____
 that I last saw him alive on *Dec 22* 19 *22*
 and that death occurred on the date stated above, at *5:15 PM*

The CAUSE OF DEATH* was as follows:

Cancer

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer)

RETIRED FARMER

9. BIRTHPLACE

(State or Country)

MARYLAND UTAH

10. NAME OF FATHER

LEVI. BERT REYNOLDS.

11. BIRTHPLACE OF FATHER

(State or Country)

MARYLAND.

12. MAIDEN NAME OF MOTHER

HANNAH JOHNSON.

13. BIRTHPLACE OF MOTHER

(State or Country)

ENGLAND.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

BOYD LEVI REYNOLDS

(Address)

VICTOR IDAHO.

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed) *E. L. Haggis, M. D.*19 *22* (Address) *Ashton Idaho.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

ASHTON IDAHO

DATE OF BURIAL

12/24/22

20. UNDERTAKER

LEWIS KISER.**ASHTON**

ADDRESS

IDAHO.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40527**
Registered No. _____

1. PLACE OF DEATH
County of *Ben* Registration District No. *6*
City of *Emmett* Primary Registration District No. _____
(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Mary Jane Burton*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *female* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *married*
(Write the word.)

6. DATE OF BIRTH *May 25 1848*
(Month) (Day) (Year)

7. AGE *74* Yrs. *6* Mos. *29* ds. IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION *Housewife*
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE *Penn*
(State or Country)

10. NAME OF FATHER *John Banister*

11. BIRTHPLACE OF FATHER *Not known*
(State or Country)

12. MAIDEN NAME OF MOTHER *"*

13. BIRTHPLACE OF MOTHER *"*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *Otha Beertore*
(Address) *Springville Wash.*

15. Filed *12/27 1922* *J. L. Reynolds*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *Dec 24 1922*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Dec 11 1922* to *Dec 24 1922*
that I last saw her alive on *Dec 21 1922*
and that death occurred on the date stated above, at *6:40 A.*
The CAUSE OF DEATH* was as follows: *Carcinoma stomach*

(Duration) _____ Yrs. _____ mos. _____ ds.
Contributory (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) *Burton O. Clark* M. D.
Dec 26 1922 (Address) *Emmett Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days
Where was disease contracted if not at place of death? _____
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL *Emmett Idaho* DATE OF BURIAL *12/27 1922*
20. UNDERTAKER *O. Buckner* ADDRESS *Emmett Idaho*

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Gooding Registration District No. 24
City of Clear Lake Primary Registration District No. 24
(No. 24 St.)

File No. 40528
Registered No. 40528

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Minnie Dahlgquist

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH June 20 1859
(Month) (Day) (Year)

7. AGE 63 Yrs. 5 Mos. 1 ds. IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Housewife

9. BIRTHPLACE

(State or Country)

Sweden

10. NAME OF FATHER

John Kanth

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME OF MOTHER

Anna Knau

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Catherine Raedels
(Address) Buho

15. Filed 11-25 1922 J. J. Canby M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 21 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1st 1922 to 11-21-1922
that I last saw him alive on 11-21-1922
and that death occurred on the date stated above, at 11 M.

The CAUSE OF DEATH* was as follows:

Pyloric Stenosis
Probably cancerous.(Duration) Yrs. 6 mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Geo. Truening M. D.11-21-1922 (Address) Bull. Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Gooding DATE OF BURIAL 11/26 1922

20. UNDERTAKER

ADDRESS

J. J. CanbyBull. Ida.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40529**
Registered No.

1. PLACE OF DEATH

County of Gooding Registration District No. 24
City of Gooding Primary Registration District No. 12 P.D. STATION (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Carl P Burch

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WID-OWED OR DIVORCED

Male | white | Single

6. DATE OF BIRTH

January 7th 1906
(Month) (Day) (Year)

7. AGE

16 Yrs. 10 Mos. 15 ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Student

9. BIRTHPLACE

(State or Country)

El Dorado Ill.

10. NAME OF FATHER

Chas M Burch

11. BIRTHPLACE OF FATHER

(State or Country)

Texas

12. MAIDEN NAME OF MOTHER

Mattie M Porter

13. BIRTHPLACE OF MOTHER

(State or Country)

Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Chas P Burch
Gooding Ill

15. Filed 11-22 1922 J. H. Crumwell
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 22 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 21 1922, to Nov 22 1922,
that I last saw him alive on 11/22 1922,
and that death occurred on the date stated above, at 3 A.M.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Duration) Yrs. 15 mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

11/22 1922 (Address) J. H. Crumwell M. D.
Gooding Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Harnsburg Ill.

19

20. UNDERTAKER

ADDRESS

A. E. ThompsonGooding

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Adeline Cramblett Stone

CERTIFICATE OF DEATH

District No.

Registration District No.

(No.

St.)

File No.

Registered No.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

40590

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

married
(Write the word.)

6. DATE OF BIRTH

Oct. 7, 1892

(Month)

(Day)

(Year)

7. AGE

30

Yrs.

27

Mos.

27

ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Nebraska

10. NAME OF FATHER

Amos M. Cramblett

11. BIRTHPLACE OF FATHER

(State or Country)

Illinois

12. MAIDEN NAME OF MOTHER

Annette M. Mc Cance

13. BIRTHPLACE OF MOTHER

(State or Country)

Illinois.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Fred Cramblett.

(Address)

Gooding, Ida.

15.

Filed

11-6-1922

19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

130

16. DATE OF DEATH

Nov.

(Month)

4

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct. 31, 1922, to Nov. 4, 1922.

that I last saw her alive on Nov. 4, 1922.

and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Eclampsia

(Duration)

Yrs.

mos.

5

ds.

Contributory
(Secondary)

Childbirth

(Duration)

Yrs.

mos.

ds.

(Signed)

(Address)

Gooding, Idaho

M. D.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Gooding

DATE OF BURIAL

11-6-1922

20. UNDERTAKER

Shannon

ADDRESS

Gooding, Ida.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **40531**

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of **Gooding**City of **Gooding**

If death occurs away from usual residence, give facts called for under special information.

BUREAU OF VITAL STATISTICS

FULL NAME **Samuel A. Gill**Registration District No. **24**

Primary Registration District No.

No.

St.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male **white****Married**
(Write the word.)

6. DATE OF BIRTH

Oct. 11th 1865
(Month) (Day) (Year)

7. AGE

67 Yrs. **1** Mos. ds.IF LESS than 1 day
how many hrs.
or min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)**farming**

9. BIRTHPLACE

(State or Country)

Penn.

10. NAME OF FATHER

Wm. Gill

11. BIRTHPLACE OF FATHER

(State or Country)

Penn.

12. MAIDEN NAME OF MOTHER

Isabella Irvine

13. BIRTHPLACE OF MOTHER

(State or Country)

Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

B. R. Gill

(Address)

Grandview Ave

15.

Filed **11-10-1922****W. Raymond**

Local Registrar

16. DATE OF DEATH

Nov. 10-1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov. 1920 to **Nov 10-1922**that I last saw him alive on **Nov 7th 1922**and that death occurred on the date stated above, at **2 a. M.**

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder(Duration) **2** Yrs. **6** mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. H. Cromwell, M. D.
Gooding, Idaho

19.

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Gooding, Idaho**11/11 1922**

20. UNDERTAKER

ADDRESS

A. E. Thompson**Gooding, Idaho**

FORM V. S. No. 5-25 M. 1-19.

40532
CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of GoodingCity of GoodingRegistration District No. 24

Primary Registration District No. _____

(No. _____)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hazel Hurd

PERSONAL AND STATISTICAL PARTICULARS

3. SEX fem.	4. COLOR OR RACE white	5. SINGLE, MARRIED, WID- OWED OR DIVORCED married (Write the word.)
----------------	---------------------------	--

6. DATE OF BIRTH

Jan. 4, 1883

(Month)

(Day)

(Year)

7. AGE

39 Yrs. 11 Mos. 26 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)housewife

9. BIRTHPLACE

(State or Country)

Nebraska

10. NAME OF FATHER

Kensey

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Hettie Mc Donald

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wallace Hurd(Address) Hagerman, Ida

15.

Filed 1-10-1923

Local Registrar

MEDICAL CERTIFICATE

16. DATE OF DEATH

Dec. 30, 1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from
Dec 26 1922, to Dec. 30 22 19that I last saw her alive on Dec 30, 1922 9:05 AM
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Tuberculous Peritonitisindefinite
(Duration)

Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) yrs. _____ mos. _____ ds.

(Signed) H. E. Paul

M. D.

12/30/22 (Address) Gooding Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

_____ 19____

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSI-
 CIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact state-
 ment of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

RECEIVED
 JAN 11 1923

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. **40533**

Registered No. _____

If death occurred in a hospital, in-
 stitution or camp give its NAME
 instead of street and number.

1. PLACE OF DEATH. **Gooding** Registration District No. _____
 County of **Gooding** Statistic Registration District No. _____
 City of **Gooding** (No. _____, St.) _____

If death occurs away from usual
 residence, give facts called
 for under special information.

2. FULL NAME **Wesley Hutchison**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED. **Married**

6. DATE OF BIRTH **March 5th 1880**
 (Month) (Day) (Year)

7. AGE **42 yrs. 9 mos. 11 ds.**
 IF LESS than 1 day
 how many hrs. or
 min.?

8. OCCUPATION **Farming**
 (a) Trade, profession or
 particular kind of work
 (b) General nature of industry
 business or establishment in
 which employed (or employer)

9. BIRTHPLACE **Nebraska**
 (State or Country)

10. NAME OF FATHER **John W. Hutchison**

11. BIRTHPLACE OF FATHER **Illinois**
 (State or Country)

12. MAIDEN NAME OF MOTHER **Ida Pinnett**

13. BIRTHPLACE OF MOTHER **Illinois**
 (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Mrs. J. W. Hutchison**(Address) **Gooding, Ida**

15. Filed **12-18-1922** **F. V. Canym**
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **Dec 15 1922**
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
12/15 1922 to **12/15 1922**

that I last saw him alive on **12/15 1922**
 and that death occurred on the date stated above, at **4:30 P.M.**

The CAUSE OF DEATH* was as follows:

Mitral insufficiency

(Duration) yrs. mos. ds.

Contributory (Secondary) _____

(Duration) yrs. mos. I ds.

(Signed) **J. H. Crowell** M. D.

19 (Address) **Gooding, Ida**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
 MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
 Transients or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted.

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

Ida DATE OF BURIAL **12-19-1922**

20. UNDERTAKER

W. Thompson ADDRESS **Gooding, Ida**

WHITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSI-
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact state-
CLANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.
ment of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

RECEIVED CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 24

County of Gooding

Primary Registration District No.

City of Gooding

(No. St.)

File No. 40534

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William W. Reynolds

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

July

19 -

1864

(Month)

(Day)

(Year)

7. AGE

58 yrs.

5 mos.

8 ds.

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of industry
business or establishment in
which employed (or employer)

Retired

9. BIRTHPLACE

(State or Country)

Ill

10. NAME OF
FATHER

Thomas Reynolds

11. BIRTHPLACE
OF FATHER

(State or Country)

England

12. MAIDEN NAME
OF MOTHER

Smith Cliff

13. BIRTHPLACE
OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Wm. Reynolds
Gooding, Ida

(Address)

15.

Filed 12-29-1912

W. W. Reynolds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec.

26 -

1912

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from
12/26-1912 to 12/26-1912

that I last saw him alive on 12/26-1912

and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

(Duration) ? yrs. mos. ds.

Contributory
(Secondary)

(Duration) ? yrs. mos. ds.

(Signed) J. H. Crowne, M. D.

12/26-1912 (Address) Gooding, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. ds. State. yrs. mos. ds.

Where was disease contracted.

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

1912

20. UNDERTAKER

ADDRESS

A. E. Thompson

Gooding, Ida

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Gooding

City of _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

JAN 1 CERTIFICATE OF DEATH

Registration District No. 24

Primary Registration District No. _____

(No. _____)

St. _____

File No. 40535

Registered No. _____

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

married
(Write the word.)

6. DATE OF BIRTH

March 19 1842
(Month) (Day) (Year)

7. AGE

80 Yrs. 8 Mos. 4 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Farmer -

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Illinois

10. NAME OF FATHER

Samuel Black -

11. BIRTHPLACE OF FATHER

(State or Country)

Tennessee

12. MAIDEN NAME OF MOTHER

Paddy

13. BIRTHPLACE OF MOTHER

(State or Country)

Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

S. A. Black

(Address)

Hagerman, Ida.

15.

Filed

12-29-1922F. V. Camp

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

November 23 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 1 1922 to Nov. 10 1922that I last saw him alive on Nov. 10 1922and that death occurred on the date stated above, at 8:20 AM

The CAUSE OF DEATH* was as follows:

Pneumonia(Duration) Yrs. mos. 3 ds.Contributory
(Secondary)Diabetes
about

(Duration) Yrs. mos. ds.

(Signed)

H. Lamb

M. D.

Nov 23, 1922 (Address) Gooding, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

19

20. UNDERTAKER

W. E. Thompson

ADDRESS

Gooding, Ida.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Gorduy*
City of *Butte*Registration District No. *24*

Primary Registration District No. _____

(No. _____) (St.) _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Leota May Tate*File No. *40536*
Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female white Married

6. DATE OF BIRTH

Mar. 12 1901
(Month) (Day) (Year)

7. AGE

21 Yrs. *8* Mos. *8* ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Nebraska

10. NAME OF FATHER

Carl Crumrey

11. BIRTHPLACE OF FATHER

(State or Country)

✓

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Charles E Tate
Butte Ida

(Address)

15.

Filed

*12-29-22**J Wanyms*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov. 20 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

*11/20 1922 to 11/20 1922*that I last saw *her* alive on *11/20 1922*and that death occurred on the date stated above, at *3 P.M.*

The CAUSE OF DEATH* was as follows:

Burned at 930 a.m.
Died of shock at 3 P.M.
(Duration) _____ Yrs. _____ mos. _____ ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

J H Crumrey M. D.
Butte Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

19 _____

20. UNDERTAKER

ADDRESS

A E Thompson *Gorduy Ida*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED CERTIFICATE OF DEATH.

1. PLACE OF DEATH.

County of Idaho
Kamiah IdaRegistration District No. 49Subsidiary Registration District No. 2428

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Thorn WarnerState of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 40538

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

MWmarried

(Write the word.)

6. DATE OF BIRTH.

Oct81850

(Month)

(Day)

(Year)

7. AGE

72

Yrs.

2

Mos.

13

ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...

(b) General nature of industry, business, or establishment in which employed (or employer).....

farmer

9. BIRTHPLACE

(State or Country)

Mich

10. NAME OF FATHER

Samuel Warner

11. BIRTHPLACE OF FATHER

(State or Country)

Id

12. MAIDEN NAME OF MOTHER

Isabella Fuller

13. BIRTHPLACE OF MOTHER

(State or Country)

Id

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Kamiah Ida

15.

Filed

12/211922J. Johnson

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec

(Month)

21

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

here, at 1922 to above 1922that I last saw him alive on Dec 20 1922and that death occurred on the date stated above, at 9:30 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration)

Yrs.

mos.

ds. 21Contributory
(Secondary)ischaemic

(Duration)

Yrs.

mos.

ds.

(Signed)

J. P. Bryan

M. D.

(Address)

Kamiah Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death.....yrs.....mos.....days

In the

State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Woodland Ida

DATE OF BURIAL

12/23 1922

20. UNDERTAKER

J. Johnson

ADDRESS

Kamiah Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

1. PLACE OF DEATH.

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED CERTIFICATE OF DEATH

JAN 20 1922

Registration District No.

Primary Registration District No.

St.

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

40539

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

Married

(Write the word.)

6. DATE OF BIRTH.

May

15

1843

(Month)

(Day)

(Year)

7. AGE

79

Yrs.

7

Mos.

10

ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

Retired (Carpenter)

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

Henry Cramer

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Christina Finney

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

C. H. Cramer

(Address)

Kamiah

15.

Filed

12/25

1922

C. J. Johnson

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

12

24

1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

about 1 year 191 to about 191

that I last saw him alive on 12/23 1922

and that death occurred on the date stated above, at 3 A. M.

The CAUSE OF DEATH* was as follows:

Mitral insufficiency
intermittent nephritis

(Duration)

2

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

C. J. Johnson

17/24 1922 (Address) Kamiah, Id.

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Soof Cem Kamiah

DATE OF BURIAL

12/25 1922

20. UNDERTAKER

C. J. Johnson

ADDRESS

Kamiah

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

State of IDAHO
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Idaho
City of Hauser

Registration District No. 106
Primary Registration District No. 2184
(St.)

File No. 4054
Registered No. 181

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Armanda Alice Strough

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH.

July 25 1857
(Month) (Day) (Year)

7. AGE

51 Yrs. 3 Mos. 25 ds.

IF LESS than 1 day
how many.....hrs. or
.....min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

at home

9. BIRTHPLACE

(State or Country)

Penn.

10. NAME OF FATHER

John Chler

11. BIRTHPLACE OF FATHER

(State or Country)

Penn.

12. MAIDEN NAME OF MOTHER

do not know

13. BIRTHPLACE OF MOTHER

(State or Country)

Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Mollie McPherson
(Address) Hauser, Ida

15.

Filed Nov 5 1922

J. M. Veck
Local Registrar

MEDICAL CERTIFICATE OF DEATH

60

16. DATE OF DEATH

Nov. 20 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 27 1922 to Nov 20 1922, that I last saw h. 51 alive on Nov 14 1922, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Duration) Sexual Yrs. mos. ds.

Contributory (Secondary)

Tuberculosis

(Duration) Sexual Yrs. mos. ds.

(Signed) H. W. H. Smith M. D.

Nov 20 1922 (Address) Stites, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Hauser

DATE OF BURIAL

11/28 1922

20. UNDERTAKER

Geo. Penney

ADDRESS

Hauser

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

RECEIVED

Registration District No. 49

County of

DEC 30 1912
Registration District No. 2478

City

BUREAU OF VITAL

St.)

File No. 40542

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

STATISTICS

Friedrich Thomas Harris

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single

(Write the word.)

6. DATE OF BIRTH.

February 10 1912
(Month) (Day) (Year)

7. AGE

10 Yrs. 9 Mos. 1 ds.

IF LESS than 1 day
how many hrs. or min. 2

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)

Child

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Fred Harris

11. BIRTHPLACE OF FATHER

(State or Country)

Kansas

12. MAIDEN NAME OF MOTHER

Mabel Williams

13. BIRTHPLACE OF MOTHER

(State or Country)

Wash

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Frank Rockefeller
Clarksburg Id

15.

Filed

11/8

24

G. Johnson

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

1912

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

Accident
shot in forehead with
a 22 rifle (by brother)
(Duration) Yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

(Address) 1118 19th

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death... yrs... mos... days In the State... yrs... mos... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

191

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. **40542**

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Idaho
City of Kamiah

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME No name Craig

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single

(Write the word.)

6. DATE OF BIRTH.

Oct. 24 1922
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds. 13

IF LESS than 1 day
how many hrs. or
min. 2

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...

That of a child

9. BIRTHPLACE

(State or Country)

Kamiah Idaho

10. NAME OF FATHER

Joe Craig

11. BIRTHPLACE OF FATHER

(State or Country)

Oregon

12. MAIDEN NAME OF MOTHER

Rena Johnson

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Rena Johnson

(Address)

Kamiah

15.

Filed

Nov 71922C J Johnson

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 6 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191, to 191,
that I last saw h. alive on 191,
and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

No Doctor in attendance

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Ind Cen No 1

DATE OF BURIAL

12/7 1922

20. UNDERTAKER

C J Johnson

ADDRESS

Kamiah Idaho

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **40544**
Registered No. **354**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of **Idaho**
City of **Grangerville**
Registration District No. **2181**
St. **Idaho**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

STATISTICAL

James Monroe Mattox

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH.

Dec 27 1866
(Month) (Day) (Year)

7. AGE

55 Yrs. **11** Mos. **13** ds.IF LESS than 1 day
how many.....hrs. or
.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).**Farmer.**

9. BIRTHPLACE

(State or Country)

Arkansas

10. NAME OF FATHER

John G Mattox

11. BIRTHPLACE OF FATHER

(State or Country)

North Carolina

12. MAIDEN NAME OF MOTHER

Leatha J Davis

13. BIRTHPLACE OF MOTHER

(State or Country)

Tennessee

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs J P Rusk

(Address)

Grangerville

15.

Filed

Jan 1 1923
G S Stockton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 10 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 8 1922 to **Dec 10 1922**
that I last saw him alive on **Dec 10 1922**
and that death occurred on the date stated above, at **5 P. M.**

The CAUSE OF DEATH* was as follows:

Croupous Pneumonia

(Duration) Yrs. mos. ds.

Contributory
(Secondary)**diabetes mellitus**

(Duration) Yrs. mos. ds.

(Signed)

G S Stockton M. D.**12/10 1922** (Address) **Grangerville Ida**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Riviera View

DATE OF BURIAL

Dec 12 1922

20. UNDERTAKER

G. J. Mangg

ADDRESS

Grangerville

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **40545**
Registered No. **34**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of **Idaho** Registration District No. **103**
City of **Grangeville** Primary Registration District No. **1001** (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Charles R. Hanson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married

(Write the word.)

6. DATE OF BIRTH.

Aug. 16 1880
(Month) (Day) (Year)

7. AGE

47 Yrs. **3** Mos. **19** ds.IF LESS than 1 day
how many hrs. or
..... min. >]

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)**Meat Butcher**

9. BIRTHPLACE

(State or Country)

California

10. NAME OF FATHER

John Hanson

11. BIRTHPLACE OF FATHER

(State or Country)

Hennrich

12. MAIDEN NAME OF MOTHER

Anna Gowau

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. G. R. Hanson

(Address)

Grangeville, Ida

15.

Filed

Jan 1 1923 **G. S. Stockton**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 5 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 5 1922 to **Dec 5 1922**that I last saw him alive on **191**and that death occurred on the date stated above, at **8 P. M.**

The CAUSE OF DEATH* was as follows:

Accidental severing of radial artery + death from hemorrhage

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) **G. S. Stockton** M. D.**12/6 1922** Address **Grangeville, Ida**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Paroow

DATE OF BURIAL

Dec 7 1922

20. UNDERTAKER

G. J. Mangy

ADDRESS

Cely

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Idaho
City of BrangervilleRegistration District No. 103Primary Registration District No. 1001

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Erastus Benjamin WhiteState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 40546Registered No. 33

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widower

(Write the word.)

6. DATE OF BIRTH

Aug 10 1829
(Month) (Day) (Year)

7. AGE

93 Yrs. 3 Mos. 22 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Farmer

(b) General nature of industry, business or establishment in which employed (or employer).

1

9. BIRTHPLACE

(State or Country) Madison Maine

10. NAME OF FATHER

John White

11. BIRTHPLACE OF FATHER

(State or Country) Madison Maine

12. MAIDEN NAME OF MOTHER

Maria White

13. BIRTHPLACE OF MOTHER

(State or Country) Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edward S Hancock(Address) Brangerville

15.

Filed Jan 1 1923 E B Bickton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 2 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 1 1922 to Dec 2 1922that I last saw him alive on Dec 2 1922and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

senile decay

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory (Secondary) arterio sclerosis

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) E B Bickton M. D.12/3 1922 (Address) Brangerville Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Prarie View

DATE OF BURIAL

Dec 5 1922

20. UNDERTAKER

E S Hancock

ADDRESS

Brangerville

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **40547**
Registered No. **3**

1. PLACE OF DEATH

County of *Idaho*
City of *Idaho*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John A. Karnes

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *maried*
(Write the word.)

6. DATE OF BIRTH

July *12* *1854*
(Month) (Day) (Year)

7. AGE

68 Yrs. *5* Mos. *15* ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).*Farmer*

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

Peter Karnes

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John A. Karnes

(Address)

Idaho

15.

Filed

Jan 1 *1923* *G. B. Stockton*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

12 *27* *1922*
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *Dec 24* *1922* to *Dec 27* *1922*
that I last saw him alive on *Dec 27* *1922*
and that death occurred on the date stated above, at *6 P. M.*

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) Yrs. mos. ds.

Contributory (Secondary) *Arterio-sclerosis*

(Duration) yrs. mos. ds.

(Signed) *G. B. Stockton* M. D.*12/27/1922* (Address) *Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Idaho

DATE OF BURIAL

12-29-1922

20. UNDERTAKER

E. S. Hancock

ADDRESS

Idaho

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40548**
Registered No. **31**

1. PLACE OF DEATH

County of Idaho
City of Idaho

JAN 1923

Registration District No. 103Primary Registration District No. 2181

STATISTICS

St.)

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

George Preston Smith

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDSingle
(Write the word.)

6. DATE OF BIRTH

April 8 1964
(Month) (Day) (Year)

7. AGE

58 Yrs. 8 Mos. 9 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of workFarm Laborer(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country)

Biglow's Mills
Indiana10. NAME OF
FATHERMichael Smith11. BIRTHPLACE
OF FATHER

(State or Country)

England12. MAIDEN NAME
OF MOTHERMary H. Heald13. BIRTHPLACE
OF MOTHER

(State or Country)

Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Adolph Smith

(Address)

Harpster, Idaho

15.

Filed

Jan 1 1923G. B. Stockton

Local Registrar

MEDICAL CERTIFICATE OF DEATH

120

16. DATE OF DEATH

Dec 17 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 1 1922 to Dec 17 1922
that I last saw him alive on Nov 1 1922
and that death occurred on the date stated above, at 12:05 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis(Duration) 8 Yrs. — mos. — ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

G. B. Stockton M. D.12/18/1922 (Address) Bozengville, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Harpster

DATE OF BURIAL

Dec 19 1922

20. UNDERTAKER

E. H. Hancock

ADDRESS

Bozengville

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH
in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40549**
Registered No. **72**

1. PLACE OF DEATH

County of Jefferson Registration District No. 98
City of Lewisville Primary Registration District No. 2176 St. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Brigham H. Eldsworth

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Unknown
(Write the word.)

6. DATE OF BIRTH

Nov 23 1850
(Month) (Day) (Year)

7. AGE

71 Yrs. 11 Mos. 26 ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Retiring Farmer
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Utah

10. NAME OF FATHER

Edmund Eldsworth

11. BIRTHPLACE OF FATHER

(State or Country) New York

12. MAIDEN NAME OF MOTHER

Elizabeth Young

13. BIRTHPLACE OF MOTHER

(State or Country) Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas. Eldsworth
(Address) Lewisville

15.

Filed 12-10 1922 Ray H. Fisher
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 19 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19
that I last saw him alive on No physician 19
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Sudden. Probably
anemia patens-
or Brain embolus.

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Ray H. Fisher M. D.

Nov 19 (Address) Regley, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Lewisville

DATE OF BURIAL

Nov 22 1922

20. UNDERTAKER

E. D. Eldsworth

ADDRESS

Regley

RECEIVED DEC 8 1922 CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of JeffersonCity of Payson

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Henry M. BillmanRegistration District No. 98Primary Registration District No. 2176

(STATISTICAL)

St.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 405
Registered No. 77

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

MaleWhiteSingle

(Write the word.)

6. DATE OF BIRTH

March 20 1907
(Month) (Day) (Year)

7. AGE

14 Yrs. 8 Mos. 18 ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Martinus Billman

11. BIRTHPLACE OF FATHER

(State or Country)

Livingston, Mont.

12. MAIDEN NAME OF MOTHER

Carrie Bate

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Martinus Billman

(Address)

Payson, ID #1

15.

Filed 12-10 1922

Ray H. Fisher
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 8 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 14 1922, to Dec 8 1922

that I last saw him alive on Dec 8 1922

and that death occurred on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:

Obstruction of Bowels

(Duration) Yrs. mos. 2 ds.

Contributory (Secondary)

Alcoholism

(Duration) yrs. mos. 30 ds.

(Signed)

H. A. Anderson

M. D.

Dec 9, 1922(Address) Payson, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho12/11 1922

20. UNDERTAKER

ADDRESS

Ed. GellinPayson, Ida

CERTIFICATE OF DEATH

40551

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Jefferson County
Heise
Registration District No. 2176
City of Heise (No. 70) St.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William Mack Blakely

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Chief

(Write the word.)

6. DATE OF BIRTH

Dec 1st 1918
(Month) (Day) (Year)

7. AGE

3 Yrs 11 Mos 20 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Chief

9. BIRTHPLACE

(State or Country)

Heise, Idaho

10. NAME OF FATHER

Wm Blakely

11. BIRTHPLACE OF FATHER

(State or Country)

Don't know

12. MAIDEN NAME OF MOTHER

Sybil Blakely

13. BIRTHPLACE OF MOTHER

(State or Country)

Don't know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wm Turner

(Address)

Highway, Ida.

15.

Filed

Dec 10 1922 Ray H. Fisher

Local Registrar

16. DATE OF DEATH

Nov. 20 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
Dead 19 when seen.

that I last saw him alive on 19.

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Accident Caught
in gasoline wood sawing
gasoline.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Saml Price M. D.

Nov. 20 1922 (Address) Heise, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Heise, Ida. Nov. 21 1922

20. UNDERTAKER

ADDRESS

Friends Heise, Ida.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Jerome*City of *Jerome*

If death occurs away from usual residence, give facts called for under special information.

Registration District No. *23*Primary Registration District No. *1017-2017*(No. *1017*)

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40553**

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME *Harry Irons*

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male*4. COLOR OR RACE *White*5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*

6. DATE OF BIRTH

(Month)

(Day)

(Year)

7. AGE *45*

Yrs.

Mos.

ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work _____

(b) General nature of industry, business or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country) *Indiana*10. NAME OF FATHER *Wm. Rhines*

11. BIRTHPLACE OF FATHER

(State or Country) *Kentucky*12. MAIDEN NAME OF MOTHER *Elizabeth Bookman*

13. BIRTHPLACE OF MOTHER

(State or Country) *Ill*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *J. H. Irons*

(Address) _____

15. Filed *June 9* 19*22**E. D. Phipps M.D.*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *June 4* 19*22*

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 19____, to _____ 19____,

that I last saw him _____ alive on _____ 19____,

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Multiple Wounds — no attending physician

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed) *Wm. F. Schmersbach*

M. D.

19*22*(Address) *Jerome Id.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL *Jerome Cemetery*DATE OF BURIAL *June 5, 1922*20. UNDERTAKER *W. F. Schmersbach*ADDRESS *Jerome*

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40554**

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of JeramRegistration District No. 23City of HazellPrimary Registration District No. 1017-2017

(No. _____)

St. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Willis Vandevine Talley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M4. COLOR OR RACE white5. SINGLE, MARRIED, WIDOWED OR DIVORCED single
(Write the word.)

6. DATE OF BIRTH

Oct 11 1922
(Month) (Day) (Year)

7. AGE

3 Yrs. 2 Mos. 0 ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country) Jeram10. NAME OF FATHER Russell Talley

11. BIRTHPLACE OF FATHER

(State or Country) Idaho12. MAIDEN NAME OF MOTHER Emma Woodell

13. BIRTHPLACE OF MOTHER

(State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Russell Talley(Address) Hazell15. Filed Dec 15 1922 E. D. Piper M.D.

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 11 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 10 1922 to Oct 11 1922
that I last saw him alive on Oct 11 1922
and that death occurred on the date stated above, at 3:10 A.M.

The CAUSE OF DEATH* was as follows:

Streptococcal sore throat(Duration) _____ Yrs. _____ mos. 2 ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) E. D. Piper M. D.10-11-1922 (Address) Hazell, Idaho

*State the Disease Causing Death; or in Deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Hazell IdahoDATE OF BURIAL Oct 12 192220. UNDERTAKER E. D. PiperADDRESS Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-1

RECEIVED

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40554**

1. PLACE OF DEATH.

DEC 20 1922

Registration District No. 23

County of

Primary Registration District No. 1017-2017

City of

(No.)

St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lettie V

Walley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F.

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widow

(Write the word.)

6. DATE OF BIRTH.

July

7

1833

(Month)

(Day)

(Year)

7. AGE

89

Yrs.

Mos.

ds.

IF LESS than 1 day
how many.....hrs. or
.....min.2)

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Denmark

10. NAME OF FATHER

Bartelson

11. BIRTHPLACE OF FATHER

(State or Country)

Denmark

12. MAIDEN NAME OF MOTHER

Don't know

13. BIRTHPLACE OF MOTHER

(State or Country)

Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Chas E. Larsen

(Address)

Jerome, Ida

15.

Filed

191

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan

26

1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 26 1922, to Jan 26 1922

that I last saw h. alive on Jan 26 1922

and that death occurred on the date stated above, at 7:45 P. M.

The CAUSE OF DEATH* was as follows:

Myocarditis
& Senesal Senility

(Duration)

Yrs.

mos.

ds.

Contributory (Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

Chas. E. Keller

M. D.

(Address)

Jerome, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death.....yrs.....mos.....days State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Jerome Cemetery

DATE OF BURIAL

Jan 26 1922

20. UNDERTAKER

D. A. L. Hansen

ADDRESS

Jerome, Ida

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Jerome Registration District No. 23
 City of Jerome Primary Registration District No. 1017-2017
 (No. _____) (St. _____)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Phoebe M. Stevens

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 40558

Registered No. _____
 If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married

6. DATE OF BIRTH

Sept 8 1876
 (Month) (Day) (Year)

7. AGE

45 Yrs. Mos. ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

House wife

9. BIRTHPLACE

(State or Country)

Michigan

10. NAME OF FATHER

James Friedt

11. BIRTHPLACE OF FATHER

(State or Country)

Pa.

12. MAIDEN NAME OF MOTHER

Louise McCall

13. BIRTHPLACE OF MOTHER

(State or Country)

Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

E. D. Piper
Jerome

15. Filed

June 24 1922 E. D. Piper M.D.

Local Registrar

16. DATE OF DEATH

June 24 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 18 1922 to June 24 1922
 that I last saw her alive on June 24 1922
 and that death occurred on the date stated above, at 6 0 A.M.

The CAUSE OF DEATH* was as follows:

Pharyngeal & Laryngeal
Diphtheria followed by
Septic Pneumonia

(Duration) Yrs. mos. ds.

Contributory
 (Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas. F. Zeller M. D.

6/24 1922 (Address) Jerome, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Jerome Idaho

19

20. UNDERTAKER

ADDRESS

D. A. L. Herison

Jerome Ida.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
4055

1. PLACE OF DEATH

County of *Jerome*City of *Eden*Registration District No. *23*Primary Registration District No. *1012-2012*

(No.)

St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William Larmer DeBout

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married

6. DATE OF BIRTH

July 19

(Month)

(Day)

1846
(Year)

7. AGE

76 Yrs.Mos. *14*

ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Richmond, Ohio

10. NAME OF FATHER

John DeBout

11. BIRTHPLACE OF FATHER

(State or Country)

Pennsylvania

12. MAIDEN NAME OF MOTHER

Margaret Kerr

13. BIRTHPLACE OF MOTHER

(State or Country)

Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Larven H DeBout

(Address)

Eden, Ida

15.

Filed *Dec 15* 19*22*19*22**E. D. Piper, M.D.*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

*Aug**3**22*

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 1 19*22* to *Aug 3* 19*22*that I last saw him alive on *Aug 1* 19*22*and that death occurred on the date stated above, at *11:00* A.M.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis with mitral insufficiency(Duration) *10* Yrs. mos. ds.Contributory (Secondary) *Chronic interstitial**nephritis* (Duration) *7* yrs. mos. ds.(Signed) *E. R. Berry* M. D.*8.3.22* (Address) *E. R. Berry, Hazelton*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Swini Falls**8/5* 19*22*

20. UNDERTAKER

ADDRESS

*P. J. Grosman**Swini Falls*

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40560**
Registered No.

1. PLACE OF DEATH

Registration District No. **23**County of **Jerome****RECEIVED**Registration District No. **1017-2017**City of **Jerome****DEC 8 1922**

(St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

BUREAU**John E. Fischer**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male**White****Widowed**

6. DATE OF BIRTH

March 20

(Month)

(Day)

1842
(Year)

7. AGE

80

Yrs

5

Mos

23

ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Farmer

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

Fischer

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Don't know

13. BIRTHPLACE OF MOTHER

(State or Country)

Don't know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Edward J. Fischer

(Address)

Jerome

15.

Filed

Aug 14**1922****E. D. Piper**

Local Registrar

16. DATE OF DEATH

Aug

(Month)

13

(Day)

1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 18 1922, to **Aug 13** 1922that I last saw him..... alive on **July 20** 1922and that death occurred on the date stated above, at **6 P. M.**

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(Duration)

Yrs

mos

ds.

Contributory
(Secondary)**mutual insufficiency**

(Duration)

Yrs

mos

ds.

(Signed)

Wm F. Schmeckel

M. D.

Aug 14 1922

(Address)

Jerome Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death..... yrs..... mos..... days

In the

State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Columbus Neb**Aug 14 1922**

20. UNDERTAKER

ADDRESS

D. A. Harrison**Jerome**

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40564**

1. PLACE OF DEATH

County of Jerome Registration District No. 23
City of 1 1/2 miles N. of Primary Registration District No. 1017-2017
(No. 1017 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lalen Louis Brown

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married

6. DATE OF BIRTH

June 29 1921
(Month) (Day) (Year)

7. AGE

1 Yrs. 3 Mos. 2 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

at Home

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

A. B. Brown

11. BIRTHPLACE OF FATHER

(State or Country)

Texas

12. MAIDEN NAME OF MOTHER

Myrtle Harris

13. BIRTHPLACE OF MOTHER

(State or Country)

Texas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

M. B. Harris

(Address)

Jerome

15.

Filed

Dec 15 1922

E. D. Piper M.D.

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 1 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 26 1922 to Oct 1 1922 that I last saw him alive on Oct 1 1922 and that death occurred on the date stated above, at 6 A.M. The CAUSE OF DEATH* was as follows:

acute Sarcot Enteritis

(Duration) Yrs. mos. 5 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

E. D. Piper

M. D.

Oct 1 1922

(Address)

Jerome Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Jerome Cemetery

Dec 2 1922

20. UNDERTAKER

ADDRESS

J. A. Harrison

Jerome

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

40562

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

RECEIVED

Registration District No. 23

County of

Primary Registration District No. 1017-2017

City of

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary E. Lineman

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

19

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

16. DATE OF DEATH

7. AGE

IF LESS than 1 day
how many hrs. or
min.

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15.

Filed

Local Registrar

17. I HEREBY CERTIFY, That I attended deceased from
that I last saw h. alive on
and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) M. D.

(Address)

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 23
County of RECEIVED
Primary Registration District No. 1012-2012
City of DEC 30 1922 (No. _____) (St.) _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mathias BowersFile No. 40563
Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female White Married

6. DATE OF BIRTH

Dec 20 1922
(Month) (Day) (Year)

7. AGE

36 Yrs. 9 Mos. 29 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Homemaker

9. BIRTHPLACE

(State or Country)

Pa.

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

John Kehrer
Pa

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Salome Roos
Pa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

L. J. Kehrer
Jerome15. Filed Oct 19 1922 E. D. Piper
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 19 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 6 1922 to Oct 19 1922
that I last saw her alive on Oct 18 1922and that death occurred on the date stated above, at 4 A. M.

The CAUSE OF DEATH* was as follows:

Purpural infection(Duration) _____ Yrs. _____ mos. 11 ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

E. D. Piper

M. D.

Oct 19 1922 (Address) Jerome Id

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Jerome Cemetery 10-21-1922

20. UNDERTAKER

ADDRESS

Dr. L. H. Erickson Jerome

MARGIN USED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40564**
Registered No.

1. PLACE OF DEATH

County of Jerome Registration District No. 23
City of Jerome Primary Registration District No. 1012-2017
(No., St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Margaret Francis Foster

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single

6. DATE OF BIRTH

Nov 27 1919
(Month) (Day) (Year)

7. AGE

2 Yrs 8 Mos 8 ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

At Home

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

O. B. Foster

11. BIRTHPLACE OF FATHER

(State or Country)

Kansas

12. MAIDEN NAME OF MOTHER

Ruth Hughes

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

O. B. Foster

(Address)

Jerome

15.

Filed Aug 5 1922 E. D. Piper M. D.
Local Registrar

16. DATE OF DEATH

Aug 4 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 4 1922, to Aug 4 1922
that I last saw him alive on Aug 4 1922
and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

accidentally stepped on by horse
24 1/2 hours
(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

E. D. Piper

M. D.

8/5 1922

(Address)

Jerome Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL
8-5 1922

20. UNDERTAKER

ADDRESS

Dr. Harrison

Jerome

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.
County of Jerome Primary Registration District No.
City of Heppner (No., (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Harman DriergerFile No. 40565
Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married

6. DATE OF BIRTH

July 23 1922
(Month) (Day) (Year)

7. AGE

7 Yrs. 7 Mos. 7 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Dick Drierger

11. BIRTHPLACE OF FATHER

(State or Country) Holland

12. MAIDEN NAME OF MOTHER

Ester Lopez

13. BIRTHPLACE OF MOTHER

(State or Country) Minnesota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dick Drierger(Address) Jerome

15.

Filed

July 29 1922 E.D. Piper M.D.

Local Registrar

16. DATE OF DEATH

July 29 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from July 23 1922, to July 29 1922
that I last saw her alive on July 27 1922
and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Natural Death
Unnatural Death(Duration) Yrs. mos. 7 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) E.D. Piper M. D.July 30 1922 (Address) Jerome Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Jerome Cemetery 7-30 1922

20. UNDERTAKER

ADDRESS

W.A. Harrison Jerome

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Jerome
 City of Jerome

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 23
 Primary Registration District No. 1017-2017
 (No. St.)

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 40566
 Registered No.

2. FULL NAME

Keith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
 (Write the word.)

6. DATE OF BIRTH

July 24 1922
 (Month) (Day) (Year)

7. AGE

X Yrs. X Mos. One ds.

IF LESS than 1 day
 how many..... hrs.
 or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

J. W. Keith

11. BIRTHPLACE OF FATHER

(State or Country) Ohio

12. MAIDEN NAME OF MOTHER

Mary E. Hite

13. BIRTHPLACE OF MOTHER

(State or Country) Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. W. Keith

(Address) Jerome

15.

Filed July 25 1922 E. D. Pifer M.D.
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 25 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 24 1922 to July 25 1922
 that I last saw her alive on July 25 1922
 and that death occurred on the date stated above, at 5 P. M.
 The CAUSE OF DEATH* was as follows:

Premature Infant

(Duration) Yrs. mos. 2 ds.

Contributory
 (Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas. E. Zalk M. D.

26 1922 (Address) Jerome, 2 Ch

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Jerome Cemetery July 25, 1922

20. UNDERTAKER

ADDRESS

Edith Christian Jerome

FORM V. S. No. 5-25 M. 1-16-13

1. PLACE OF DEATH **RECEIVED**

CERTIFICATE OF DEATH.

40566

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 126

County of Kootenai

City of Harrison Registration District No. 2204

File No. 3

Registered No. 12

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Frank Thornton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

April 12 1882
(Month) (Day) (Year)

7. AGE

29 Yrs. 8 mos. 8 ds.

IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...

Cook

9. BIRTHPLACE

(State or Country)

Clintonville, Ohio

10. NAME OF FATHER

Richard M. Thornton

11. BIRTHPLACE OF FATHER

(State or Country)

New York State

12. MAIDEN NAME OF MOTHER

Elara Howe

13. BIRTHPLACE OF MOTHER

(State or Country)

Grantown, Wis.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

L. C. S. S. S.

(Address)

Harrison

15.

Filed

Jan 1 1922

M. B. S.

Local Registrar

MEDICAL CERTIFICATE OF DEATH

28

16. DATE OF DEATH

Dec 20 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1922 to Dec 20 1922

that I last saw him alive on Dec 6 1922

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

M. B. S.

(Address)

Harrison

*State the DISEASE CAUSING DEATH; or in death from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death... yrs... mos... days. In the State... yrs... mos... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Harrison

DATE OF BURIAL

12-23 1922

20. UNDERTAKER

Ketchum & Company

ADDRESS

Harrison

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of **40568**

1. PLACE OF DEATH

Registration District No. 30
County of Logan Primary Registration District No. 105
City of Rathdrum St. Idaho

File No. _____

Registered No. 1163

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

A. M. Boston

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

Nov. 3 1865
(Month) (Day) (Year)

7. AGE

57 Yrs. 0 Mos. 17 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

Labourer

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

A. M. Boston

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Mary Feazel

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Guy C. Boston

(Address)

Post Falls Idaho

15.

Filed

1-71923D. P. Hansen
Local RegistrarMEDICAL CERTIFICATE OF DEATH 64

16. DATE OF DEATH

November 20. 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____ 19____, to _____ 19____

that I last saw him _____ alive on _____ 19____

and that death occurred on the date stated above, at 3:00 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy - sudden death. I was called, but found the man dead; exam-

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory none and inquiry
(Secondary) indicated clearly the cause of death
(Duration) _____ yrs. _____ mos. _____ ds.(Signed) Frank Henry M. D.11/22 1922 (Address) Rathdrum, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Evergreen. Post Falls

DATE OF BURIAL

11/21 1922

20. UNDERTAKER

C. C. Carey

ADDRESS

Rathdrum Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **40569**Registered No. **1164**

1. PLACE OF DEATH

County of **Idaho**
City of **Coeur d'Alene**Registration District No. **30**
Primary Registration District No. **1051**
(No. **826** **5 1/2** **25** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary S. Topping

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widow
(Write the word.)

6. DATE OF BIRTH

Aug 16 1842
(Month) (Day) (Year)

7. AGE

79 Yrs. **3** Mos. **16** ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).**Retired**

9. BIRTHPLACE

(State or Country)

Conn.

10. NAME OF FATHER

Orestes Crandall

11. BIRTHPLACE OF FATHER

(State or Country)

New York State

12. MAIDEN NAME OF MOTHER

Rachel Tupper

13. BIRTHPLACE OF MOTHER

(State or Country)

New York State

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Fred Topping

(Address)

Coeur d'Alene, Ida.

15.

Filed

1-7 1923

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 22 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 3 1922 to Dec 1 1922that I last saw h. er, alive on **Dec 1 1922**and that death occurred on the date stated above, at **11 A.M.**

The CAUSE OF DEATH* was as follows:

Valvular Disease(Duration) **1** Yrs. **0** mos. **0** ds.Contributory
(Secondary)**Prophyl.** (Duration) **0** yrs. **6** mos. **0** ds.(Signed) **F. D. Brennan** M. D.**12/2 1922** (Address) **Coeur d'Alene, Ida.**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State **30** yrs. **3** mos. **0** days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Spokane, Wash.

DATE OF BURIAL

Dec 5 1922

20. UNDERTAKER

P. B. M. M. M.

ADDRESS

Coeur d'Alene

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Boole*
City of *Boole*Registration District No. *30*Primary Registration District No. *1051*City of *Boole* (No. *911* - *312* St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Roy Dorsey Sawyer*File No. *40570*Registered No. *1165*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

single

(Write the word.)

6. DATE OF BIRTH

July 31 1922
(Month) (Day) (Year)

7. AGE

0 Yrs. *4* Mos. *12* ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Dorsey Sawyer

11. BIRTHPLACE OF FATHER

(State or Country)

Penn

12. MAIDEN NAME OF MOTHER

Fannie L. Parson

13. BIRTHPLACE OF MOTHER

(State or Country)

Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Dorsey Sawyer

(Address)

911-5 street

15.

Filed

1-7-23

19

Ed Dranna

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 13 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 1 1922 to *Dec 13 1922*that I last saw him alive on *Dec 13 1922*and that death occurred on the date stated above, at *1* M.

The CAUSE OF DEATH* was as follows:

Pneumonia(Duration) Yrs. mos. *10* ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

D. Dranna M. D.*12-13-22* (Address) *Boole*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Forest-Cem. CIDA.

DATE OF BURIAL

12-14-22

20. UNDERTAKER

Classed

ADDRESS

Boole

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40571**
Registered No. **1166**

1. PLACE OF DEATH

Registration District No. **30**
County of **Kootenai** Primary Registration District No. **1051**
City of **Pourtaulieu** (No. **817**) **Sherman** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Fred A. Blackwell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Married**
(Write the word.)

6. DATE OF BIRTH

Dec 23 1858
(Month) (Day) (Year)

7. AGE

69 Yrs. **11** Mos. **15** ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Retired

9. BIRTHPLACE

(State or Country)

Maine

10. NAME OF FATHER

D. R. Blackwell

11. BIRTHPLACE OF FATHER

(State or Country)

Maine

12. MAIDEN NAME OF MOTHER

Larry Nye

13. BIRTHPLACE OF MOTHER

(State or Country)

Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

P. F. Blackwell

(Address)

Spokane, Wn.

15.

Filed

1-7

1923

L. D. Drennon
Local Registrar

MEDICAL CERTIFICATE OF DEATH

81

16. DATE OF DEATH

Dec 7 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Dec. 28 1922** to **Dec. 8 1922**
that I last saw him alive on **Dec. 8 1922**
and that death occurred on the date stated above, at **8:00** M.

The CAUSE OF DEATH* was as follows:

**Arterio Sclerosis, central nervous system
Spinal cord degeneration**

(Duration) **2** Yrs. mos. ds.
Contributory (Secondary) **General Arterio Sclerosis**

(Duration) **10** Yrs. mos. ds.

(Signed) **J. C. Drennon** M. D.
Dec. 9, 1922 (Address) **Pourtaulieu, Ida**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State **22** yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Forest Cemetery

DATE OF BURIAL

12/10 1922

20. UNDERTAKER

P. B. Mooney

ADDRESS

Pourtaulieu

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Kootenai
City of Prer d AllenRegistration District No. 30
Primary Registration District No. 1051
(No. 320 Forest Drive St.)File No. 40572
Registered No. 1167

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Richard King

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

Oct 28 1844
(Month) (Day) (Year)

7. AGE

78 Yrs. 1 Mos. 11 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Retired

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Newfoundland

10. NAME OF FATHER

William King

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Mrs. Richard King
Prer d Allen

15.

Filed

1-7 1923
L. D. Drennon
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 9 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 1 1922 to Dec 9 1922
that I last saw him alive on Dec 9 1922
and that death occurred on the date stated above, at 3 P. M.
The CAUSE OF DEATH* was as follows:Senility

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

Dec 11 1922 (Address) Prer d Allen, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State 2 yrs. 6 mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Forest Cemetery

DATE OF BURIAL

12/15 1922

20. UNDERTAKER

P. B. Mooney

ADDRESS

Prer d Allen

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

40573

1. PLACE OF DEATH

County of *Kootenai* Registration District No. *30*
City of *Coeur d'Alene* Primary Registration District No. *105-1*
(No. *752* *1/2* St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Augusta C Kunderlich

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *F* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *widow*
(Write the word.)

6. DATE OF BIRTH

6 *21* *844*
(Month) (Day) (Year)

7. AGE

78 Yrs. *5* Mos. *19* ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)*Housewife*

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

Carl Lenke

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Wilhemina Kroeger

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Otelia Kunderlich

(Address)

15. *1-7*

Filed

1923

Local Registrar

16. DATE OF DEATH

Dec. *10* *1922*
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *Dec. 1* *1922*, to *Dec. 10* *1922*that I last saw him alive on *Dec. 9* *1922*, and that death occurred on the date stated above, at *3 P.* M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Dec. 11, 1922

(Address)

Channah Ida

M. D.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Forest Cem. CDA

DATE OF BURIAL

12-12 1922

20. UNDERTAKER

C. Carstedt

ADDRESS

Walene

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **40574**Registered No. **1169**

1. PLACE OF DEATH

County of *Kootenai*
City of *Coeur d'Alene*Registration District No. *30*Primary Registration District No. *1051*(No. *802* St.) *7th*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Michael James Hutt.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

married
(Write the word.)

6. DATE OF BIRTH

4 - 13 - 1864
(Month) (Day) (Year)

7. AGE

58 Yrs. *7* Mos. *29* ds.IF LESS than 1 day
how many.....hrs.
or.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Laborer

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

N. Y.

10. NAME OF FATHER

J. Hutt

11. BIRTHPLACE OF FATHER

(State or Country)

N. Y.

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John E. Hutt

(Address)

4512 No. Ave. Jarman Wash.

15.

Filed

*1-7-1923**D. D. Brennan*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec. 12 19*22*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov. 30 19*22* to *Dec. 12* 19*22*that I last saw him alive on *Dec. 12* 19*22*and that death occurred on the date stated above, at *8:30 P.*

The CAUSE OF DEATH* was as follows:

Pneumonia(Duration) Yrs. *12* mos. *12* ds.Contributory
(Secondary)(Duration) Yrs. *10* yrs. *10* mos. *10* ds.

(Signed)

Dec. 12

(Address)

Coeur d'Alene, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. *12* mos. *12* days. In the State Yrs. *12* mos. *12* days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

St. Thomas Cem.

DATE OF BURIAL

12-14-1922

20. UNDERTAKER

C. Carney

ADDRESS

Coeur d'Alene

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
40575
File No. _____
Registered No. 1170

1. PLACE OF DEATH

County of Kootenai
City of Poer d alene

Registration District No. 30
Primary Registration District No. 1051
(No. Poer d alene Jones St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jacob S. Foss

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male | White | Single (Write the word.)

6. DATE OF BIRTH

April | 11 | 1873
(Month) (Day) (Year)

7. AGE

79 Yrs. 8 Mos. 2 ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Norway

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country) Sweden

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Poer d alene Jones
(Address) Poer d alene 2nd

15. Filed 1-7 19 23 Ed. J. Dressman
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec | 13 | 19 22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 1 19 22 to Dec 13 19 22

that I last saw him alive on..... 19.....
and that death occurred on the date stated above, at 8:30 P.M.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration, Interstitial nephritis

(Duration) Post-natal mos. ds.

Contributory (Secondary) Arterio Sclerosis

(Duration) Post-natal mos. ds.

(Signed) J. C. Jones M. D.

12/16/1922 (Address) Poer d alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. 7 days. In the State..... yrs. mos. 7 days

Where was disease contracted if not at place of death?.....

Former or usual residence Peashtin Nw

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL.
Forest Cemetery | 12/13/1922

20. UNDERTAKER | ADDRESS
P. B. Jones | Poer d alene

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Boulenger*
City of *Lofts Bay*Registration District No. *30*Primary Registration District No. *1051*(No. *2* St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Howard Shewfelt*File No. *40577*Registered No. *1172*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M.* 4. COLOR OR RACE *W.* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *single*
(Write the word.)6. DATE OF BIRTH *Mar. 5 1903*
(Month) (Day) (Year)7. AGE *19* Yrs. *9* Mos. *12* ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)*Laborer*

9. BIRTHPLACE

(State or Country)

Mich

10. NAME OF FATHER

John W. Shewfelt

11. BIRTHPLACE OF FATHER

(State or Country)

Wis

12. MAIDEN NAME OF MOTHER

Sephrona Bigger

13. BIRTHPLACE OF MOTHER

(State or Country)

Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

David Shewfelt

15.

Filed

*1-7 1923**Ed Orennan*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sie. 17 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19....., to 19.....
that I last saw h..... alive on 19.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

*Death from blood poisoning
due to from Mrs. Wright
& snow*

(Duration) Yrs..... mos..... ds.

Contributory (Secondary) *No. Omen*

(Duration) yrs..... mos..... ds.

(Signed) *Ed Orennan* M. D.

19..... (Address).....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

Lofts Bay, Ida.

DATE OF BURIAL

12-19 1922

20. UNDERTAKER

E. Cassidy

ADDRESS

Ed Orennan

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Kootenai*
City of *Coeur d'Alene*Registration District No. *30*Primary Registration District No. *1051*(No. *3*) *Blackwell Add. St.*File No. *40578*Registered No. *1174*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lillian Jeannette Dahl

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F.

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

single

(Write the word.)

6. DATE OF BIRTH

Feb. 4, 1896
(Month) (Day) (Year)

7. AGE

26 Yrs. *10* Mos. *16* ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Clerk.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Minn.

10. NAME OF FATHER

Ingemar Dahl

11. BIRTHPLACE OF FATHER

(State or Country)

Norway

12. MAIDEN NAME OF MOTHER

Anna Mervin

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ingemar Dahl

(Address)

15.

Filed

1-7

19

*23**D. D. Brennan*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec. 20, 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *Dec. 12, 1922* to *Dec. 20, 1922*that I last saw him alive on *Dec. 19, 1922* and that death occurred on the date stated above, at *5:30 P.M.*

The CAUSE OF DEATH* was as follows:

Cerebral Embolism(Duration) Yrs. mos. *8* ds.Contributory (Secondary) *Valvular endocarditis*(Duration) *20* yrs. mos. ds.

(Signed)

J. C. Papp M. D.
Dec. 21, 1922 (Address) *Coeur d'Alene, Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Forest Cem. Coeur d'Alene

DATE OF BURIAL

12-22-1922

20. UNDERTAKER

Carrey

ADDRESS

Coeur d'Alene

CERTIFICATE OF DEATH

40579

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 2147

County of Latah

Registration District No. 67

City of Arvon R.T.

(Name)

St.)

File No. 3

Registered No. 1

If death occurs away from usual residence, give facts called for under special information.

2.

FULL NAME

Hakan Hakanon

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH.

Oct

24

1851

(Month)

(Day)

(Year)

7. AGE

70

11

Mos.

23

ds.

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...

farmer

9. BIRTHPLACE

(State or Country)

Vermont Sweden

10. NAME OF FATHER

Hakan Hakanon

11. BIRTHPLACE OF FATHER

(State or Country)

Vermont Sweden

12. MAIDEN NAME OF MOTHER

Ingeborg Danielson

13. BIRTHPLACE OF MOTHER

(State or Country)

Vermont Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. Melvin Olson

(Address)

Arvon, Idaho

15.

Filed

Oct. 19 1922

22

R. C. Faust

Local Registrar

MEDICAL CERTIFICATE OF DEATH

40

16. DATE OF DEATH

Oct

17

1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept. 9 1912 to Oct. 12 1922

that I last saw him alive on Oct. 12 1922

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Carcinoma of the liver

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas. J. Gutierrez M. D.

10/9 1922 (Address) Moscow, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rory Creek Co.

Oct. 20 1922

20. UNDERTAKER

John Pickard

ADDRESS

Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

40580

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.

County of

Primary Registration District No.

City of

(No.)

St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw her alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Signed)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

1. PLACE OF DEATH

County of *Latah*
City of *Deary*

CERTIFICATE OF DEATH

Registration District No. *2147*Primary Registration District No. *67*(No. *3*)File No. *3*Registered No. *3*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Thos. Saul Baker

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

*W.*5. SINGLE, MARRIED, WIDOWED OR DIVORCED
(Write the word.)*married*

6. DATE OF BIRTH

Sept. 22 1875
(Month) (Day) (Year)

7. AGE

47 2 14
Yrs. Mos. ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)*C. laborer*

9. BIRTHPLACE

(State or Country)

Minn.

10. NAME OF FATHER

Edw. Baker

11. BIRTHPLACE OF FATHER

(State or Country)

Ky.

12. MAIDEN NAME OF MOTHER

Hizziah Justice

13. BIRTHPLACE OF MOTHER

(State or Country)

W. Va.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Henry Baker

(Address)

Deary Ida.

15.

Filed *12/6* 19 *22**22*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec. 6 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY That I attended deceased from

*8/24 1922 to 11/26 1922*that I last saw him alive on *11/26 1922*and that death occurred on the date stated above, at *2 P. M.*

The CAUSE OF DEATH* was as follows:

Promotor Ataxia(Duration) *5* Yrs. *0* mos. *0* ds.Contributory
(Secondary)*Syphilis*(Duration) *0* yrs. *0* mos. *0* ds.

(Signed)

R. C. Faust M. D.(Address) *Deary*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Pine Crest Cem.

DATE OF BURIAL

12/7 1922

20. UNDERTAKER

J. E. Erickson

ADDRESS

Deary

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 601
County of Latah Primary Registration District No. 2141
City of Moscow (No. JAN St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William WalkerFile No. **40582**
Registered No. 41

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-OWED OR DIVORCED Married
(Write the word.)6. DATE OF BIRTH November 8 1886
(Month) (Day) (Year)7. AGE 66 Yrs. 1 Mos. 7 ds. IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Farmer

9. BIRTHPLACE

(State or Country) Iowa

10. NAME OF FATHER

George Walker

11. BIRTHPLACE OF FATHER

(State or Country) Indiana

12. MAIDEN NAME OF MOTHER

Orilla Rainer

13. BIRTHPLACE OF MOTHER

(State or Country) Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo. F. Walker
(Address) Burnston, Wash.15. Filled Dec 15 1922 W. H. Barithers
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 15 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Jan 24 1922 to Dec 15 1922
that I last saw him alive on Dec 15 1922
and that death occurred on the date stated above, at M.
The CAUSE OF DEATH* was as follows:
Carcinoma of Prostate(Duration) Yrs. 6 mos. ds.
Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. H. Clarke M. D.12/15/1922 (Address) Moscow

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 15 yrs. mos. days. In the State 15 yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence 219. PLACE OF BURIAL OR REMOVAL Moscow, Ida. DATE OF BURIAL Dec 16 192220. UNDERTAKER H. R. Short ADDRESS Moscow

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH JAN 8 1922

Registration District No. 61

County of Latah

Primary Registration District No. 2141

City of Viola

(No. St.)

File No. 40583

Registered No. 110

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Margaret Anne Rothwell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female White Single (Write the word.)

6. DATE OF BIRTH

October 22 1845
(Month) (Day) (Year)

7. AGE

27 Yrs. 1 Mos. 14 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

At Home

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

John Rothwell

11. BIRTHPLACE OF FATHER

(State or Country)

Missouri

12. MAIDEN NAME OF MOTHER

Sara Mc Intyre

13. BIRTHPLACE OF MOTHER

(State or Country)

Tennessee

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Frank Winsor

(Address) Viola, Ida.

15.

Filed Dec 15 1922

M. E. Carithers

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 14 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 24 1922, to Dec 14 1922
that last saw her alive on Aug 24 1922
and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

Probably several years
(Duration) Yrs. mos. ds.
Contributory Cause of
(Secondary) heart several years
(Duration) Yrs. mos. ds.

(Signed) W. A. Adams M. D.

Dec 15 1922 (Address) Moscow Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death, yrs. mos. days. In the State, yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence 9 Mos. 9 ds.

19. PLACE OF BURIAL OR REMOVAL

Viola

DATE OF BURIAL

Dec 16 1922

20. UNDERTAKER

F. R. Short

ADDRESS

Moscow

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH
 County of Latah
 City of Moscon

Registration District No. 61
 Primary Registration District No. 1011
 (No. _____ St.)

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 40584
 Registered No. 39

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Walter Oliver

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED single
 (Write the word.)

6. DATE OF BIRTH Nov 28 1922
 (Month) (Day) (Year)

7. AGE 11 Yrs. Mos. ds. IF LESS than 1 day
 how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE Moscon
 (State or Country)

10. NAME OF FATHER Bert Oliver

11. BIRTHPLACE OF FATHER Tennessee
 (State or Country)

12. MAIDEN NAME OF MOTHER Edith Scheminske

13. BIRTHPLACE OF MOTHER Wash.
 (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Bert Oliver
 (Address) Moscon

15. Filed 12/9 1922 W H Baruthers
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 8 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 8th 1922 to 19
 that I last saw him alive on Dec 8 1922
 and that death occurred on the date stated above, at 2⁴⁵ PM.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(Duration) Yrs. mos. ds.
 Contributory (Secondary) Cardiac failure
4 hours
 (Duration) Yrs. mos. ds.

(Signed) Dr. Orangel M. D.
Dec 1922 (Address) Moscon

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. 11 days. In the State Yrs. mos. 11 days

Where was disease contracted if not at place of death? At home

Former or usual residence none

19. PLACE OF BURIAL OR REMOVAL Moscon DATE OF BURIAL 12/10 1922

20. UNDERTAKER H. R. Short ADDRESS Moscon

FORM V. S. No. 5-25 M. 1-19.

JAN 6 1923

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

40586

1. PLACE OF DEATH

BUREAU

Registration District No.

County of *Latah*

Primary Registration District No.

File No.

City of *Kendrick*

(No. _____ St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Katherine Burns Metcalf

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

*Female**White**Married*
(Write the word.)

6. DATE OF BIRTH

May 28th

(Month)

(Day)

1888
(Year)

7. AGE

75 yrs. *7* Mos. *2* ds.

IF LESS than 1 day

how many _____ hrs.

or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

Mother
Homemaker

9. BIRTHPLACE

(State or Country)

Freetown Prince Edward Island

10. NAME OF FATHER

David Kirk

11. BIRTHPLACE OF FATHER

(State or Country)

Dumfriesshire, Scotland

12. MAIDEN NAME OF MOTHER

Katherine McClelland

13. BIRTHPLACE OF MOTHER

(State or Country)

Ayrshire, Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Olto D Burns

(Address)

Lewiston, Idaho

15.

Filed _____ 19 _____

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

December 30 19*22*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 28 1922, to *Dec 30* 1922that I last saw her alive on *Nov 28* 1922and that death occurred on the date stated above, at *2.30 PM*

The CAUSE OF DEATH* was as follows:

Parenchymatous nephritis
myocarditis(Duration) *Many* yrs. _____ mos. _____ ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) *Andrew Otterson* M. D.*Dec 31* 1922 (Address) *Kendrick, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Kendrick Id *Jan 3* 1923

20. UNDERTAKER

ADDRESS

J. H. J. Perkins

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 (2011-16-12)

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40587**

1. PLACE OF DEATH.

Registration District No. **64**

County of **Latah**

Primary Registration District No. **2144**

City of **Troy**

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Baby Glaser**

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

Dec. 14

1922

(Month)

(Day)

(Year)

7. AGE

_____ yrs. _____ mos. _____ ds.

IF LESS than 1 day
how many _____ hrs. or
30 mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

none

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Troy Ida

10. NAME OF FATHER

Joseph Glaser

11. BIRTHPLACE OF FATHER

(State or Country)

Nebr.

12. MAIDEN NAME OF MOTHER

Millie Chadick

13. BIRTHPLACE OF MOTHER

(State or Country)

Wis

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Joseph Glaser

(Address)

Troy Ida

15.

Filed

Dec 31

1922

Lucy M. Pickard
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec.

14

1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 14

1922

to

Dec 14

1922

that I last saw him alive on **Dec 14** **1922**

and that death occurred on the date stated above, at **6:20** **P.M.**

The CAUSE OF DEATH* was as follows:

(Signature with 5 1/2 month gestation)
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory

(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

(Signature) M. D.

12/16 **1922** (Address) **Monroe, Idaho**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days.

In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Buchanan cem.

Dec 16 **1922**

20. UNDERTAKER

ADDRESS

None

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-17

JAN 3 1923

CERTIFICATE OF DEATH.

1. PLACE OF DEATH **BUREAU HOSPITAL** District No. 65
County of Latah Primary Registration District No. 2145
City of Princeton (No. _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. **40588**

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert G. Pankey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH.

May 9 1849
(Month) (Day) (Year)

7. AGE

73 Yrs. 7 Mos. 16 ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

Farmer

9. BIRTHPLACE

(State or Country) Virginia

10. NAME OF FATHER

Peter Pankey

11. BIRTHPLACE OF FATHER

(State or Country) Not Known

12. MAIDEN NAME OF MOTHER

Not Known

13. BIRTHPLACE OF MOTHER

(State or Country) Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) P. B. Pankey(Address) Princeton

15.

Filed Dec. 26 1922

J. W. Thompson
Local Registrar

MEDICAL CERTIFICATE OF DEATH 19

16. DATE OF DEATH

Dec. 23 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Dec. 20 1922, to Dec. 23 1922,

that I last saw him alive on Dec. 20 1922,
and that death occurred on the date stated above, at 107 M.

The CAUSE OF DEATH* was as follows:

Chronic myo carditis

(Duration) 10 Yrs. mos. ds.

Contributory (Secondary)

senility

(Duration) yrs. mos. ds.

(Signed)

Wm. G. Over M. D.

12/25/1922 (Address) Princeton - 2nd Ave

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted
if not at place of death?.....

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Mendenhall Cemetery

DATE OF BURIAL

Dec. 26 1922

20. UNDERTAKER

E. Drwin

ADDRESS

Palouse

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Latah
City of BozellRegistration District No. 66Primary Registration District No. 2176(No. Bozell Hospital St.)File No. 7Registered No. 40589

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Carl Leaser

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Not Known

(Month)

(Day)

(Year)

7. AGE

22

Yrs.

Mos.

ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business or establishment in which employed (or employer)

Rutledge Lumber Co.

9. BIRTHPLACE

(State or Country)

Not Known

10. NAME OF FATHER

Carl Leaser

11. BIRTHPLACE OF FATHER

(State or Country)

Not Known

12. MAIDEN NAME OF MOTHER

Not Known

13. BIRTHPLACE OF MOTHER

(State or Country)

Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Carl Leaser

(Address)

15.

Filed Dec 7 1922 Wm F C Gibson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec61922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 6 - 1922, to Dec 6 - 1922that I last saw him alive on Dec 6 - 1922and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Depressed Skull Fracture(Accidental Injury)

(Duration)

Yrs.

mos.

ds.

Contributory

(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

F. C. Gibson

M. D.

1922

(Address)

Bozell Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... 1 days

Where was disease contracted if not at place of death?

Former or usual residence

Ruff Wm

19. PLACE OF BURIAL OR REMOVAL

Ruff Washington

DATE OF BURIAL

2/7 1922

20. UNDERTAKER

Mitchell & Manager

ADDRESS

St. Marys

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12-14 M. 7-24-11

RECEIVED

CERTIFICATE OF DEATH

40590

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8

Registered No.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH. JAN 8 1922 Registration District No. 66
County of Latah BUREAU Primary Registration District No. 2186
City of Burville STATION (No. Burville Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sophie Hagen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female White Single (Write the word.)
6. DATE OF BIRTH Mar 9 1892
(Month) (Day) (Year)

7. AGE 37 yrs. 10 mos. 9 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work at home
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Norway.

10. NAME OF FATHER A. Olsen

11. BIRTHPLACE OF FATHER (State or Country) Norway.

12. MAIDEN NAME OF MOTHER Hansen.

13. BIRTHPLACE OF MOTHER (State or Country) Norway.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. Olsen
(Address) Pocatello

15. Filed Dec. 11 1922 Mrs. F. C. Gilman
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 10 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 2 - 1922, to Dec 10 - 1922
that I last saw her alive on Dec 10 - 1922
and that death occurred on the date stated above, at 2 P.M.
The CAUSE OF DEATH* was as follows:

General Peritonitis following ruptured appendix of 3 days standing

(Duration) yrs. mos. ds.

Contributory (Secondary) Chronic Appendicitis

(Duration) yrs. mos. ds.

(Signed) F. C. Gilman M. D.
12/10/1922 (Address) Pocatello

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted, At home
If not at place of death?
Former or usual residence Pocatello, Idaho

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Pocatello Idaho Dec 13 1922

20. UNDERTAKER ADDRESS
E. H. Brown Pocatello, Idaho

CERTIFICATE OF DEATH.

40591

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of *Latah* Registration District No. *66*
City of *#* Primary Registration District No. *2146*
St.)File No. *9*

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Annis Lee

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH.

February 9 - 1856
(Month) (Day) (Year)

7. AGE

66 Yrs. *10* Mos. ds.IF LESS than 1 day
how many hrs. or
.... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....*Housewife*

9. BIRTHPLACE

(State or Country)

Norway

10. NAME OF FATHER

Larson

11. BIRTHPLACE OF FATHER

(State or Country)

Norway

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Hartwick Lee

(Address)

Jeany Idaho

15.

Filed *12/12/1922**Mrs. J. P. Gibson*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec. 11 - 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *February 1922*, to *Dec 11 - 1922*, that I last saw her alive on *Oct 5 - 1922*, and that death occurred on the date stated above, at M.
The CAUSE OF DEATH* was as follows:*Chronic Myocarditis*

(Duration) Yrs. mos. ds.

Contributory (Secondary)

Chronic Interstitial Nephritis(Duration) *5* yrs. mos. ds.(Signed) *H. C. Gibson* M. D.*12/11/1922* (Address) *Bozill Idaho*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SURGICAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Jeany Idaho**Dec 13 1922*

20. UNDERTAKER

ADDRESS

*Hartwick Lee**Jeany Idaho*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12-14-11

CERTIFICATE OF DEATH

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. **40592**
 Registered No. _____

1. PLACE OF DEATH _____ Registration District No. **65**
 County of **Idaho** Primary Registration District No. **2145**
 City of **Princeton** (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Leila Elaine Cochran

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Infant**
 (Write the word.)

6. DATE OF BIRTH **Dec 4 1922**
 (Month) (Day) (Year)

7. AGE _____ yrs. _____ mos. **14** ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work **Infant**
 (b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) **Idaho**

10. NAME OF FATHER

Eugene Cochran

11. BIRTHPLACE OF FATHER

(State or Country) **Ida.**

12. MAIDEN NAME OF MOTHER

Edna Bunnay

13. BIRTHPLACE OF MOTHER

(State or Country) **Nebr.**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(Address) **Eugene Cochran**

15.

Princeton Idaho

Filed **Dec. 6** 1922

J. H. Thompson

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb. Dec. 6 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Dec. 4 1922**, to **Dec. 6 1922**

that I last saw her alive on **Dec. 4 1922** and that death occurred on the date stated above, at **11:57** M.

The CAUSE OF DEATH* was as follows:

Tuberc. Caeruleus.

_____ (Duration) _____ yrs. _____ mos. **1** ds.

Contributory (Secondary) ☒

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) **J. H. Thompson** M. D.

13/6/ 1922 (Address) **Pottatch**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
 of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
 Where was disease contracted, _____
 If not at place of death? _____
 Former or _____
 usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Mendenhall Cemetery Dec 7 1922

20. UNDERTAKER

ADDRESS

C. M. Irwin

Patou

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40593**
Registered No.

1. PLACE OF DEATH. Registration District No. **65**
County of **Latah** Primary Registration District No. **2145**
City of **Potlatch** (No., St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Donald Stuart McKersher**
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Married**
(Write the word.)
6. DATE OF BIRTH **May 2 1883**
(Month) (Day) (Year)

7. AGE **39** yrs. mos. ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION **Engineer**
(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE **Nova Scotia**
(State or Country)

10. NAME OF FATHER **A. H. Kersher**

11. BIRTHPLACE OF FATHER **Bathurst New Brunswick**
(State or Country)

12. MAIDEN NAME OF MOTHER **Mary Lusk**

13. BIRTHPLACE OF MOTHER **Bathurst New Brunswick**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) **J. E. Andrew**
(Address) **Potlatch Idaho**

15. Filed **Dec. 9 1922** **J. M. Thompson**
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH **Dec. 9 1922**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Dec 1 1922** to **Dec 8 1922**
that I last saw **him** alive on **Dec 8 1922**
and that death occurred on the date stated above, at **7:45 AM**.
The CAUSE OF DEATH* was as follows:

Tuberculosis Disease (Consumption) of Anterior Mediastinum, Aneurysm of Transverse Aorta (8 yrs.)
(Duration) **2** yrs. mos. ds.
Contributory **Hemorrhage**
(Secondary) (Duration) **3** yrs. mos. ds.
(Signed) **J. M. Thompson** M. D.
12/9/1922 (Address) **Potlatch**

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL **Polouse** DATE OF BURIAL **Dec. 12 1922**

20. UNDERTAKER **E. M. Irwin** ADDRESS **Polouse**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho

BOARD OF HEALTH

Bureau of Vital Statistics

File No. **40594**

Registered No. _____

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH. Registration District No. 65
County of Latah Primary Registration District No. 2145
City of Potlatch (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Winnifried Fay Nolan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. single
(Write the word.)

6. DATE OF BIRTH Oct 1 1915
(Month) (Day) (Year)

7. AGE 7 yrs. 1 mos. 7 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work

school

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ida

10. NAME OF FATHER

P.P. Nolan

11. BIRTHPLACE OF FATHER

(State or Country)

Ill

12. MAIDEN NAME OF MOTHER

Mary Wright

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Harry Wright

(Address)

15.

Filed Nov 15 1922

D. J. Thompson
Local Registrar

MEDICAL CERTIFICATE OF DEATH. 103

16. DATE OF DEATH

Nov 11 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-6 1922, to 11-14 1922

that I last saw her alive on 11-14 1922
and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Gastritis

_____ (Duration) _____ yrs. _____ mos. 10 ds.

Contributory
(Secondary)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. S. E. Pugh M. D.

11-16 1922 (Address) Potlatch

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Nov 16 Nov 16 1922

20. UNDERTAKER ADDRESS

E. M. Irwin Polmer

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 1922

CERTIFICATE OF DEATH

1. PLACE OF DEATH. Registration District No. H 6.5
 County of Latah Primary Registration District No. 2145
 City of _____ (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Missouri Ann Berry

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 40595
 Registered No. _____

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widow
 (Write the word.)

6. DATE OF BIRTH Oct. 14 1846
 (Month) (Day) (Year)

7. AGE 76 yrs. 1 mos. 23 ds. IF LESS than 1 day
 how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Arkansas

10. NAME OF FATHER

Willson

11. BIRTHPLACE OF FATHER

(State or Country)

Arkansas

12. MAIDEN NAME OF MOTHER

Not known

13. BIRTHPLACE OF MOTHER

(State or Country)

Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

C. E. Berry

(Address)

Asotin Wash

15.

Filed Dec. 10 1922 D. M. Thompson
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 9 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1, 1922 to Dec 7, 1922
 that I last saw her alive on Dec 7 1922
 and that death occurred on the date stated above, at _____ M.
 The CAUSE OF DEATH* was as follows:

Inflammatory Rheumatism

(Duration) _____ yrs. _____ mos. 12 ds.
 Contributory Cancer of Throat
 (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) Walter H. H. H. M. D.
Dec 10, 1922 (Address) Palouse Wash

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
 of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
 Where was disease contracted,
 If not at place of death?
 Former or
 usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Palouse Wash Dec 10 1922

20. UNDERTAKER

ADDRESS

D. M. Irvine Palouse, W.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of **40597**
File No. _____
Registered No. _____

1. PLACE OF DEATH

Registration District No. _____

County of Latah**RECEIVED**Primary Registration District No. 2942City of Genesee

JAN 4 1922

St.)

Registered No. _____

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Herman Fredrick Heppner

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WID-

OWED OR DIVORCED

married.

(Write the word.)

6. DATE OF BIRTH

September 28

(Month)

(Day)

1848

(Year)

7. AGE

74Yrs. 2Mos. 14

ds.

IF LESS than 1 day

how many _____ hrs.

or _____ min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of workFarmer(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country)

Germany10. NAME OF
FATHERHerman Heppner11. BIRTHPLACE
OF FATHER

(State or Country)

Germany12. MAIDEN NAME
OF MOTHERWilhelmine Lubke13. BIRTHPLACE
OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Carl Heppner

(Address)

Moscow, Idaho

15.

Filed Dec 14 1922W. H. Heppner
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec. 12

(Month)

(Day)

1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 19, 1921, to Dec 1, 1922that I last saw him alive on Sept. 19, 1922and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Pruritic Anemia

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Chas. L. Gentry, M. D.12/18/22 (Address) Moscow, Idaho*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted
if not at place of death?Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Genesee

DATE OF BURIAL

12-16-22

20. UNDERTAKER

F. L. Lambert

ADDRESS

Genesee

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

40598

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of IdahoCity of GeneRegistration District No. 62Primary Registration District No. 2142(No. 1010)

St.)

File No. 5Registered No. 5

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mrs. Carrie Larson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

F

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

April
(Month)23
(Day)1858
(Year)

7. AGE

68 Yrs.7 Mos.23 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housekeeper

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Norway

10. NAME OF FATHER

Hans Norlee

11. BIRTHPLACE OF FATHER

(State or Country)

Norway

12. MAIDEN NAME OF MOTHER

Sofie Gudmowen

13. BIRTHPLACE OF MOTHER

(State or Country)

Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Anton Norlee

(Address)

Genesee Idaho

15.

Filed 12-17-192210:00 AM

Local Registrar

16. DATE OF DEATH

Dec
(Month)16
(Day)22
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 28 - 1922 to Nov 28 - 1922that I last saw her alive on Nov 28 1922and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH was as follows:

Apoplexy(Duration) 3 Yrs. _____ mos. _____ ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

W. H. Egan M. D.

(Address)

W. H. Egan

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Genesee Idaho12-17-1922

20. UNDERTAKER

ADDRESS

L. H. LambertGenesee Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Lincoln
City of SalmonRegistration District No. 41
Primary Registration District No. 2116
(No. _____ St.)File No. 40600
Registered No. _____If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Alma Pearl Ruff WhiteIf death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH

August 6th 1892
(Month) (Day) (Year)

7. AGE

40 Yrs. 4 Mos. 13 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)House wife

9. BIRTHPLACE

(State or Country) Chanute, Kansas10. NAME OF
FATHERMillard Ruff11. BIRTHPLACE
OF FATHER(State or Country) Not known12. MAIDEN NAME
OF MOTHERNot known
Lydia13. BIRTHPLACE
OF MOTHER(State or Country) Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) M. G. White
(Address) Salmon Ida

15.

Filed Jan 12 - 1923Cliff C. Bellamy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 19 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
Dec 3 1922, to Dec 16 1922
that I last saw him alive on Dec 16 1922
and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Puerperal septicemia
about 5 weeks

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Chas. F. Hammer M. D.17 1923 (Address) Salmon*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted
if not at place of death?Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Salmon Cemetery

DATE OF BURIAL

12-20 1922

20. UNDERTAKER

H. C. Doebler

ADDRESS

Salmon
Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH
in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A--25 M. 1-19.

RECORDED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Lenzie
City of Salmon

Registration District No. 41
Primary Registration District No. 2116
(No. St.)

File No. 40601
Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Cih yen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE Yellow 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Not known
(Write the word.)

6. DATE OF BIRTH Not known
(Month) (Day) (Year)

7. AGE 77 Yrs. Mos. ds. IF LESS than 1 day how many. hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

Vegetable Gardening

9. BIRTHPLACE

(State or Country)

China

10. NAME OF FATHER

Not known

11. BIRTHPLACE OF FATHER

(State or Country)

"

12. MAIDEN NAME OF MOTHER

"

13. BIRTHPLACE OF MOTHER

(State or Country)

"

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. C. Jaebler
(Address) Salmon Ida.

15. Filed Jan. 10 1923

Dr. C. Bellamy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

12-10 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 19..... to 19..... that I last saw h..... alive on..... 19..... and that death occurred on the date stated above, at 7:30 P.M. The CAUSE OF DEATH* was as follows:

Brachio-pericarditis

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. C. Jaebler Coroner
12-10 1922 (Address) Salmon, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Salmon Cemetery
20. UNDERTAKER W. C. Jaebler

DATE OF BURIAL

12-12 1922

ADDRESS

Salmon, Ida.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **40602**

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

Registration District No. **41**
County of **Latah** Primary Registration District No. **2116**
City of **Salmon** (State)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

James Fisher Melvin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male **White** **Married**
(Write the word.)

6. DATE OF BIRTH

Feb 16th **1860**
(Month) (Day) (Year)

7. AGE

61 Yrs. **9** Mos. **14** ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).**Editor**

9. BIRTHPLACE

(State or Country) **Maryland**

10. NAME OF FATHER

Thomas Melvin

11. BIRTHPLACE OF FATHER

(State or Country) **Maryland**

12. MAIDEN NAME OF MOTHER

Mary Elizabeth Fisher Melvin

13. BIRTHPLACE OF MOTHER

(State or Country) **Maryland**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Mrs. Evelyn Melvin**(Address) **Salmon, Ida.**

15.

Filed **Dec. 10** 19**22****Chas. Bellamy**
DR. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

November 11th 19**22**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19..... to 19.....
that I last saw him..... alive on..... 19.....and that death occurred on the date stated above, at **4 P. M.**

The CAUSE OF DEATH* was as follows:

By means of excitement and over exertion.

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) **H. C. Doebler, Coroner****11/13** 19**22** (Address) **Salmon, Ida.**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Salmon Cemetery

DATE OF BURIAL

11/14 19**22**

20. UNDERTAKER

H. C. Doebler

ADDRESS

Salmon, Ida.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40603**

Registered No. _____
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Lemhi
City of Salmon

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

J. J. Corroy

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married

(Write the word.)

6. DATE OF BIRTH

Sept 22

(Month)

(Day)

1859
(Year)

7. AGE

63 Yrs.

2 Mos.

12 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Rancher

9. BIRTHPLACE

(State or Country)

New York

10. NAME OF FATHER

James Corroy

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Not known

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs J. J. Corroy

(Address)

Baker, Ida.

15.

Filled

Dec 10

19

Chas. B. B. B.

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 4

(Month)

(Day)

1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 4 1922, to Dec 4 1922, that I last saw him alive on Dec 4 1922, and that death occurred on the date stated above, at 7 P. M. The CAUSE OF DEATH* was as follows:

Gangrene of lung

(Duration) Not known Yrs. mos. ds.
Contributory (Secondary) Prob. Influenza Pneumonia
(Duration) Not known Yrs. mos. ds.
(Signed) J. S. Wright M. D.
14 1922 (Address) Salmon

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Salmon Cemetery

DATE OF BURIAL

12-9 1922

20. UNDERTAKER

W. C. Thobler

ADDRESS

Salmon, Ida.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 41
County of Lemhi Primary Registration District No. 2116
City of Sibbonsville (No. 2) St.File No. 40604
Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Baker Achord

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH

March 27 1864
(Month) (Day) (Year)

7. AGE

58 Yrs. 7 Mos. 26 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

rancher

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Missouri, Wade Co.

10. NAME OF FATHER

Samuel Achord

11. BIRTHPLACE OF FATHER

(State or Country) Missouri

12. MAIDEN NAME OF MOTHER

Laria Underwood

13. BIRTHPLACE OF MOTHER

(State or Country) Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Jennie Achord(Address) Sibbonsville, Ida

15.

Filed

Dec. 10 - 1922Chas. Bellamy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 27 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 1916 to Aug 1922
that I last saw him alive on Aug 1922
and that death occurred on the date stated above, at M.
The CAUSE OF DEATH* was as follows:Cerebral Hemorrhage(Duration) 6 Yrs. mos. ds.
Contributory Stroke sent to hospital on Nov 17/22
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. S. Wright M. D.(Address) Sibbonsville

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Sibbonsville Cemetery

DATE OF BURIAL

11/30/22

20. UNDERTAKER

J. C. Jaebler

ADDRESS

Sibbonsville Ida.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40605**

1. PLACE OF DEATH

Registration District No. **41**
County of **Shoshone** Primary Registration District No. **2116**
City of **Shoshone** (St.)

If death occurs away from usual residence, give facts called for under special formation.

FULL NAME **Jane Stuart**

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Widowed**
(Write the word.)

6. DATE OF BIRTH

May 6th 1884
(Month) (Day) (Year)

7. AGE

68 Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)**Living on Ranch**

9. BIRTHPLACE

(State or Country)

Scotland

10. NAME OF FATHER

Not known

11. BIRTHPLACE OF FATHER

(State or Country)

"

12. MAIDEN NAME OF MOTHER

"

13. BIRTHPLACE OF MOTHER

(State or Country)

"

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Henry H. Wernick
Shoshone Ida.

(Address)

15.

Filed **Dec. 10** 1922**Chas. Bellarmy**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

19

16. DATE OF DEATH

November 1st 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19
that I last saw h. alive on 19
and that death occurred on the date stated above, at 12 A.M.

The CAUSE OF DEATH* was as follows:

Natural
Causes due to heart failure(Duration) Yrs. mos. ds.
Contributory (Secondary)(Duration) yrs. mos. ds.
(Signed) **H.C. Joebles** Coroner11/3" 1922 (Address) **Salmon Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

H.C. Joebles**11/3" 1922**

20. UNDERTAKER

Pine Creek Ida.

ADDRESS

Shoshone Ida.

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED **CERTIFICATE OF DEATH.**
JAN 31 1923
BUREAU OF VITAL STATISTICS
 1. PLACE OF DEATH. Registration District No. 30
 County of Lewis Registration District No. 2/29
 City of Craigmont St.)
 If death occurs away from usual residence, give facts called for under special information.

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. **40606**
 Registered No. 20

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charity Simmons

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH 64

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
 (Write the word.)

6. DATE OF BIRTH. Nov 9 1852
 (Month) (Day) (Year)

7. AGE 70 Yrs. 1 Mos. — ds.
 IF LESS than 1 day how many hrs. or min.?)

8. OCCUPATION Housewife
 (a) Trade, profession or particular kind of work...
 (b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE Indiana
 (State or Country)

10. NAME OF FATHER James E. Smith

11. BIRTHPLACE OF FATHER Pennsylvania
 (State or Country)

12. MAIDEN NAME OF MOTHER Charity Smith

13. BIRTHPLACE OF MOTHER Pennsylvania
 (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dr. Q. Simmons
 (Address) Craigmont Ida

15. Filed 12/10 1922 R. Q. Duvall
 Local Registrar

16. DATE OF DEATH Dec 9 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1922 to Dec 9 1922, that I last saw him alive on Dec 7 1922 and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:
Cerebral Thrombosis

(Duration) Yrs. 25 mos. — ds.
 Contributory (Secondary) Cholelithiasis

(Duration) Seven Yrs. — mos. — ds.
 (Signed) R. Q. Duvall M. D.
 Address Craigmont Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
 Where was disease contracted if not at place of death?.....
 Former or usual residence

19. PLACE OF BURIAL OR REMOVAL To of cemetery DATE OF BURIAL 12/11 1922

20. UNDERTAKER Storck & Sons Co. ADDRESS Craigmont

1. PLACE OF DEATH

County of Lewis
 City of Russel Idaho
 If death occurs away from
 usual residence, give facts
 called for under special
 information. R.I.D.

2. FULL NAME

RECEIVED CERTIFICATE OF DEATH

Registration District No. 8 47Primary Registration District No. 8(No. 8)

STATE

40607

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 89

Registered No. 89
 If death occurred in a hos-
 pital, institution or camp,
 give its NAME instead of
 street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED. Single

6. DATE OF BIRTH

Nov 30 1922
 (Month) (Day) (Year)

7. AGE

IF LESS than 1 day
 how many 4 hrs. 30 min.?

8. OCCUPATION

(a) Trade, profession or
 particular kind of work
 (b) General nature of in-
 dustry, business, or estab-
 lishment in which em-
 ployed (or employer)

Infant

9. BIRTHPLACE

(State or Country) Russel Idaho

10. NAME OF FATHER

John H. Albert

11. BIRTHPLACE OF FATHER

(State or Country) Keokuk Iowa

12. MAIDEN NAME OF MOTHER

Burns Edna Miller

13. BIRTHPLACE OF MOTHER

(State or Country) Cheney Wash.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John H. Albert(Address) Orlando Idaho

15.

Filed 12-10-1922

Albert H. Albert
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

151-a

16. DATE OF DEATH

Dec 1 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 30 1922 to Dec 1 1922that I last saw him alive on Nov 30 1922and that death occurred on the date stated above, at 1:30 A.M.

The CAUSE OF DEATH* was as follows:

Premature - 7 months

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) J. H. Albert M. D.Orlando Idaho

*State the Disease Causing Death; or in deaths from Violent
 Causes, state (1) Means of Injury; and (2) whether Accidental,
 Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
 of death yrs. mos. days, State yrs. mos. days

Where was disease contracted
 if not at place of death?

Former or
 usual residence

19. PLACE OF BURIAL OR REMOVAL

Russel Idaho

DATE OF BURIAL

12-2-1922

20. UNDERTAKER

ADDRESS

Albert H. Albert

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
40608

1. PLACE OF DEATH.

County of Lewis
City of Myer, Idaho (N. E. corner of Route 3)
Registration District No. 47
Primary Registration District No. _____ St. _____

Registered No. _____

If death occurs away from usual residence, give facts calling for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Katharine Margarete Jones

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

female white

Child (Write the word.)

6. DATE OF BIRTH.

Oct 3 1922
(Month) (Day) (Year)

7. AGE

Yrs. 2 Mos. 7 ds. 7
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...

child

9. BIRTHPLACE

(State or Country)

Myer, Idaho

10. NAME OF FATHER

Ralph Jones

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Ruth Wallace

13. BIRTHPLACE OF MOTHER

(State or Country)

Montana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Ralph Jones

(Address)

Myer, Idaho

15.

Filed 12-12-1922

Albert Huff
Local Registrar

16. DATE OF DEATH

12-9 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-9 1922, to 12-9 1922, and that death occurred on the date stated above, at 12 P M.

The CAUSE OF DEATH* was as follows:

Anemia

(Duration) Yrs. 3 mos. ds.

Contributory (Secondary)

(Duration) Yrs. 3 mos. ds.

(Signed) to register M. D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Myer, Idaho

12-12-1922

20. UNDERTAKER

ADDRESS

Albert Huff

Myer, Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **40610**Registered No. **24**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of **Lincoln**City of **Shoshone**

If death occurs away from usual residence, give facts called for under special information.

Registration District No. **16**Primary Registration District No. **1016**(No. **Mary E Draper** St.)

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

married

(Write the word.)

6. DATE OF BIRTH

April 22 1864

(Month)

(Day)

(Year)

7. AGE

58 years 8 mos 1 day

Yrs.

Mos.

ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

House wife

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Martin Taylor

11. BIRTHPLACE OF FATHER

(State or Country)

Iowa

12. MAIDEN NAME OF MOTHER

Corelia Mount-

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Orren Draper

(Address)

Cory Idaho

15.

Filed

Dec 23 1922**J. L. Jones**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

12
(Month)**23**
(Day)**1922**
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

12/10 1922 to **12/23 1922**
that I last saw him alive on **12/22 1922**
and that death occurred on the date stated above, at **59 M.**

The CAUSE OF DEATH* was as follows:

Myocardial Infarction
Heart Disease

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

12/23 1922

(Address)

Shoshone Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Cory Idaho

DATE OF BURIAL

19

20. UNDERTAKER

O. J. Mann

ADDRESS

Shoshone

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of LewistonCity of ShoshoneRegistration District No. 16Primary Registration District No. 1046

(No. _____)

St.)

File No. 40611Registered No. 23

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME Baby.

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Male

4. COLOR OR RACE

white5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDBaby
(Write the word.)

6. DATE OF BIRTH

12/
(Month)22
(Day)1922
(Year)

7. AGE

00 Yrs.00 Mos.00 ds.

IF LESS than 1 day
how many 1 hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.Baby.(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer).

9. BIRTHPLACE

(State or Country)

Shoshone Id.10. NAME OF
FATHERFrank E. Johnson11. BIRTHPLACE
OF FATHER

(State or Country)

Michigan12. MAIDEN NAME
OF MOTHERAllen Cooper13. BIRTHPLACE
OF MOTHER

(State or Country)

Id.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Dr. Dier

(Address)

15.

Filed 12-221922J. L. Stacey
Local Registrar

16. DATE OF DEATH

12
(Month)22
(Day)1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

1/22 1922, to 12/22 1922that I last saw him alive on 1/22 1922and that death occurred on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Premature birth.
6 mo pregnant.

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

1/22 1922

(Address)

Shoshone Id.

M. D.

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place

of death

Yrs.

mos.

days.

In the

State

Yrs.

mos.

days

Where was disease contracted
if not at place of death?

Former or
usual residenceShoshone Id.

19. PLACE OF BURIAL OR REMOVAL

Shoshone

DATE OF BURIAL

12-23 1922

20. UNDERTAKER

O. J. Burman Shoshone
Idaho

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **40612**Registered No. **22**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

Registration District No. **1646**
County of **Lincoln** Primary Registration District No. **1646**
City of **Shoshone** (No. **1** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Meir Carrington

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **F** 4. COLOR OR RACE **W** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Single**
(Write the word.)6. DATE OF BIRTH **May 13 1922**
(Month) (Day) (Year)7. AGE **6 Mos 13 ds.** IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work **none**
(b) General nature of industry, business or establishment in which employed (of employer)

9. BIRTHPLACE

(State or Country) **Idaho**

10. NAME OF FATHER

Arthur Carrington

11. BIRTHPLACE OF FATHER

(State or Country) **Montana**

12. MAIDEN NAME OF MOTHER

Grace Polson

13. BIRTHPLACE OF MOTHER

(State or Country) **Michigan**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Arthur Carrington**
(Address) **Richfield Idaho**15. **Nov 27 1922** **J. J. J. J.**
Filed Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 26 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from **Nov. 24th 1922** to **Nov. 26th 1922** that I last saw her alive on **Nov. 26th 1922** and that death occurred on the date stated above, at **2 PM**.
The CAUSE OF DEATH* was as follows:
Transition(Duration) Yrs. **1** mos. **14** ds.
Contributory **Enter Colitis**
(Secondary)(Duration) yrs. **2** mos. ds.
(Signed) **Herbert C Deane** M. D.**11/26 1922** (Address) **Shoshone Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death? **Richfield Idaho**Former or usual residence **Richfield Idaho**19. PLACE OF BURIAL OR REMOVAL **Richfield Idaho** DATE OF BURIAL **19**20. UNDERTAKER **O. J. J. J.** ADDRESS **Shoshone Idaho**

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40613**
Registered No. **21**

1. PLACE OF DEATH

County of Lincoln
City of Shoshone

Registration District No. 16Primary Registration District No. 1016

(No. _____ St.)

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Ignacio Eguren

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED
married
(Write the word.)

6. DATE OF BIRTH

July 31 1887
(Month) (Day) (Year)

7. AGE

35 3
Yrs. Mos. ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (for employer)

Shredder

9. BIRTHPLACE

(State or Country) Spain Vizcaya, Spain

10. NAME OF FATHER

Ramon Eguren

11. BIRTHPLACE OF FATHER

(State or Country) Spain

12. MAIDEN NAME OF MOTHER

Maria Josefa

13. BIRTHPLACE OF MOTHER

(State or Country) Spain Unionabrena, Spain.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Julian Paplago
(Address) Shoshone, Idaho

15.

Nov 24 1922 J. L. Green
Filed Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 22 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Nov 20 1922 to Nov 22 1922
that I last saw h. alive on Nov 22 1922
and that death occurred on the date stated above, at 4:30 PM.

The CAUSE OF DEATH* was as follows:

Perforated Intestinal Hernia
fecal.

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

11/22 1922 (Address) Shoshone, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. one In the _____ days State _____ yrs. _____ mos. _____ days

Where was disease contracted
if not at place of death? on range

Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Shoshone

DATE OF BURIAL

11-24-1922

20. UNDERTAKER

O. J. Gorman Shoshone
Idaho

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Luzerne
City of ShoshoneRegistration District No. _____
Primary Registration District No. No 1
(No. _____ St.)

Registered No. _____

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Ignacio EguenIf death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Married
(Write the word.)6. DATE OF BIRTH Aug 31 1887
(Month) (Day) (Year)7. AGE 1 IF LESS than 1 day
how many _____ hrs.
or _____ min.?
Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)Shepherd
Holiban

9. BIRTHPLACE

(State or Country)

Prizey Spain10. NAME OF
FATHERRamon Eguen11. BIRTHPLACE
OF FATHER

(State or Country)

Spain12. MAIDEN NAME
OF MOTHERMarir Garza13. BIRTHPLACE
OF MOTHER

(State or Country)

Ureonabrena Spain

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Cecilia Eguen

(Address)

15.

Filed _____ 19 _____

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 22 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
Nov 20 1922 to Nov 22 1922that I last saw him alive on Nov 22 1922
and that death occurred on the date stated above, at 3:30 P.M.

The CAUSE OF DEATH* was as follows:

Internal Strangulated
abdominal hernia
operated.(Duration) Yrs. mos. 2 ds.Contributory
(Secondary)Tubercular(Duration) Yrs. mos. 1 ds.

(Signed)

3/9 1924

(Address)

Shoshone Idaho*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. 2 daysWhere was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Shoshone

DATE OF BURIAL

19

20. UNDERTAKER

O. J. Burman Shoshone Idaho

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH
in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

Registration District No.

Primary Registration District No.

(No. St.)

File No.

Registered No.

If death occurs away from
usual residence, give facts
called for under special in-
formation.If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.2. FULL NAME Ignacio Eguren

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Sexo 4. COLOR OR RACE Color 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Soltero, Casado, Viudo
(Write the word.)6. DATE OF BIRTH Cancho
Día de nacimiento. 31 de
Julio 1887 Mes (Month) Día (Day) Año (Year)7. AGE Edad IF LESS than 1 day
Viscaya how many hrs.
Años Yrs. Meses Mo. Dias ds. or min.?8. OCCUPATION Pofesion.
(a) Trade, profession or particular kind of work. Shepherd.
(b) General nature of in- Pastor
dustry, business or estab-
lishment in which employ-
ed (or employer).9. BIRTHPLACE Lugar de nacimiento.
(State or Country) nacido Solibar
Vizcaya, España.10. NAME OF FATHER Nombre del padre.
Ramon
given11. BIRTHPLACE Lugar de nacimiento
OF FATHER padre.
(State or Country) Solibar Vizcaya España12. MAIDEN NAME Nombre y apellido de la
OF MOTHER madre.
María Teresa Vizcaya13. BIRTHPLACE Lugar de nacimiento
OF MOTHER la madre.
(State or Country) Solibar Vizcaya España14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
Firma del o de la declarante,
(Informant) que puede ser su padre, madre,
(Address) o esposa. En el último caso de15. be firmar así Mrs. Ignacio
Filed Eguren.
19.....

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 22 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
Nov 20, 1922 to Nov 22 1922
that I last saw him alive on Nov 22 1922
and that death occurred on the date stated above, at 3:28 M.

The CAUSE OF DEATH* was as follows:

Intestinal Strangulation abdominal
hernia. Operated(Duration) Yrs. mos. ds.
Contributor Sudden
(Secondary) extinction(Duration) yrs. mos. ds.
(Signed) E. J. Dyll M. D.119 1922 (Address) Shoshone Id*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

1. PLACE OF DEATH

County of Lincoln
City of Shoshone

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ignacio Eguren

CERTIFICATE OF DEATH

Registration District No. 16Primary Registration District No. 1016
(No. _____) (St.) _____State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 40613

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

m

4. COLOR OR RACE

w

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

married
(Write the word.)

6. DATE OF BIRTH

July
(Month)31
(Day)1887
(Year)

7. AGE

35 Yrs.3 Mos.

ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Shepherd

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Vizcaya, Spain

10. NAME OF FATHER

Ramon Eguren

11. BIRTHPLACE OF FATHER

(State or Country)

Spain

12. MAIDEN NAME OF MOTHER

Maria Josefa

13. BIRTHPLACE OF MOTHER

(State or Country)

Unionabrena, Spain

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Julian Pappago
Shoshone, Idaho

(Address)

15.

Filed _____ 19 _____

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov.
(Month)22
(Day)1922
(Year)17. I HEREBY CERTIFY, That I attended deceased from
Nov. 20 1922 to Nov. 22 1922
that I last saw him alive on Nov. 22 1922
and that death occurred on the date stated above, at 4:30 P.
The CAUSE OF DEATH* was as follows:Strangulated Internal HerniaOperated

(Duration)

Yrs.

mos. 2 ds.Contributory
(Secondary)Lifting

(Duration)

Yrs.

mos. _____ ds.

(Signed)

C. W. Dill

M. D.

11/23 1922 (Address) Shoshone, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. one In the _____ days. State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

on range

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Shoshone

DATE OF BURIAL

11-24 1922

20. UNDERTAKER

A. J. Brennan

ADDRESS

Shoshone, Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **40614**
Registered No. **76**

1. PLACE OF DEATH

County of Madison
City of Rexburg

RECEIVED

Registration District No. 100

JAN 3 1923

Primary Registration District No. 2178

BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Fulmer Otto Hartvigsen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Divorced
(Write the word.)

6. DATE OF BIRTH

May 1st 1888
(Month) (Day) (Year)

7. AGE

34 Yrs. 7 Mos. 24 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Mount Sterling, Utah.

10. NAME OF FATHER

Niels J. Hartvigsen

11. BIRTHPLACE OF FATHER

(State or Country)

Norway

12. MAIDEN NAME OF MOTHER

Hannah Andersen

13. BIRTHPLACE OF MOTHER

(State or Country)

Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. A. Hartvigsen
Donnelly, Ida.

15.

Filed

12/28 1922

Local Registrar

16. DATE OF DEATH

December 25th 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Dec 15 1922, to Dec 24 1922.that I last saw him alive on Dec 24 1922 P
and that death occurred on the date stated above, at 4:30 M.

The CAUSE OF DEATH* was as follows:

Chronic nephritis(Duration) 2 Yrs. 1 mos. 1 ds.Contributory
(Secondary)Myocarditis(Duration) 1 yr. 6 mos. 1 ds.

(Signed)

Louis F. Rich M. D.12/25 1922 (Address) Rexburg Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Independence, Ida.

DATE OF BURIAL

12/28 1922

20. UNDERTAKER

David Young

ADDRESS

Rexburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH JAN 1

Registration District No. 100

County of Madison

Primary Registration District No. 2178

City of Plover

(No. St.)

File No. 40615

Registered No. 78

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Margaret White

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female

White

(Write the word.)

6. DATE OF BIRTH

12 - 19 1922
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

Yrs. Mos. 7 ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

Child

9. BIRTHPLACE

(State or Country)

Plover - Idaho

10. NAME OF FATHER

Jno A White

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Michaela Jolley

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. H. Jolley
Plover, Idaho

15.

Filed

12/28 1922

Local Registrar

16. DATE OF DEATH

12 - 25 - 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-19-1922 to 12-24-1922.

that I last saw her alive on 12-24-1922

and that death occurred on the date stated above, at 2 A. M.

The CAUSE OF DEATH* was as follows:

Premature birth

Child not viable

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

12/26 (Signed) Loring F. Rich M. D.

Plover, Idaho (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Plover -

12-25-1922

20. UNDERTAKER

ADDRESS

no undertaker

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. *Madison*
County of *Madison* Registration District No. *100*
City of *Peyton* Primary Registration District No. *100*
(No. , St.)

File No. **40616**
Registered No. *79*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Alma W. Simpson*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. *Married*
(Write the word.)

6. DATE OF BIRTH *April 12 1865*
(Month) (Day) (Year)

7. AGE *57 yrs. 3 mos. 15 ds.*
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work *Laborer*
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE *England*
(State or Country)

10. NAME OF FATHER *W. G. Simpson*

11. BIRTHPLACE OF FATHER *England*
(State or Country)

12. MAIDEN NAME OF MOTHER *Elizabeth F. Smith*

13. BIRTHPLACE OF MOTHER *England*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *W. G. Simpson*
(Address) *Peyton*

15. Filed *12/28 1911* *J. Young* Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH *Dec 14 1911*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *July 1 1912* to *Dec 15 1911*
that I last saw him alive on *Dec 10 1911*
and that death occurred on the date stated above, at *12 P.M.*

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) *3 yrs. 1 mos. 15 ds.*
Contributory (Secondary)

(Duration) yrs. mos. ds.
(Signed) *W. G. Simpson* M. D.
19 *Peyton Idaho* Address

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Peyton* DATE OF BURIAL *12-15 1911*

20. UNDERTAKER *J. Young* ADDRESS *Peyton*

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
406181. PLACE OF DEATH RECEIVED
Registration District No. 116
County of Madison Primary Registration District No. 215
City of Rehburg (No. _____, St.)File No. _____
Registered No. 72

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Okie H. Anderson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH

Jan. 16 1858
(Month) (Day) (Year)

7. AGE

64 yrs. 10 mos. 15 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)Farmer

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Okie Anderson

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME OF MOTHER

Betsy Ahenstrom

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mr. Olef Anderson

(Address)

Rehburg

15.

Filed

12/2/22

191

J. Young

Local Registrar

MEDICAL CERTIFICATE OF DEATH. 113

16. DATE OF DEATH

Dec11922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 15 1922, to Dec 1 1922that I last saw him alive on Dec 1 1922and that death occurred on the date stated above, at 3:30 P.M.

The CAUSE OF DEATH* was as follows:

Atrophic Cirrhosis of Liver(Duration) 2 yrs. mos. ds.Contributory
(Secondary)arterio-sclerosis(Duration) 4 yrs. mos. ds.

(Signed)

12/2 1922 (Address) Rehburg Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rehburg12/4 1922

20. UNDERTAKER

ADDRESS

John PhillipsRehburg

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **40619**
Registered No. **73**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH **RECEIVED**
 County of **Madison** Registration District No. **100**
JAN 3 1923 Primary Registration District No. **2178**
 City of **Rexburg** (No. **1137**) St.)
 If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Harriet E. Norton Jones**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Married**
 (Write the word.)

6. DATE OF BIRTH **November 16th 1856**
 (Month) (Day) (Year)

7. AGE **66** Yrs. **23** Mos. **23** ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. **Housewife**
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) **Utah**

10. NAME OF FATHER

Charles Norton

11. BIRTHPLACE OF FATHER

(State or Country) **U. S. A.**

12. MAIDEN NAME OF MOTHER

Fannie E. Hiscock

13. BIRTHPLACE OF MOTHER

(State or Country) **U. S. A.**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **J. A. Palmer**(Address) **Rexburg**

15.

Filed **12/11** 19 **22**Local Registrar **D. Young**

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec. 9th 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 1922 to **Dec. 9 1922**
 that I last saw her alive on **Dec. 9 1922**, P
 and that death occurred on the date stated above, at **12:30 M**

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach(Duration) **10** Yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) **M. Sutherland**

M. D.

12-11-1922(Address) **Rexburg**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Burton, Ida.

DATE OF BURIAL

12/11 1922

20. UNDERTAKER

David Young

ADDRESS

Rexburg

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40620**
Registered No. **74**

1. PLACE OF DEATH
County of **Madison** Registration District No. **100**
City of **Rexburg** Primary Registration District No. **2178**
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Henry A. Goodliffe

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Married**
(Write the word.)

6. DATE OF BIRTH

May **16th** **1868**
(Month) (Day) (Year)

7. AGE

54 Yrs. **6** Mos. **25** ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Shoemaker

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

Arnold Goodliffe

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Esther Arbon

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Mrs. A. J. Goodliffe**
(Address) **Rexburg, Idaho**

15.

Filed

12/14**1922****W. Young**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec. **11th** **1922**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

12-10-1922 to **12-11-1922**

that I last saw ~~him~~ alive on **12-10-1922**

and that death occurred on the date stated above, at **6 A.M.**

The CAUSE OF DEATH* was as follows:

mitral insufficiency

(Duration) Yrs. **6** mos. ds.

Contributory **Cardiac asthma**
(Secondary)

(Duration) yrs. **6** mos. ds.

(Signed) **W. J. Parkinson, M.D.**

19 (Address) **Rexburg, Ida.**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Rexburg, Ida.

DATE OF BURIAL

12/14/22

20. UNDERTAKER

David Young

ADDRESS

Rexburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
40621

1. PLACE OF DEATH. Registration District No. 100
County of Madison Primary Registration District No. 2188
City of Sugar (No. , St.)

File No. 75
Registered No. 75

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Don Kirkham

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH Nov. 27 1922
(Month) (Day) (Year)

7. AGE 0 yrs. 0 mos. 14 ds. IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION (a) Trade, profession or particular kind of work none (b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Madison Co. Ida.

10. NAME OF FATHER Benj. Franklin Kirkham

11. BIRTHPLACE OF FATHER England (State or Country)

12. MAIDEN NAME OF MOTHER Ade Eames

13. BIRTHPLACE OF MOTHER U.S.A. (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ben Kirkham (Address) Sugar City.

15. Filed 12/14 1922 J. G. Young Local Registrar

MEDICAL CERTIFICATE OF DEATH. 92

16. DATE OF DEATH Dec. 11 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 8 1922 to Nov. 11 1922 that I last saw him alive on Nov. 11 1922 and that death occurred on the date stated above, at 11:30 A.M.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia
(Duration) yrs. mos. 3 ds.
Contributory Prematurity.
(Secondary)
(Duration) yrs. mos. ds.
(Signed) J. D. Ellison M. D.
12/13 1922 (Address) Sugar City Idaho
*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL Sugar City Ida. 12/14 1922

20. UNDERTAKER ADDRESS David Young Kibburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH **RECEIVED**
County of **Madison** Registration District No. **100**
City of **Sugar** Primary Registration District No. **2-178**
(No. _____ St. _____)

File No. **40622**
Registered No. **151-a**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Faustine Gaddie**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Import**

6. DATE OF BIRTH **Dec. 18 1922**
(Month) (Day) (Year)

7. AGE **0 yrs. 0 mos. 0 ds.** IF LESS than 1 day how many **1** hrs. or **1** mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work **None**
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) **Sugar City, Idaho**

10. NAME OF FATHER **Roland B. Gaddie**

11. BIRTHPLACE OF FATHER (State or Country) **Utah**

12. MAIDEN NAME OF MOTHER **Alice Bertie Sanders**

13. BIRTHPLACE OF MOTHER (State or Country) **Utah**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **R. B. Gaddie**

(Address) **Sugar City, Idaho**

15. Filed **12/25 1922** Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **Dec. 19 1922**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Dec. 18 1922** to **Dec. 19 1922** that I last saw **her** alive on **Dec. 19 1922** and that death occurred on the date stated above, at **12:25 M.**

The CAUSE OF DEATH* was as follows:

Premature Birth.

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) **J. A. Ellison M. D.**

Dec. 19 1922 (Address) **Sugar City, Idaho**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Sugar City, Idaho **12/19 1922**

20. UNDERTAKER ADDRESS

David Young Rexburg

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Mundwaha*City of *Keyburn* *JAWNS*

If death occurs away from usual residence, give facts called for under special information.

Registration District No. *19*Primary Registration District No. *2015*

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **40623**Registered No. *51*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

BUREAU OF VITAL STATISTICS

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

*Dec. 27 1922**E. O. Elmer*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from *Nov 2 1922* to *Nov 2 1922*that I last saw him alive on *Nov 2 1922* and that death occurred on the date stated above, at *8 P.M.*

The CAUSE OF DEATH* was as follows:

Contributory (Secondary) *Don't know*(Signed) *Joseph Frymoyer* M. D.19. (Address) *Burley Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Keyburn, Ida.**Nov. 17, 1922*

20. UNDERTAKER

ADDRESS

*L. B. Galloway**Burley, Ida.*

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40625**
Registered No. **58**

1. PLACE OF DEATH.

Registration District No. **19**
County of **Minidoka** Primary Registration District No. **2013**
City of **Paul** (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Kinnie Oishi

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH.

Sept. 23 1921
(Month) (Day) (Year)

7. AGE

1 Yrs. Mos. ds.

If LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

Baby

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Tom Oishi

11. BIRTHPLACE OF FATHER

(State or Country)

Japan

12. MAIDEN NAME OF MOTHER

Sue Okazaki

13. BIRTHPLACE OF MOTHER

(State or Country)

Japan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Tom Oishi

(Address)

Paul, Idaho

15.

Filled **Dec. 13 1922**

W. H. Elmore
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec. 11 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Dec. 10 1922** to **Dec. 12 1922**

that I last saw him alive on **Dec. 11 1922**
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Cerebro-Spinal meningitis

(Duration) Yrs. mos. **7** ds.

Contributory **Bronch. - Pneumonia**
(Secondary)

(Duration) yrs. mos. **10** ds.

(Signed) **E. O. Elmore** M. D.

12-11-1922 (Address) **Paul, Idaho**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Buried Ida

DATE OF BURIAL

12-11-1922

20. UNDERTAKER

Watts R. Watts

ADDRESS

Paul, Idaho

1. PLACE OF DEATH

County of My Perce
City of Agathu

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED CERTIFICATE OF DEATH

Registration District No. 92Primary Registration District No. 2170(No. 1108)

40626

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 7Registered No. 6

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widow

(Write the word.)

6. DATE OF BIRTH

February 25 1922
(Month) (Day) (Year)

7. AGE

72 Yrs 9 Mos 10 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

At Home

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Linn Co Oregon

10. NAME OF FATHER

Thomas Fields

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Rebecca Riggs

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

N Aldrich

(Address)

Caldesae Idaho

15.

Filed 12-9 1922E.E. Watts

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 7 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 4 1922, to 19that I last saw her alive on Dec 4 1922and that death occurred on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia(Duration) Yrs. 4 mos. 4 ds.

Contributory (Secondary)

Acute Bronchitis(Duration) yrs. 10 mos. 10 ds.

(Signed)

H. T. Seeley

M. D.

Dec 8 1922

(Address)

Leland Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Efford Idaho

DATE OF BURIAL

12-9 1922

20. UNDERTAKER

L. Labarth (acting)

ADDRESS

Efford

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40627**

1. PLACE OF DEATH **RECEIVED**
Registration District No. **97**
County of **Nez Perce** Primary Registration District No. **2174**
City of **Lapwai** (No. **BUREAU** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Henry Young Bear

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **Indian** 5. SINGLE, MARRIED, WIDOWED OR 'DIVORCED. **Single**
(Write the word.)

6. DATE OF BIRTH.

April 15 1904
(Month) (Day) (Year)

7. AGE

18 Yrs. **7** Mos. **17** ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

Student

9. BIRTHPLACE

(State or Country)

Montana

10. NAME OF FATHER

Chas. Young Bear

11. BIRTHPLACE OF FATHER

(State or Country)

Montana

12. MAIDEN NAME OF MOTHER

Rosie

13. BIRTHPLACE OF MOTHER

(State or Country)

Montana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Geo O Keck M.D.
Lapwai, Idaho

15.

Filed

Dec. 3 1912

1912

W. H. Hahl

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec. 2 1912
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **August 18, 1912** to **Dec. 2 1912**
that I last saw him alive on **Dec. 2 1912**
and that death occurred on the date stated above, at **9:30 P.M.**

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

Geo O Keck M.D.
Lapwai, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Montana

Former or usual residence

Montana

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Torsyth Mont

191

20. UNDERTAKER

ADDRESS

L. B. Blum
Bozeman, Idaho

RECEIVED

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

40628

1. PLACE OF DEATH. *Nez Perce*
 County of *Nez Perce* Registration District No. *97*
 City of *Lapwai* Primary Registration District No. *2174*
 (No. St.)

File No. _____
 Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Morgan Jepson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED.

Male Indian Single
 (Write the word.)

6. DATE OF BIRTH.

Unknown *909*
 (Month) (Day) (Year)

7. AGE

13
 Yrs. Mos. ds.

IF LESS than 1 day
 how many hrs. or
 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
 (b) General nature of industry, business, or establishment in which employed (or employer).....

Talent Savatorium

9. BIRTHPLACE

(State or Country)

Washington

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Geo O. Neck, M.D.
Lapwai, Idaho.

15.

Filed

Dec. 20. 1922 *Wilhelm H. Hahl.*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

December 19 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
May 10. 1922 to *Dec. 19 1922*

that I last saw him alive on *Dec. 19 1922*
 and that death occurred on the date stated above, at *90* M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed)

Geo O. Neck, M.D.
12/19/1922 (Address) *Lapwai, Idaho.*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs. *10* mos. *30* days. In the State.....yrs. *10* mos. *20* days

Where was disease contracted if not at place of death? *Washington*

Former or usual residence *Washington*

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Fort Lapwai Sanatorium *12/20 1922*

20. UNDERTAKER

ADDRESS

L. O. Naum *Servston*

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40629**

1. PLACE OF DEATH.

Registration District No. **97**

County of **Neper**

Primary Registration District No. **2174**

City of **No. Bismarck**

(No. _____)

(St. _____)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary E. Erickson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female White

Widow
(Write the word.)

6. DATE OF BIRTH

Sept 24 1852
(Month) (Day) (Year)

7. AGE

70 yrs. 2 mos. 25 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Norway

10. NAME OF FATHER

Olaf Foss

11. BIRTHPLACE OF FATHER

(State or Country)

Norway

12. MAIDEN NAME OF MOTHER

Not Known

13. BIRTHPLACE OF MOTHER

(State or Country)

Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

P. J. Zimmerman

(Address)

Spalding, Idaho

15.

Filed

Dec 19 1912

1912

W. A. Hahl

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 19 1912
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 1912 to Dec 19 1912

that I last saw he alive on **Dec 19 1912**

and that death occurred on the date stated above, at **9 A.M.**

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. ds.

Contributory (Secondary)

W. S. Schuris

(Duration) yrs. mos. ds.

(Signed)

W. A. Hahl

M. D.

19

(Address)

Spalding, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

..... yrs. mos. days.

In the State

..... yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Revisator Idaho

191

20. UNDERTAKER

ADDRESS

W. A. Hahl

Revisator Idaho

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40630**

1. PLACE OF DEATH **Nez Perce** Registration District No. **99**
County of **Lapwai** Primary Registration District No. **2174**
City of **Lapwai** St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Isabel**Gabin**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **M** 4. COLOR OR RACE **Indian** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Single**

(Write the word.)

6. DATE OF BIRTH.

Jan. 1

(Month)

(Day)

1915 (Year)

7. AGE

7 Yrs. **11** Mos. **14** ds.

IF LESS than 1 day
how many.....hrs. or
.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

Child

9. BIRTHPLACE

(State or Country)

Washington

10. NAME OF FATHER

Gabriel Gabin

11. BIRTHPLACE OF FATHER

(State or Country)

Washington

12. MAIDEN NAME OF MOTHER

Louise Smith

13. BIRTHPLACE OF MOTHER

(State or Country)

Washington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

**Geo O. Keck
Lapwai, Idaho.**

15.

Filed

Dec 15**1915****Welf. and Hahl**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec. 14

(Month)

(Day)

1922 (Year)17. I HEREBY CERTIFY, That I attended deceased from **Oct 10** **1922** to **Dec. 14** **1922**that I last saw her alive on **Dec 14** **1922** and that death occurred on the date stated above, at **4:45** M.

The CAUSE OF DEATH* was as follows:

**Pulmonary Abscess
(Tuberculous)**(Duration) Yrs. **1** mos. **1** ds.Contributory (Secondary) **Tuberculous Adenitis**(Duration) Yrs. **2** mos. **7** ds.**12/14** (Signed) **Geo O. Keck** M. D.
1922 (Address) **Lapwai, Idaho.**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted **Lapwai, Idaho.**
if not at place of death?Former or usual residence **Washington**

19. PLACE OF BURIAL OR REMOVAL

Mayville, Ida.

DATE OF BURIAL

Dec. 16 **1922**

20. UNDERTAKER

L. B. Wynn

ADDRESS

Lewiston

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *My Peru*
City of *Lewiston*

JAN 11 1923

Registration District No. 96

BUREAU OF VITAL STATISTICS

Registration District No. 1009

(No.)

(St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Laura Elvira Blewett*State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 40631

Registered No. 211

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

June 26 1913
(Month) (Day) (Year)

7. AGE

*9 Yrs. 5 Mos. 4 ds.*IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).*School Girl*

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

D W Blewett

11. BIRTHPLACE OF FATHER

(State or Country)

Wisconsin

12. MAIDEN NAME OF MOTHER

Lillian Umbreit

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

*J. L. Blewett
Gifford Ida.*

15.

Filed *1/8/* 19 *23*

F. T. Harris, M.D.

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 14 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
Nov 27 1922 to *Dec 14 1922*that I last saw him alive on *Dec 14 1922*and that death occurred on the date stated above, at *10 P.M.*

The CAUSE OF DEATH* was as follows:

Arteriosclerosis as result of ruptured appendix(Duration) Yrs. mos. *14* ds.Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

19 (Address)

*J. P. Thorne M. D.
Lewiston Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Gifford Ida

DATE OF BURIAL

12/4 1922

20. UNDERTAKER

H. R. Muchant

ADDRESS

Blackfoot Ida.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40632**
Registered No. **215**

1. PLACE OF DEATH

County of **Nezperce**City of **Lewiston, Idaho**Registration District No. **96**Primary Registration District No. **1009**

(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

James H. Simmons

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

(Month) _____ (Day) _____ (Year) _____

7. AGE

70 Yrs. _____ Mos. _____ ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)**County charge**

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

**St. Joseph's Hospital
Records Lewiston**

15.

Filed **1/8/1923****F. T. Harris, M.D.**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 8 19**22**
(Month) _____ (Day) _____ (Year) _____

17. I HEREBY CERTIFY, That I attended deceased from

Dec 1921 to **Dec 8 1922**
that I last saw him alive on **Dec 8 1922**
and that death occurred on the date stated above, at **10 A.M.**

The CAUSE OF DEATH* was as follows:

Old Pleurisy(Duration) _____ Yrs. _____ mos. **1** ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) **John H. Allen** M. D.**18** (Address) **Lewiston***State the Disease Causing Death; or in deaths from **Violent Causes**, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lewiston Idaho **Dec 9 1922**

20. UNDERTAKER

ADDRESS

Lewiston**Idaho**

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of My Pledge
City of LevistonRegistration District No. 96
Primary Registration District No. 1009
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mrs. Amelia AlbertsState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 40633
Registered No. 216

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE Indian 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH

..... 1
(Month) (Day) (Year)

7. AGE

..... Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)At home

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed 1/8/ 1923 F. T. Harris, M. D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 9 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
..... 19..... to 19.....that I last saw her alive on Dec 9 1922
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Peripneumonia(Duration) Yrs. mos. 4 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

19..... (Address) Leviston

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lapwai Ida12/12/1922

20. UNDERTAKER

ADDRESS

Vassarland CoLeviston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40634**
Registered No. **212**

1. PLACE OF DEATH
County of Latah
City of Lewiston
Registration District No. 96
Primary Registration District No. 1009
St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eva Jane Fuller

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH **43**

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH Jan 12 1877
(Month) (Day) (Year)

7. AGE 45 Yrs. 10 Mos. 19 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Nashville Tenn.

10. NAME OF FATHER Samuel Long

11. BIRTHPLACE OF FATHER
(State or Country) Memphis Tenn

12. MAIDEN NAME OF MOTHER Elizabeth Crow

13. BIRTHPLACE OF MOTHER
(State or Country) Memphis Tenn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Emil Brower
(Address) Lewiston Ida

15. Filed 1/8/ 19 23 F.T. Harris M.D.
Local Registrar

16. DATE OF DEATH Dec 12 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 15 1922 to Dec 1 1922
that I last saw h.w. alive on Dec 1 1922
and that death occurred on the date stated above, at 11:20 P.M.

The CAUSE OF DEATH* was as follows:
Carcinoma of breast with metastases.
(Duration) 8 Yrs. mos. ds.

Contributory (Secondary) same
(Duration) 7 Yrs. mos. ds.
(Signed) Edgar A. White M. D.
Dec 1 1922 (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Lewiston Ida DATE OF BURIAL 12/14 1922

20. UNDERTAKER Wasson Undertaking Co ADDRESS Lewiston Ida

1. PLACE OF DEATH

County of Nez Perce
 City of Lewiston

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED CERTIFICATE OF DEATH

Registration District No. 96
 Primary Registration District No. 1009
 (No. _____) (St.) _____

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 40635
 Registered No. 214

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WID-OWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

Nov 24 1848
 (Month) (Day) (Year)

7. AGE

74 Yrs. 12 ds.

IF LESS than 1 day
 how many _____ hrs.
 or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Retired Farmer

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Wisconsin

10. NAME OF FATHER

Casper Prunus

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Katherine

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Prunus Family

(Address) Prospect Ave, Lewiston, Ida.

15.

Filed 1/8/ 1923

F. T. Harris, M.D.
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

December 6 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 1 1915, to Dec 6 1922

that I last saw him alive on Dec 6 1922

and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Diabetes

(Duration) 10 Yrs. _____ mos. _____ ds.

Contributory
 (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) John H. Alley D.

19 (Address) _____

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Lewiston Idaho

DATE OF BURIAL

December 1922

20. UNDERTAKER

ADDRESS

Lewiston
 Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40636**
Registered No. **217**

1. PLACE OF DEATH **RECEIVED**
County of **Nezperces,** Registration District No. **96**
City of **Lewiston, Ida.** Primary Registration District No. **1009**
(No. **1** St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME **Arza H. Garlinghouse**

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX **male** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **married**
(Write the word.)

6. DATE OF BIRTH **June 29 1850**
(Month) (Day) (Year)

7. AGE **72** Yrs. **5** Mos. **13** ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work **Monumental Worker**
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE **Ill.**
(State or Country)

10. NAME OF FATHER **Bingaman Garlinghouse**

11. BIRTHPLACE OF FATHER **Kentucky**
(State or Country)

12. MAIDEN NAME OF MOTHER **Williams**

13. BIRTHPLACE OF MOTHER

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) **Vassar Undertaking Co.**
(Address) **Lewiston, Ida.**

15. Filed **1/8/ 1923** **F. A. Morris, M.D.**
Local Registrar

16. DATE OF DEATH **Dec 11 1922**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Dec 5- 1922** to **Dec 11 1922**
that I last saw him alive on **Dec 11 1922**
and that death occurred on the date stated above, at **7 P.** M.

The CAUSE OF DEATH* was as follows:
Chronic Interstitial Nephritis
(Duration) **Do not know but for long period**

Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) **Paul W. Johnson** M. D.
12/14/22 (Address) **Lewiston, Ida.**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **Lewiston, Ida.** DATE OF BURIAL **12-13 1922**

20. UNDERTAKER **Vassar Undertaking Co.** ADDRESS **Lewiston, Ida.**

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Braddock
State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40637**

1. PLACE OF DEATH

County of **Nezperce**City of **Lewiston, Ida.**Registration District No. **96**Primary Registration District No. **1009**

(No. _____ St.)

Registered No. **218**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Earnest Heitman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

May 16 1882
(Month) (Day) (Year)

7. AGE

40 Yrs. 6 Mos. 26 ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Farmer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

William Heitman

11. BIRTHPLACE OF FATHER

(State or Country)

Germany
Alsace Lorraine

12. MAIDEN NAME OF MOTHER

Elora Lange

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Henry Heitman

(Address)

Lewiston.

15.

Filed **1/8/ 1923**

F. T. Harris, M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 12 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 7 1922 to Dec 12 1922

that I last saw him alive on **Dec 12 1922**

and that death occurred on the date stated above, at **5 P.M.**

The CAUSE OF DEATH* was as follows:

Septicemia(Duration) Yrs. **1** mos. **3** ds.

Contributory (Secondary)

Infection beginning in middle finger R hand

(Duration) yrs. _____ mos. _____ ds.

(Signed)

J. C. Braddock M. D.

Dec 19 22 (Address) **Lewiston, Ida.**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. **2** days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Gifford Idaho

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

Lewiston, Ida.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 96

County of

Primary Registration District No. 1009

City of

(No. St.)

File No.

Registered No. 219

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1/8/ 1923

F. T. Harris, M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 13th 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 12th 1922 to Dec 13th 1922
that I last saw h. alive on Dec 12th 1922

and that death occurred on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia
(Duration) Yrs. mos. ds.Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) M. D.

19 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lewiston Idaho 12-15-1922

20. UNDERTAKER

ADDRESS

Lewiston Idaho

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

Quinn
State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
40639
File No. _____
Registered No. 222

1. PLACE OF DEATH *JAN*
County of *Boise*
City of *Lewiston*

Registration District No. *96*
Primary Registration District No. *1009*
(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Millina A. Branson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*
(Write the word.)

6. DATE OF BIRTH *April 27th 1866*
(Month) (Day) (Year)

7. AGE *16* Yrs. *7* Mos. *16* ds.
IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work *Housewife*
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE *Texas*
(State or Country)

10. NAME OF FATHER *John H. Musgrave*

11. BIRTHPLACE OF FATHER *Ill*
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER *Mo*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Vassar Undertaking Co.*
(Address) *Lewiston, Ida.*

15. Filed *1/8/ 1923* *F.T. Harris, M.D.*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 13th 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *19* to *Dec 13th 1922*
that I last saw him alive on *1922*
and that death occurred on the date stated above, at *8:20 P.M.*
The CAUSE OF DEATH* was as follows:

Acute Dilation Heart
(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) *O. C. Branson* M. D.
19 (Address) *Lewiston, Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL *Caldwell, Idaho* DATE OF BURIAL *12-16-1922*

20. UNDERTAKER *Lewiston, Ida.* ADDRESS _____

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

40640

1. PLACE OF DEATH

County of Nez Perce
City of Lewiston,Registration District No. 96
Primary Registration District No. 1009
(No. St.)File No.
Registered No. 223

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elvira Jane*Wills*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH

May 14th 1864
(Month) (Day) (Year)

7. AGE

58 Yrs. 7 Mos. 0 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. At Home
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Indiana

10. NAME OF FATHER

James Banta

11. BIRTHPLACE OF FATHER

(State or Country) Indiana

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country) -----

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

A. J. Blyton

(Informant)

(Address) Lewiston, Ida

15.

Filed 1/8/ 1923 F. T. Harris, M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 14 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Dec 13 1922 to Dec 14 1922
that I last saw him alive on Dec 14 1922
and that death occurred on the date stated above, at 10 P M.

The CAUSE OF DEATH* was as follows:

apoplexy(Duration) Yrs. mos. 2 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Paul W. Johnson M. D.14/5.19.22 (Address) Clarkston Wash

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Clarkston, Wash

DATE OF BURIAL

12/16/22

20. UNDERTAKER

H. R. Merchant

ADDRESS

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Myer
City of LewistonRegistration District No. 96
Primary Registration District No. 1009
(No. _____ St.)File No. 40641
Registered No. 224

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John W. Little

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widowed
(Write the word.)

6. DATE OF BIRTH

1862
(Month) (Day) (Year)

7. AGE

70 Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Retired Farmer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Ill.

10. NAME OF FATHER

Elijah Little

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Vassar Undertaking Co.(Address) Lewiston, Ida.

15.

Filed 1/8/ 1923 F.T. Harris, M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec

(Month)

15
(Day)1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 1920, to Dec 15 1922that I last saw him alive on Dec 15 1922and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

arterial sclerosis

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

John W. Alley M. D.12/6/1922 (Address) Lewiston, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lewiston, Ida.12/17/1922

20. UNDERTAKER

ADDRESS

Vassar Undertaking Co. Lewiston.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH Key Perce Registration District No. 128
 County of Key Perce Primary Registration District No. Caldesac
 City of Caldesac Ida. (No. Neerinity St.)

File No. **40642**

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Adrian Reynolds

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
 (Write the word.)

6. DATE OF BIRTH Dec. 1 1922
 (Month) (Day) (Year)

7. AGE _____ IF LESS than 1 day how many _____ hrs. or _____ min. ?
 Yrs. Mos. 2 ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work _____
 (b) General nature of industry, business or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

William Elmer Reynolds

11. BIRTHPLACE OF FATHER

(State or Country) Idaho

12. MAIDEN NAME OF MOTHER

Mildred Loretta Austin

13. BIRTHPLACE OF MOTHER

(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William Elmer Reynolds
 (Address) Caldesac Idaho

15. Filed Dec. 19 22 George Gaignard
 Local Registrar

16. DATE OF DEATH

Dec. 3 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 1- 1922 to Dec. 3- 1922
 that I last saw him alive on Dec. 3 1922
 and that death occurred on the date stated above, at 5:45 AM.

The CAUSE OF DEATH* was as follows:

jaundice(Duration) _____ Yrs. mos. 2 ds.Contributory
(Secondary)

(Duration) _____ yrs. mos. ds.

(Signed)

George Gaignard M. D.
Dec. 19 22 (Address) Caldesac Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. mos. days. In the State _____ yrs. mos. days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Caldesac Idaho Dec 4 1922

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Oneida Registration District No. 26
 City of Malad Primary Registration District No. 2069
 (No. 1 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jordan Lowry

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 40643

Registered No. 44

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-OWED OR DIVORCED Child
 (Write the word.)

6. DATE OF BIRTH

Nov - 1 - 1912
 (Month) (Day) (Year)

7. AGE

10 Yrs. 13 Mos. 13 ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

Child

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Charles James Lowry

11. BIRTHPLACE OF FATHER

(State or Country)

Virginia

12. MAIDEN NAME OF MOTHER

Rosa E. Jones

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. Lowry

15.

Filed

Nov 1922

R.T. Wares
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 14 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 1 1922 to Nov 14 1922
 that I last saw him alive on Nov 14 1922
 and that death occurred on the date stated above, at 6 P. M.
 The CAUSE OF DEATH* was as follows:

marasmus

(Duration) Yrs. 3 mos. ds.

Contributory (Secondary) congenital malformation

(Duration) yrs. mos. ds.

(Signed) R.T. Wares M. D.

Nov 14 1922 (Address) Malad Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Malad Ida. Nov. 16 1922

20. UNDERTAKER

ADDRESS

J. Guy Benson Malad Ida.

WRITE PLAINLY, WITH ENFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

1. PLACE OF DEATH. **RECEIVED**
County of *Grand* Registration District No. *2069*
City of *Stone* (No. *2069* St.)
BUREAU OF VITAL STATISTICS
2. FULL NAME *James Garbanati*

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40644**
Registered No. **40**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. *Single*
(Write the word.)

6. DATE OF BIRTH. *November 1 1920*
(Month) (Day) (Year)

7. AGE *1* Yrs. *7* Mos. *ds.*
IF LESS than 1 day how many *hrs.* or *min.*

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

child

9. BIRTHPLACE

(State or Country)

Fremont Utah

10. NAME OF FATHER

James Henry Garbanati Jr

11. BIRTHPLACE OF FATHER

(State or Country)

Snowville Utah

12. MAIDEN NAME OF MOTHER

Ethelbert Stada

13. BIRTHPLACE OF MOTHER

(State or Country)

Pleasant View Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

James Garbanati Jr
Stone Ida

15.

Filed

Nov 1922 - RTH mll

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

191*22*
(Year)

17. I HEREBY CERTIFY, That I attended deceased from *June 2 1922* to *June 2 1922*,
that I last saw him on *June 2 1922*
and that death occurred on the date stated above, at *3 P.M.*
The CAUSE OF DEATH* was as follows:

Drowning - accidental

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

(Address)

M. D.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death

yrs. mos. days

State

yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Snowville Utah

191

20. UNDERTAKER

ADDRESS

*Joe J. Larkin**Snowville*

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
40643

1. PLACE OF DEATH

County of Oneida JAN 3 1923
City of Malad St. Idaho
Registration District No. 2069
Primary Registration District No. 2069

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ellen ScottFile No. 41
Registered No. 41

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-OWED OR DIVORCED Widow
(Write the word.)

6. DATE OF BIRTH

June 20 1877
(Month) (Day) (Year)

7. AGE

4 Yrs. 4 Mos. 12 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Child

9. BIRTHPLACE

(State or Country)

Guernsey & Idaho

10. NAME OF FATHER

Geo Milton Scott

11. BIRTHPLACE OF FATHER

(State or Country)

Salt Lake

12. MAIDEN NAME OF MOTHER

Naomi Rodrick

13. BIRTHPLACE OF MOTHER

(State or Country)

Samuel

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Geo M. Scott

(Address)

Guernsey & Idaho

15.

Filed

Nov 22 1922P. E. Johnson

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

11 - 1 - 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 1 1922 to Nov 1 1922that I last saw him alive on Nov 1 1922

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Cholera Infantum(Duration) _____ Yrs. _____ mos. 14 ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

J. M. Kerns M. D.

(Address)

Malad Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Malad

DATE OF BURIAL

Nov 3 1922

20. UNDERTAKER

P. E. Johnson

ADDRESS

Malad

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH **RECEIVED**
Registration District No. **24**
County of **oneida** JAN 5 1923
Primary Registration District No. **2009**
City of **malad** (No. **10** St.)

File No. **40646**
Registered No. **42**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Alma Wallace Facer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **male** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Single**

6. DATE OF BIRTH.

Dec. 19 1912
(Month) (Day) (Year)

7. AGE

17 Yrs. **10** Mos. **12** ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).

Farmer

9. BIRTHPLACE

(State or Country)

Cheyenne Creek

10. NAME OF FATHER

James A. Facer

11. BIRTHPLACE OF FATHER

(State or Country)

Hilland ut

12. MAIDEN NAME OF MOTHER

Rose Dolton

13. BIRTHPLACE OF MOTHER

(State or Country)

Hilland ut

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

James A. Facer

(Address)

Rt 2 Box 2

15.

Filed

Nov 1922

R. W. Mavor

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 7 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 6 1922 to **Nov 6 1922**

that I last saw him alive on **Nov 6 1922**

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Diabetes

(Duration) **1** Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) **J. M. Kering M.D.**

11/8 1922 (Address) **malad ut**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Malad

DATE OF BURIAL

Nov 9 1922

20. UNDERTAKER

D. J. Johnson

ADDRESS

Malad

FORM V. S. No. 5-A-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH
 County of Malaga Registration District No. 25
 City of Malaga Primary Registration District No. 2069
 (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Henry Chivers

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 40647
 Registered No. 43

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married

6. DATE OF BIRTH

Nov 14 1922
 (Month) (Day) (Year)

7. AGE

73 Yrs. 11 Mos. 29 ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Wales

10. NAME OF FATHER

James Charles

11. BIRTHPLACE OF FATHER

(State or Country)

Wales

12. MAIDEN NAME OF MOTHER

Mary Ann Niblet

13. BIRTHPLACE OF MOTHER

(State or Country)

Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Fannie Lewis

(Address)

15.

Filed

Nov 22 1922

PTW
 Local Registrar

16. DATE OF DEATH

Nov 13 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1st 1922, to Nov 13 1922
 that I last saw him alive on Nov 1st 1922
 and that death occurred on the date stated above, at 12:40 PM
 The CAUSE OF DEATH* was as follows:

Distitis

(Duration) Yrs. mos. ds.

Contributory
 (Secondary)

(Duration) yrs. mos. ds.

(Signed)

11-16-22

(Address)

M. D.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Malaga Ida 11-16-1922

20. UNDERTAKER

ADDRESS

D. E. Johnson Malaga

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully applied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of **Oneida**
City of **Malad**

Registration District No. **24**
Primary Registration District No. **2069**
(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Melvin Scrowther

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40648**
Registered No. **45**
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Married**
(Write the word.)

6. DATE OF BIRTH **Not Known**
(Month) _____ (Day) _____ (Year) _____

7. AGE **Not Known** IF LESS than 1 day how many _____ hrs. or _____ min.?
Yrs. _____ Mos. _____ ds.

8. OCCUPATION **Farmer**
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE **Not Known**
(State or Country)

10. NAME OF FATHER **Not Known**

11. BIRTHPLACE OF FATHER **Not Known**
(State or Country)

12. MAIDEN NAME OF MOTHER **Not Known**

13. BIRTHPLACE OF MOTHER **Not Known**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) **R. T. Mauer M.D.**
(Address) **Malad**

15. Filed **Nov. 22** **R. T. Mauer**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **Nov. 19 1922**
(Month) _____ (Day) _____ (Year) **1922**

17. I HEREBY CERTIFY, That I attended deceased from **Nov. 19 1922** to **Nov 19 1922**
that I last saw him **in** on **Nov 19 1922**
and that death occurred on the date stated above, at **2 A.M.**
The CAUSE OF DEATH* was as follows:
accidental

(Duration) _____ Yrs. _____ mos. _____ ds.
Contributory (Secondary) **auto lacerated over**

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) **R. T. Mauer M.D.**
Nov 19 22 (Address) **Malad, Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **Smithfield Utah** DATE OF BURIAL **19**

20. UNDERTAKER **D.E. JOHNSON** ADDRESS **MALAD**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. INDEXED

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH JAN 3
Registration District No. 26
County of oneida Primary Registration District No. 2069
City of malad (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lee David Hall

File No. 40649
Registered No. 46

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-OWED OR DIVORCED. Child
(Write the word.)

6. DATE OF BIRTH.

Nov. 8 22
(Month) (Day) (Year)

7. AGE

Yrs. 16 Mos. _____ ds. _____

IF LESS than 1 day
how many _____ hrs. or
_____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

Child

9. BIRTHPLACE

(State or Country)

Malad

10. NAME OF FATHER

Richard L Hall

11. BIRTHPLACE OF FATHER

(State or Country)

Polay Wt.

12. MAIDEN NAME OF MOTHER

Leona Edwards

13. BIRTHPLACE OF MOTHER

(State or Country)

St John

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Richard L Hall

(Address)

15.

Filed

Nov. 1922

R. J. Mear
Local Registrar

MEDICAL CERTIFICATE OF DEATH

90

16. DATE OF DEATH

Nov. 24 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov. 21 1922 to Nov. 24 1922
that I last saw him alive on Nov. 24 1922
and that death occurred on the date stated above, at 9:10 P. M.

The CAUSE OF DEATH* was as follows:

Bronchitis(Duration) _____ Yrs. _____ mos. 4 ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. M. Herpin M. D.
19 22 (Address) Malad Id.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Malad

DATE OF BURIAL

Nov 26 1922

20. UNDERTAKER

D. E. Johnson

ADDRESS

Malad

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **40650**Registered No. **47**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH **Quetta**
Registration District No. **26**
County of **Blaine** Primary Registration District No. **2061**
City of **Blaine** (No. **1** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mrs. W. V. Bunderson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Married**
(Write the word.)6. DATE OF BIRTH **December 18 1862**
(Month) (Day) (Year)7. AGE **59** Yrs. **11** Mos. **7** ds.
IF LESS than 1 day how many hrs. or min. 2)

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...**Housewife**

9. BIRTHPLACE

(State or Country)

Denmark

10. NAME OF FATHER

Andrew Peterson Norr

11. BIRTHPLACE OF FATHER

(State or Country)

Denmark

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

**Mrs. W. V. Bunderson
Blaine Idaho**

15.

Filed

Nov 22 1922**RTW/ues**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

64

16. DATE OF DEATH

November 25 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from **Nov 12 1922** to **Nov 25 1922**, that I last saw her alive on **Nov 24 1922** and that death occurred on the date stated above, at **2:45 P.M.**

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) Yrs. mos. ds.

Contributory (Secondary)

Arteriosclerosis

(Duration) Yrs. mos. ds.

(Signed)

William H. Hughes

19 (Address)

Snoville Utah

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death....yrs....mos....days In the State....yrs....mos....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Snoville Utah Nov 25 1922

20. UNDERTAKER

ADDRESS

Joe J. Hansen**Snoville Utah**

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

40651

1. PLACE OF DEATH

County of *Prinida*City of *Malad*Registration District No. *26*Primary Registration District No. *2069*

(No. _____ St.)

File No. _____

Registered No. *48*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jane Williams Mandray

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

*White*5. SINGLE, MARRIED, WID-
OWED OR DIVORCED*Widow*

6. DATE OF BIRTH

June 7 1845
(Month) (Day) (Year)

7. AGE

79 Yrs. *5* Mos. *13* ds.IF LESS than 1 day
how many _____ hrs.
or _____ min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)*House wife*

9. BIRTHPLACE

(State or Country)

Wales

10. NAME OF FATHER

Jinbin Williams

11. BIRTHPLACE OF FATHER

(State or Country)

Wales

12. MAIDEN NAME OF MOTHER

Eliza Price

13. BIRTHPLACE OF MOTHER

(State or Country)

Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Rebecca Williams

15.

Filed

*Nov 1922**R. W. Jones*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov. 30 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *Nov 24 1922* to *Nov 30 1922* that I last saw her alive on *Nov 29 1922* and that death occurred on the date stated above, at *2 P.* M. The CAUSE OF DEATH* was as follows:*Cerebral Hemorrhage*

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed) *J. H. Alton* M. D.*12-2 1922* (Address) *Malad*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*St. John**Dec 4 1922*

20. UNDERTAKER

ADDRESS

J. Guy Benson *Malad*

CERTIFICATE OF DEATH

State of Idaho

BOARD OF HEALTH
Bureau of Vital Statistics

File No. 40652

Registered No. 50

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Conida
City of MaladRegistration District No. 26
Primary Registration District No. 2069
(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Griffith Newton Greer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word)

6. DATE OF BIRTH

April

(Month)

(Day)

(Year)

7. AGE

15

Yrs.

Mos.

ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Student

9. BIRTHPLACE

(State or Country)

Trade Town

10. NAME OF FATHER

Alfred Austin Greer

11. BIRTHPLACE OF FATHER

(State or Country)

Trade Town

12. MAIDEN NAME OF MOTHER

Alice Thomas

13. BIRTHPLACE OF MOTHER

(State or Country)

Trade Town

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Malad Ida

15.

Filed

Dec. 19 22R. M. Jones

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec

(Month)

8

(Day)

19 22

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov. 15 - 19 22 to Dec. 8 19 22that I last saw him alive on Dec. 6 19 22and that death occurred on the date stated above, at 12 00 M.

The CAUSE OF DEATH* was as follows:

abcess of lung

(Duration)

Yrs.

3

mos.

ds.

Contributory
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

J. M. Thomas M. D.

(Address)

Malad Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Malad Ida

DATE OF BURIAL

12-11 19 22

20. UNDERTAKER

D. E. Johnson

ADDRESS

Malad

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Oneida*City of *Miner*Registration District No. *26*Primary Registration District No. *2069*

(No.)

St.)

File No. *40653*Registered No. *5*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Merwin John Jones

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

90

3. SEX

male

4. COLOR OR RACE

*white*5. SINGLE, MARRIED, WID-
OWED OR DIVORCED*child*
(Write the word.)

6. DATE OF BIRTH

Nov 9 1922
(Month) (Day) (Year)

7. AGE

*1 Mos. 11 ds.*IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)*Child*

9. BIRTHPLACE

(State or Country)

Cherry Creek

10. NAME OF FATHER

Hyrum Jones

11. BIRTHPLACE OF FATHER

(State or Country)

Cherry Creek

12. MAIDEN NAME OF MOTHER

Sarah J. Jones

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Hyrum J. Jones
Miner ID 2069

15.

Filed *Dec 19 22**19 22**RTW/over*

Local Registrar

16. DATE OF DEATH

Dec 14 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

*Dec 8 1922 to Dec 14 1922*that I last saw him alive on *Dec 13 1922*and that death occurred on the date stated above, at *6:00* M.

The CAUSE OF DEATH* was as follows:

Bronchitis

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

J. F. Allen M. D.

(Address)

Malad

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Cherry Creek**Dec 17 1922*

20. UNDERTAKER

ADDRESS

*D. C. Johnson**Malad*

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Oneida*
City of *Cherry Creek*

Registration District No. *26*
Primary Registration District No. *2009*
(No. _____ St.)

File No. *40654*
Registered No. *57*

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Mary Selia Williams

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *F.* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*

6. DATE OF BIRTH *March 19 1895*
(Month) (Day) (Year)

7. AGE *27* Yrs. *9* Mos. *26* ds. IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work *At Home*
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE *Malad Ida*
(State or Country)

10. NAME OF FATHER *William J. Williams*

11. BIRTHPLACE OF FATHER *Utah*
(State or Country)

12. MAIDEN NAME OF MOTHER *Mary E. Mufflin*

13. BIRTHPLACE OF MOTHER *Salt Lake City Ut*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *W. J. Williams*
(Address) *Cherry Creek Ida*

15. Filled *Dec 2 1922* *R. H. Jones*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *Dec 15 1922*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Dec 6 1922* to *Dec 15 1922* that I last saw him alive on *Dec 10 1922* and that death occurred on the date stated above, at *11 A.M.* The CAUSE OF DEATH* was as follows:

Heart attack from rheumatism

(Duration) _____ Yrs. _____ mos. *9* ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) *M. Kerns* M. D.

1700 1922 (Address) *Malad Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Malad Ida* DATE OF BURIAL *12-18 1922*

20. UNDERTAKER *R. E. Johnson* ADDRESS *Malad*

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **40655**Registered No. **106**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of oneida
City of maladRegistration District No. 26Primary Registration District No. 2069(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary S. Jones

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widowed
(Write the word.)

6. DATE OF BIRTH

June 20 1882
(Month) (Day) (Year)

7. AGE

80 Yrs. 6 Mos. 2 ds.IF LESS than 1 day
how many.....hrs. or
.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...Housewife

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

David P Stephens

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Jane Stephens

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

David S. Jones
St. John

(Address)

15.

Filed

Dec 22 1922R. H. Jones
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 22 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

12/6 1922 to Dec 22 1922
that I last saw her alive on Dec 21 1922
and that death occurred on the date stated above, at 10:15 A.M.

The CAUSE OF DEATH* was as follows:

Gal. Stones & Small Intestine(Duration) 2 Yrs. mos. ds.Contributory (Secondary) Gal. stones(Duration) 3 yrs. mos. ds.(Signed) J. M. Jones M. D.1225 E 2nd Address Threat Sta

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. John

191

20. UNDERTAKER

ADDRESS

J. M. Jones
Threat Sta

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Oneida
City of MaladRegistration District No. 26
Primary Registration District No. 2069
(No. JAN St.)File No. 40656
Registered No. 49If death occurs away from
usual residence, give facts
called for under special
information.2. FULL NAME Peter VanderwoodIf death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED. Single

6. DATE OF BIRTH.

Sept. 10 1879
(Month) (Day) (Year)

7. AGE

44 Yrs. 2 Mos. 21 ds.IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work...
(b) General nature of in-
dustry, business, or estab-
lishment in which employ-
ed (or employer).....Farmer

9. BIRTHPLACE

(State or Country) Idaho10. NAME OF
FATHERA. W. Vanderwood11. BIRTHPLACE
OF FATHER(State or Country) Idaho12. MAIDEN NAME
OF MOTHERCatherine Jones13. BIRTHPLACE
OF MOTHER(State or Country) Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ernest Vanderwood

(Address)

15.

Filed Dec 22 1922 RTM aver.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 1 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 27 19122 to Dec 1st 19122
that I last saw him alive on Dec 1st 19122
and that death occurred on the date stated above, at 20 M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) Yrs. mos. ds.

Contributory
(Secondary)absent & lung

(Duration) Yrs. mos. ds.

(Signed) J. J. Gillingham

M. D.

19 (Address) Malad*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs mos days In the State yrs mos days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Malad

DATE OF BURIAL

Dec 3 1922

20. UNDERTAKER

D. E. Jones

ADDRESS

Malad

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Oneida
City of MaladRegistration District No. 29
Primary Registration District No. 2069
(No. _____ St.)File No. 40657
Registered No. 53

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Peter Peterson

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male White Widowed

6. DATE OF BIRTH

Aug - 28 - 1840
(Month) (Day) (Year)

7. AGE

82 Yrs. 3 Mos. 16 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)Farmer

9. BIRTHPLACE

(State or Country)

Sweden

10. NAME OF FATHER

Monson Peterson

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME OF MOTHER

unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John H. Peterson

(Address)

15.

Filed

Dec. 19 22R. T. Mauer
Local Registrar

16. DATE OF DEATH

Dec. 14 19 22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 12 1922 to Dec 14 1922that I last saw him alive on Dec 12 1922and that death occurred on the date stated above, at 6 1/2 M.

The CAUSE OF DEATH* was as follows:

Senile decay

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

J. F. Alton M. D.12-28-22 (Address) Malad

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Old John

DATE OF BURIAL

Dec 16 19 22

20. UNDERTAKER

J. F. Alton

ADDRESS

Malad Idaho

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **40658**Registered No. **54**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of **Oneida**
City of **Malad**Registration District No. **26**Primary Registration District No. **2069**

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Wm Ashton Daly

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Single**
(Write the word.)

6. DATE OF BIRTH.

Dec 18, 1922
(Month) (Day) (Year)

7. AGE

Yrs. **2** Mos. **2** ds.IF LESS than 1 day
how many _____ hrs. or
_____ min.

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country) **Hardy Idaho**

10. NAME OF FATHER

Wm Ashton

11. BIRTHPLACE OF FATHER

(State or Country) **Portage Ut.**

12. MAIDEN NAME OF MOTHER

Elizabeth Allen

13. BIRTHPLACE OF MOTHER

(State or Country) **Portage Ut.**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) **William Ashton**(Address) **Mineral R 7 D #2**

15.

Filed **Dec. 22** 19**22** **WPT/aver**
Local RegistrarMEDICAL CERTIFICATE OF DEATH **90**

16. DATE OF DEATH

Dec - 21 19**22**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Birth 19**22**, to **Dec 21** 19**22**,
that I last saw her alive on **Dec 18** 19**22**,
and that death occurred on the date stated above, at **9 P** M.

The CAUSE OF DEATH* was as follows:

Bronchitis

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed)

12-22-22 (Address) **J. J. Allen** M. D.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Malad

DATE OF BURIAL

Dec. 23, 1922

20. UNDERTAKER

D. E. Johnson

ADDRESS

Malad

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of PayetteCity of New Plymouth

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 5Primary Registration District No. 1009(No. 8)

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 40659Registered No. 8

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Edwidge Lawrence Longwell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

School boy

(Write the word.)

6. DATE OF BIRTH

Dec131908

(Month)

(Day)

(Year)

7. AGE

13

Yrs.

11

Mos.

27

ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Student

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Mo.

10. NAME OF FATHER

E. C. Longwell

11. BIRTHPLACE OF FATHER

(State or Country)

Mo.

12. MAIDEN NAME OF MOTHER

Orella E. Hagdus

13. BIRTHPLACE OF MOTHER

(State or Country)

Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. C. Longwell

(Address)

New Plymouth Ida

15.

Filed

Dec 101922Wm J. Dwydall

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec101922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 61922

to

Dec 101922

that I last saw him alive on..... " "..... 1922

and that death occurred on the date stated above, at 10:40 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia(Duration)..... Yrs..... mos. 5 ds.Contributory
(Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed)

J. R. Smith

M. D.

12/10 1922(Address) New Plymouth Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Archie Mo

DATE OF BURIAL

12/15 1922

20. UNDERTAKER

H. L. Peterson

ADDRESS

Ontario On

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH
in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Payette **RECEIVED**
City of Mrs Plymouth **JAN 4 1922**
Registration District No. 1009
St. Idaho

File No. **40660**
Registered No. 9

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Infant Larsen

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M- 4. COLOR OR RACE W 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Infant
(Write the word.)

6. DATE OF BIRTH Dec 18 1922
(Month) (Day) (Year)

7. AGE IF LESS than 1 day
how many 7 hrs.
or 7 min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE Idaho
(State or Country)

10. NAME OF FATHER Edward C. Larsen

11. BIRTHPLACE OF FATHER Denmark
(State or Country)

12. MAIDEN NAME OF MOTHER Jessie Hulse

13. BIRTHPLACE OF MOTHER Utah
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edward C. Larsen
(Address) Mrs Plymouth Ida

15. Filed 12/18 1922 Wm J. Drysdale
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 18 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
at birth to 19
that I last saw him alive on Dec 18 1922
and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Insufficient foetal develop-
ment (2 1/2 mos premature)

(Duration) Yrs. mos. ds.
Contributory Pneumonia in mother
(Secondary)

(Duration) Yrs. mos. ds.
(Signed) Wm J. Drysdale M. D.

12/18/1922 (Address) Mrs Plymouth Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State. Yrs. mos. days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL Mrs Plymouth DATE OF BURIAL 12/19 1922

20. UNDERTAKER Father of child ADDRESS Mrs Plymouth

1. PLACE OF DEATH

County of Payette
City of Mr. Plymouth

If death occurs away from usual residence, give facts called for under special information.

RECEIVED CERTIFICATE OF DEATH

JAN 4 1928
Registration District No. 5
Primary Registration District No. 2009
STATISTICSState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 40661
Registered No. 10

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Violet Clanton Steiner

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Married
(Write the word.)

6. DATE OF BIRTH

Aug 15 1895
(Month) (Day) (Year)

7. AGE

27 Yrs. 4 Mos. 3 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Housewife

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Stephen Clanton

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Elizabeth Anna Farson

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. W. Clanton

(Address)

Payette Ida

15.

Filed 12/19 1927Wm J. Drysdale

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 18 1927
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 5 1927, to Dec 18 1927that I last saw him alive on 18 1927and that death occurred on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:

Small Pox(Duration) Yrs. mos. 14 ds.Contributory (Secondary) Pregnancy child birth

(Duration) yrs. mos. ds.

(Signed) P. M. Drake M. D.12/19 1927 (Address) Mrs. Plymouth

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Payette Ida12/19 1927

20. UNDERTAKER

ADDRESS

Steven C. Clanton Payette Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-48

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40662**

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH. **RECEIVED JAN 3 1922**
County of **Payette** Registration District No.
City of **Frontland** (No. **103**) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Mitchell Flock**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **M.** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Married**
(Write the word.)

6. DATE OF BIRTH **March 26 1839**
(Month) (Day) (Year)

7. AGE **83 yrs. 8 mos. 0 ds.**
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION **Farmer**
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE **Ohio**
(State or Country)

10. NAME OF FATHER **Morris Flock**

11. BIRTHPLACE OF FATHER **New Jersey**
(State or Country)

12. MAIDEN NAME OF MOTHER **Anderson**

13. BIRTHPLACE OF MOTHER **Ohio**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **C. C. Flock**(Address) **Frontland**

15. Filed **Dec 29 - 1922** **C. C. Paxton**
Local Registrar

MEDICAL CERTIFICATE OF DEATH. **64**

16. DATE OF DEATH **Dec 26 1922**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Dec 23 - 1922** to **Dec 26 1922**, that I last saw him alive on **Dec 26 1922** and that death occurred on the date stated above, at **7 P.M.**
The CAUSE OF DEATH* was as follows:

Apoplexy(Duration) — yrs. — mos. **4** ds.

Contributory (Secondary)

(Duration) — yrs. — mos. — ds.

(Signed) **C. C. Paxton M. D.****12/29/1922** (Address) **Frontland Idaho**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

New Plymouth Idaho Dec 30 1922

20. UNDERTAKER

ADDRESS

H. L. Peterson **Ontario Ore**

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

IDAHO

OREGON STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

1 PLACE OF DEATH

State Registered No. **40663**County Payette

State

Local Registered No.

Township

or

Village

or

City Frankland

No.

St. Ward

(If death occurred in a hospital or institution, give its name instead of street and number)

2 FULL NAME

Bowers

(a) Residence. No.

St.

(Usual place of abode)

(If nonresident, give city or town and state)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>7.</u>	4 COLOR OR RACE <u>white</u>	5 Single, Married, Widowed, or Divorced (write the word) <u>baby</u>
--------------------	---------------------------------	---

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of baby

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If less than 1 day—hrs. or—min.
				<u>4</u>

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9 BIRTHPLACE (city or town) Frankland
(State or country) Idaho10 NAME OF FATHER Roy Bowers11 BIRTHPLACE OF FATHER (city or town) Salina
(State or country) Kansas12 MAIDEN NAME OF MOTHER Clara Chambers13 BIRTHPLACE OF MOTHER (city or town) Medicine
(State or country) Kansas14 Informant Roy Bowers(Address) Frankland Ida15 Filed Nov 20 19 22C. C. Paxton

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 17 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 16, 1922 to Nov 17, 1922, that I last saw h. ex. alive on Nov 17, 1922, and that death occurred on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Premature birth.

..... (duration) yrs., mos., days.

CONTRIBUTORY

(Secondary)

..... (duration) yrs., mos., days.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

11/17 (Signed) William J. Hesse, M. D.
1922 (Address) Ontario Ore

* State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Near Frankland Ida11/18 1922

20 UNDERTAKER

ADDRESS

Roy BowersFrankland Ida

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **40664**Registered No. **41**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of **Payette**
City of **Payette**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED
DEC 3 1922
FURNISHED
STATISTICALRegistration District No. **2008**
(No. **1111**)**Laura B. Bader**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married (Write the word.)

6. DATE OF BIRTH

Feb 9 1863
(Month) (Day) (Year)

7. AGE

59 Yrs. **9** Mos. **23** ds.
IF LESS than 1 day how many.....hrs. or.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).**Housewife**

9. BIRTHPLACE

(State or Country)

Indiana

10. NAME OF FATHER

Mr. Williams

11. BIRTHPLACE OF FATHER

(State or Country)

Indiana

12. MAIDEN NAME OF MOTHER

Mrs. Larmore

13. BIRTHPLACE OF MOTHER

(State or Country)

Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

L. B. Bader
Payette, Ida.

15.

Filed

Dec 3 1922
J. C. Woodward
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 2 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 22 1922 to Dec 2 1922that I last saw him alive on **Nov 28 1922**and that death occurred on the date stated above, at **1034** M.

The CAUSE OF DEATH* was as follows:

Tubercular Erythema of Lungs
Tubercular Peritonitis(Duration) Yrs. **6** mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. R. Woodward

M. D.

12/29/22 (Address) **Payette Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Borise Ida

DATE OF BURIAL

12-4 1922

20. UNDERTAKER

Glenn C. Landon

ADDRESS

Payette Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40665**
Registered No. **42**

1. PLACE OF DEATH

Registration District No. **4**
County of **Payette** Primary Registration District No. **1008**
City of **Payette** (No. **1008**) St.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

George R Fulton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Married**

6. DATE OF BIRTH

Aug 18 1839
(Month) (Day) (Year)

7. AGE

83 Yrs. **3** Mos. **19** ds.
IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. **Retired Farmer**
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) **Ohio**

10. NAME OF FATHER

John Fulton

11. BIRTHPLACE OF FATHER

(State or Country) **New York**

12. MAIDEN NAME OF MOTHER

Green

13. BIRTHPLACE OF MOTHER

(State or Country) **Not Known**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Chas S Fulton**
(Address) **Payette Idaho**

15.

Filed **Dec 8 1922** **J. C. Woodward**
Local Registrar

SYNCE-YORK CO. PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 7 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 2 1922 to **Dec 7 1922**
that I last saw him alive on **Dec 6 1922**

and that death occurred on the date stated above, at **1:30 A.M.**

The CAUSE OF DEATH* was as follows:

Asphyxia

(Duration) **10** Yrs. _____ mos. _____ ds.

Contributory (Secondary) **Pneumonia**

(Duration) **10** yrs. _____ mos. _____ ds.

(Signed) **George R Fulton** M. D.

127 19 **22** (Address) **Payette, Ida**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Manysville Kans **12-9 1922**

20. UNDERTAKER

William Payette Ida

ADDRESS

1. PLACE OF DEATH

County of *Payette*City of *Payette*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No. *4*Primary Registration District No. *1008*State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *40666*Registered No. *43*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from *Nov 24* 19*22* to *Dec 6* 19*22*that I last saw her alive on *Dec 6* 19*22* and that death occurred on the date stated above, at *10:42* M.

The CAUSE OF DEATH* was as follows:

Gas
Cancer of Liver
(Duration) Yrs. mos. ds.

Contributory (Secondary)

Unknown (Duration) Yrs. mos. ds.

(Signed)

J.C. Woodward M. D.
12/8/22 (Address) *Payette Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Payette Ida *12-9-1922*

20. UNDERTAKER

ADDRESS

J.H. Adams Payette Ida

1. PLACE OF DEATH

County of Payette
City of Payette

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary Josephine Buell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

single
(Write the word.)

6. DATE OF BIRTH

May 13 1919
(Month) (Day) (Year)

7. AGE

3 Yrs. 7 Mos. 2 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Charles W. Buell

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Mary E. Wieg

13. BIRTHPLACE OF MOTHER

(State or Country)

Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

C. W. Buell
Payette, Idaho

15.

Filed

Dec 16 1922 J. C. Woodward
Local Registrar

RECEIVED CERTIFICATE OF DEATH

Registered District No. 4Primary Registration District No. 1008(No. 1008)

(St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

40667

Registered No.

44

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

105

16. DATE OF DEATH

Dec. 15 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

December 10 1922, to December 15 1922that I last saw him alive on December 15 1922and that death occurred on the date stated above, at 5:30 A. M.

The CAUSE OF DEATH* was as follows:

Enteric - Colitis(Duration) Yrs. mos. 5 ds.Contributory Broncho pneumonia
(Secondary)(Duration) yrs. mos. 2 ds.(Signed) B. H. Avery M. D.7/16/1922 (Address) Payette, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Payette Idaho Dec. 17 1922

20. UNDERTAKER

ADDRESS

Glenn C. Lundon Payette, Id.

1. PLACE OF DEATH

CERTIFICATE OF DEATH

40668

State of Idaho
DEPT. OF PUBLIC
WELFARE

County of Power Registration District No. 25
 City of American Falls Primary Registration District No. 272
 If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henry Roth

Bureau of Vital Statistics
 File No. 4
 Registered No. 177
 If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX. Male 4. COLOR OR RACE. White 5. Single, married, Widowed or Divorced.
 (Write the Word.)

6. DATE OF BIRTH. Oct 12th, 1922
 (Month) (Day) (Year)

7. AGE. IF LESS than 1 day, how many.....hrs. or min.?
 Yrs. 2 Mos. 24 ds.

8. OCCUPATION.

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9. BIRTHPLACE.

(State or Country.)

10. NAME OF FATHER.

11. BIRTHPLACE OF FATHER.

(State or Country.)

12. MAIDEN NAME OF MOTHER.

13. BIRTHPLACE OF MOTHER.

(State or County.)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15.

Filed 12-26, 1922 Mrs. R. K. Roth
 Local Registrar.

Place Where Remains are to be Sent

Date of Shipment

SHIPPING UNDERTAKER

ADDRESS

Firm Name

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH.

Dec 24th, 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 22, 1922, to Dec 24, 1922, and

that I last saw him alive on Dec 24, 1922and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH was as follows:

The patient must have died from pneumonia according to report of the father on the above stated date.
 (Duration) Years mos. ds.

Contributory (Secondary.)

(Duration) Years mos. ds.

Signed

M. D.

19..... (Address) American Falls

* State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (for Hospitals, Institutions, Transient or Recent Residents.)

At place..... in the.....

of death..... yrs..... mos..... days State..... yrs..... mos..... ds

Where was disease contracted

if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL.

Date of Burial

20. UNDERTAKER.

Address

CERTIFICATE OF DEATH.

40669

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of **Power**City of **American Falls, Idaho**Registration District No. **25**Primary Registration District No. **2072**File No. **4**Registered No. **176**If death occurs away from
usual residence, give facts
called for under special
information.2. FULL NAME **Louis Renke**If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.**Married**
(Write the word.)

6. DATE OF BIRTH.

June**10****1853**

(Month)

(Day)

(Year)

7. AGE

69Yrs. **5**Mos. **28**

ds.

IF LESS than 1 day
how many.....hrs. or
.....min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.....
(b) General nature of in-
dustry, business, or estab-
lishment in which employ-
ed (or employer).....**House wife**

9. BIRTHPLACE

(State or Country)

Germany10. NAME OF
FATHER**Not known**11. BIRTHPLACE
OF FATHER

(State or Country)

Germany12. MAIDEN NAME
OF MOTHER**Tharau
Not Known**13. BIRTHPLACE
OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) **Louis Renke**

(Address)

American Falls, Idaho

15.

Filed

191

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov. 15 1922 to **Dec 8** 1922that I last saw her alive on **Dec 8** 1922and that death occurred on the date stated above, at **8 P.** M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration)

4

Yrs.

mos.

ds.

Contributory
(Secondary)**Pneumonia**

(Duration)

Yrs.

mos.

ds.

(Signed)

C. F. Schiefel

M. D.

17/19 24 Address **Amer. Falls, Ida.***State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place

In the

of death.....yrs.....mos.....days State.....yrs.....mos.....days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

American Falls, Idaho

DATE OF BURIAL

12/10/22

20. UNDERTAKER

A.W. Davis,**American Falls, Ida**

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS
should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement
of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
 N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

40670

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Power Registration District No. 25
 County of Power Registration District No. 207D File No. 4
 City of American Falls, Idaho Bethony Deaconest Hospital Registered No. 175

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph N Wagner

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

Male

White

Single
(Write the word.)

6. DATE OF BIRTH.

Oct 1 1907
(Month) (Day) (Year)

7. AGE

15 Yrs. 1 Mos. 18 ds.

IF LESS than 1 day
how many.....hrs. or
.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
 (b) General nature of industry, business, or establishment in which employed (or employer).....

Student

9. BIRTHPLACE

(State or Country)

Chicago, Ills

10. NAME OF FATHER

Joseph Wagner

11. BIRTHPLACE OF FATHER

(State or Country)

Hungaria

12. MAIDEN NAME OF MOTHER

Mary Kokron

13. BIRTHPLACE OF MOTHER

(State or Country)

Hungarian

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

American Falls, Idaho

15.

Filed 191

Local Registrar

16. DATE OF DEATH

Nov 18 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 11 1922, to Nov 12 1922,

that I last saw him alive on Nov 12 1922,

and that death occurred on the date stated above, at 6:45 A.M.

The CAUSE OF DEATH* was as follows:

gunshot wound of thigh
accidental

(Duration) Yrs. mos. 1 ds.

Contributory (Secondary)

Shock

(Duration) yrs. mos. 1 ds.

(Signed) C. F. Schick M. D.

11/18/22 (Address) American Falls Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

American Falls, Idaho 11/18/22

20. UNDERTAKER

ADDRESS

American Falls, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

40671

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Power

Registration District No. 25

County of

Primary Registration District No. 2072

City of

American Falls Idaho Stetham Hospital St.)

File No. 4

Registered No. 174

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Alma Wahlen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Female white

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH.

Dec 19 1922
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs. or
30 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Fred Wahlen

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME OF MOTHER

Alma Malmberg

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Fred Wahlen

(Address)

Aberdeen Ida

15.

Filed

12-20 1922

1922

M. R. K. K.

Local Registrar

16. DATE OF DEATH

Dec 19 22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 19 1922 to Dec 19 1922, that I last saw him alive on Dec 19 1922, and that death occurred on the date stated above, at 10:15 A.M.

The CAUSE OF DEATH* was as follows:

Premature birth - 26th week
Albuminuria of pregnancy
in mother.

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. C. Markinson M. D.

1922 (Address) Aberdeen Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Aberdeen Ida

DATE OF BURIAL

Dec 19 1922

20. UNDERTAKER

Friends

ADDRESS

1. PLACE OF DEATH

County of *Shoshone*City of *Heerwy*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED CERTIFICATE OF DEATH

Registration District No. *123*

Primary Registration District No.

(No.)

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *40672*Registered No. *36*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Divorced
(Write the word.)

6. DATE OF BIRTH

July
(Month)*27*
(Day)*1895*
(Year)

7. AGE

27

Yrs.

Mos.

ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Labarer

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Robt. L. Davis

11. BIRTHPLACE OF FATHER

(State or Country)

Texas

12. MAIDEN NAME OF MOTHER

Margaret E. Davis

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

R. L. Davis

(Address)

Rose Lake, Idaho

15.

Filed

12/14/22

19

E. E. Hardy

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

*Nov**9**22*

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

*Nov 7 1922, to Nov 9 1922*that I last saw him alive on *Nov 9 1922*and that death occurred on the date stated above, at *5:15 A.M.*

The CAUSE OF DEATH* was as follows:

Tuberculosis Empyema

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)*Diabetes*

(Duration)

Yrs.

mos.

ds.

(Signed)

J. R. Mason M. D.*11/9 1922* (Address) *Heerwy, Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Rose Lake, Ida**Nov 10, 1922*

20. UNDERTAKER

ADDRESS

*M. C. Thumling**Heerwy, Ida*

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Shoshone*City of *Kellogg*Registration District No. *123*

Primary Registration District No. _____

(No. _____)

St.) _____

File No. _____

40673

Registered No. *40*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

May Catherine Storalovich

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

*White*5. SINGLE, MARRIED, WID-
OWED OR DIVORCED*married*
(Write the word.)

6. DATE OF BIRTH

July 20 1883
(Month) (Day) (Year)

7. AGE

39 Yrs. 4 Mos. 22 ds.

IF LESS than 1 day

how many _____ hrs.

or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Tennessee

10. NAME OF FATHER

No information

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mike Storalovich

(Address)

Kellogg, Idaho

15. Filed

12/14/22

19

E. E. Hardy

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 12 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

*Dec 12 1922, to Dec 12 1922*that I last saw him alive on *Dec 12 1922*and that death occurred on the date stated above, at *6:30 P.M.*

The CAUSE OF DEATH* was as follows:

Post Partum Hemorrhage

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) *J. P. Mason* M. D.*12/14 1922* (Address) *Kellogg, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Spokane Wash

DATE OF BURIAL

Dec 15, 1922

20. UNDERTAKER

M. C. Thornbier

ADDRESS

Kellogg, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
40674
32

1. PLACE OF DEATH
County of *Shoshone*
City of *Wardner*
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME *James A. Oldham*
Registration District No. *123*
Registration District No. *123*
JAN 4 1923
St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M.* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*
6. DATE OF BIRTH *October 8*
7. AGE *68* Yrs. *7* Mos. *2* ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work *musician*
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) *Missouri*

10. NAME OF FATHER
G. H. Oldham

11. BIRTHPLACE OF FATHER
(State or Country) *Kentucky*

12. MAIDEN NAME OF MOTHER
Bean

13. BIRTHPLACE OF MOTHER
(State or Country) *Bean*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *Mrs. A. Oldham*
(Address) *Wardner Idaho*

15. Filed *12/14/22* Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug 2
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Aug 2* 19*22* to *July 31* 19*22* that I last saw him alive on *July 31* 19*22* and that death occurred on the date stated above, at *M.* M.
The CAUSE OF DEATH* was as follows:

General debility

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) *J. R. Mason* M. D.

9/6 19*22* (Address) *Keokuk, Iowa*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Keokuk Iowa* DATE OF BURIAL *Aug 4, 1922*

20. UNDERTAKER *Mr. J. Thorndike* ADDRESS *Keokuk Iowa*

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of ShoshoneCity of Kellogg

If death occurs away from usual residence, give facts called for under special information.

Reception District No. 123Principal Registration District No. JAN 14 1922

BUREAU OF VITAL STATISTICS

File No. 40675Registered No. 3

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jessie Geraldine Hall

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

married
(Write the word.)

6. DATE OF BIRTH

Dec 20 1895
(Month) (Day) (Year)

7. AGE

26 Yrs. 9 Mos. 21 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Godess and

(b) General nature of industry, business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

P. C. Mashburn

11. BIRTHPLACE OF FATHER

(State or Country)

N.C.

12. MAIDEN NAME OF MOTHER

Allilee Whitner

13. BIRTHPLACE OF MOTHER

(State or Country)

N.C.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Florence Mashburn(Address) Shoshone, Idaho15. 12/14/22 E. E. HardyFiled 12/14/22 E. E. Hardy
Local RegistrarMEDICAL CERTIFICATE OF DEATH 30

16. DATE OF DEATH

Oct 12 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

9/23/1922 to 10/12/1922that I last saw him alive on 10/12/1922and that death occurred on the date stated above, at 11:00 AM

The CAUSE OF DEATH* was as follows:

Tubercular Meningitis(Duration) Yrs. 2 mos. 7 ds.Contributory (Secondary) Pelvic Cellulitis(Duration) Yrs. 1 mos. 21 ds.(Signed) P. C. Mashburn M. D.10/14/22 (Address) Kellogg, Idaho

*State the Disease Causing Death; or in death from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL St. Maries, Idaho. DATE OF BURIAL Oct. 14, 192220. UNDERTAKER C. Thornhill, Kellogg, Idaho. ADDRESS

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

JAN

Registration District No. 123

County of

Shoshone

JAN

Primary Registration District No.

City of

Kellogg

St. No.

St.)

File No.

40676

Registered No.

34

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Carr G. Redfield

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

Color

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single (word.)

6. DATE OF BIRTH

Nov.

17,

1881

(Month)

(Day)

(Year)

7. AGE

40

Yrs.

11

Mos.

5

ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Laborer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Wisconsin

10. NAME OF FATHER

Lee R. Redfield

11. BIRTHPLACE OF FATHER

(State or Country)

Wisconsin

12. MAIDEN NAME OF MOTHER

Ada Gardner

13. BIRTHPLACE OF MOTHER

(State or Country)

Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Carl E. Redfield

(Address)

Kellogg, Idaho

15.

12/14/22

19

E. E. Hardy

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct

19,

1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb. 17th 1922, to Oct. 19 — 1922

that I last saw him alive on Oct. 19 — 1922

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 6 Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

E. E. Hardy

M. D.

Oct. 19, 1922 (Address) Kellogg, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Coeur d'Alene

Oct 20, 1922

20. UNDERTAKER

ADDRESS

M. P. Thornhill

Kellogg, Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40677**
Registered No. **35**

1. PLACE OF DEATH **RECEIVED**
Registration District No. **123**
County of **Shoshone** JAI Primary Registration District No. **33**
City of **Kellogg** (No. **33**) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jessie Gill

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **F.** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **widowed**

6. DATE OF BIRTH

Sept 12 1954
(Month) (Day) (Year)

7. AGE

68 Yrs. **1** Mos. **19** ds.

IF LESS than 1 day
how many.....hrs.
or.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

housewife

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

Wm Harrico

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

H. L. Lawrence

(Address)

Kellogg, Idaho

15.

Filled

12/14/22

E. E. Hardy

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 1 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Oct 18 1922** to **Nov 1 1922**

that I last saw her alive on **Oct 21 1922**

and that death occurred on the date stated above, at **5 P.M.**

The CAUSE OF DEATH* was as follows:

Heart trouble.

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) **J. R. Mason** M. D.

11/9/22 (Address) **Kellogg, Idaho.**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Kellogg, Idaho **Nov 4, 1922**

20. UNDERTAKER

ADDRESS

M. C. Thompson **Kellogg, Idaho**

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Shoshone Registration District No. 12.3
City of Kellogg Primary Registration District No. _____
(No. _____) (St.) _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Richella BiottiFile No. 40678
Registered No. 37

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE Caucasian 5. SINGLE, MARRIED, WID-OWED OR DIVORCED widow
(Write the word.)6. DATE OF BIRTH November 7 — 1858
(Month) (Day) (Year)7. AGE 64 Yrs. — 4 Mos. — 4 ds. IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Housewife

9. BIRTHPLACE

(State or Country)

Italy

10. NAME OF FATHER

Jacomo Vergosbi

11. BIRTHPLACE OF FATHER

(State or Country)

Italy

12. MAIDEN NAME OF MOTHER

Giovanna Melnatti

13. BIRTHPLACE OF MOTHER

(State or Country)

Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles P. Biotti
(Address) 139 W. Mission - Kellogg Ida15. Filed 12/14/32 E. E. Hardy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

19

16. DATE OF DEATH

November 11 th 1932
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Nov 8th 1932 to Nov 11th 1932
that I last saw her alive on Nov 11th 1932
and that death occurred on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:

Dilatation of the Heart (acute)(Duration) _____ Yrs. _____ mos. 15 minutes ds.
Contributory Chronic Fibillation & Myocarditis
(Secondary)(Duration) 2 yrs. _____ mos. _____ ds.
(Signed) E. E. Hardy M. D.12/1/32 (Address) Kellogg Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Kellogg Idaho

DATE OF BURIAL

Nov 12 1932

20. UNDERTAKER

M. C. Thorne

ADDRESS

Kellogg Ida

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Shoshone Registration District No. 123
 City of Stellerg Primary Registration District No. 4
 (No. 4 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

James Albert Brown

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 40679
 Registered No. 38

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

19

3. SEX M. 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED married
 (Write the word.)

6. DATE OF BIRTH

Aug. 25 1878
 (Month) (Day) (Year)

7. AGE

44 Yrs. 2 Mos. 22 ds.

IF LESS than 1 day
 how many..... hrs.
 or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

Miner

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

W. L. Brown

11. BIRTHPLACE OF FATHER

(State or Country)

Missouri

12. MAIDEN NAME OF MOTHER

Sarah Armstrong

13. BIRTHPLACE OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Albert H. Brown
 (Address) St. John, Wash.

15. Filed 12/14/22 E. E. Hardy
 19 22 Local Registrar

16. DATE OF DEATH

Nov 16, 19 22
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
 19....., to 19.....
 that I last saw h..... alive on 19.....
 and that death occurred on the date stated above, at M.
 The CAUSE OF DEATH* was as follows:

Patient was dead when
assessed.
 (Duration) Yrs. mos. ds.

Contributory
 (Secondary)

(Duration) Yrs. mos. ds.

(Signed) A. M. McDougall M. D.

19..... (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Monrovia, Wash. DATE OF BURIAL Nov 17, 1922

20. UNDERTAKER M. P. Thornhill ADDRESS Stellerg, Idaho

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

19

Local Registrar

CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

St.)

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Signed)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs mos days In the State yrs mos days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

1. PLACE OF DEATH

County of ShoshoneCity of Kellogg

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Melise

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

October

(Month)

8th

(Day)

1866

(Year)

7. AGE

56

Yrs.

Mos.

2

ds.

16

or

IF LESS than 1 day

how many hrs.

min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Smelter Man

(b) General nature of industry, business or establishment in which employed (or employer).

Smelter Work

9. BIRTHPLACE

(State or Country)

Italy

10. NAME OF FATHER

Not known.

11. BIRTHPLACE OF FATHER

(State or Country)

Italy,

12. MAIDEN NAME OF MOTHER

Not known.

13. BIRTHPLACE OF MOTHER

(State or Country)

Italy.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Emma Melise

(Address)

Kellogg, Idaho.

15.

Filed Dec. 17th, 19 22.

Local Registrar

RECEIVED
JAN 1923
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 123

Primary Registration District No.

(No.)

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

40681

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec

(Month)

16

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 1, 19 22 to Dec. 16, 19 22that I last saw him alive on Dec. 16, 19 22,and that death occurred on the date stated above, at 130 P. M.

The CAUSE OF DEATH* was as follows:

Aortic Regurgitation

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)Asthma

(Duration)

yrs.

mos.

ds.

(Signed)

George Kenneth M. D.Dec 17, 1922

(Address)

Kellogg, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

yrs.

mos.

days.

In the

State

yrs.

mos.

days

Where was disease contracted if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

Greenwood Cemetery

DATE OF BURIAL

Dec 19, 19 22

20. UNDERTAKER

McKinnon

ADDRESS

Kellogg, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH Shoshone JAN 4 1923
County of Shoshone District No. 123
City of Seeley Primary Registration District No. _____
(No. _____ St.)

File No. 40682
Registered No. 42

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Williams

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-OWED OR DIVORCED Married
(Write the word.)
6. DATE OF BIRTH _____
(Month) (Day) (Year)
7. AGE _____
IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Miner
(b) General nature of industry, business or establishment in which employed (or employer) _____

9. BIRTHPLACE
(State or Country) no inf

10. NAME OF FATHER " "

11. BIRTHPLACE OF FATHER
(State or Country) _____

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER
(State or Country) _____

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M. P. Thornhill
(Address) Seeley

15. Filed 12/27/1922 E. E. Hard
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 19 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 5 1922 to Dec 19 1922
that I last saw him alive on Dec 19 1922
and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:
myocarditis

(Duration) 2 Yrs. _____ mos. _____ ds.
Contributory Chronic alcoholism
(Secondary)
(Duration) 5 yrs. _____ mos. _____ ds.
(Signed) Geo. H. Kennel M. D.
Dec 19 1922 (Address) Seeley, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Anacanda Mont DATE OF BURIAL Dec 23, 1922

20. UNDERTAKER M. P. Thornhill ADDRESS Seeley, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. ... **40684** ...
Registered No. ...
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of *Idaho*
City of *Siler*
If death occurred away from usual residence, give facts called for under special information.
Registration District No. *38*
Primary Registration District No. *2086*
(No. ... St.)

2. FULL NAME

Edward J. Price

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OF RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*
(Write the word.)

6. DATE OF BIRTH. *Mar 24*
(Month) (Day) (Year)

7. AGE *68* Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Wales

10. NAME OF FATHER

John W. Price

11. BIRTHPLACE OF FATHER

(State or Country)

Wales

12. MAIDEN NAME OF MOTHER

Morgan

13. BIRTHPLACE OF MOTHER

(State or Country)

Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *W. H. Price*
(Address) *Siler*

15. *Jan 1* 191... *99 Newberry*
Filed Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *Dec 4* 19*22*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Nov. 21* 19*22* to *Nov. 26* 19*22* that I last saw him alive on *Nov. 26* 19*22* and that death occurred on the date stated above, at *10 A.M.*

The CAUSE OF DEATH* was as follows:

Acute nephritis 10 days

Arterio-sclerosis

(Duration) *10* Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) *H. A. Wright* M. D.

Dec 28 1922 (Address) *Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. mos. days. In the State ... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Do not

20. UNDERTAKER

H. A. Wright

ADDRESS

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-17

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH JAN 3 1923 Registration District No. 36
County of Twin Falls Primary Registration District No. STATISTICS
City of Kimberly (No. _____) St.)

If death occurs away from usual residence, give facts called for under special information.

FULL NAME Sabra Adaline Lee

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 40685
Registered No. 13

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widowed
(Write the word.)

6. DATE OF BIRTH

June 1831
(Month) (Day) (Year)

7. AGE

91 yrs. 6 mos. ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) housewife

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A.D. Sartwell
(Address) Kimberly, Idaho

15.

Filed Dec. 5, 1922 191

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

December 4 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 2, 1922 191., to Dec. 4, 1922 191., that I last saw h. er alive on Dec. 4, 1922 191., and that death occurred on the date stated above, at 6P M. The CAUSE OF DEATH* was as follows:

Acute bronchitis

(Duration) yrs. mos. 8 ds.

Contributory senility
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Joseph M. Damm M. D.

Dec. 5, 1922 (Address) Kimberly, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Twin Falls, Idaho Dec. 7, 1922

20. UNDERTAKER

J.E. DeWitt, Twin Falls, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. **40686**
 Registered No.
 If death occurred in a hos-
 pital, institution or camp,
 give its NAME instead of
 street and number.

1. PLACE OF DEATH **See Salton**
 County of **See Salton** Registration District No. **37**
 City of **See Salton** Primary Registration District No. **1085**
 If death occurs away from usual residence, give facts called for under special information. (No. St.)

2. FULL NAME **E. O. Engle**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED. **married**
 (Write the word.)
 6. DATE OF BIRTH. **Jan 1 1880**
 (Month) (Day) (Year)
 7. AGE **42** Yrs. **11** Mos. **23** ds.
 IF LESS than 1 day
 how many hrs. or
 min.?"

8. OCCUPATION

(a) Trade, profession or
 particular kind of work
 (b) General nature of in-
 dustry, business, or estab-
 lishment in which em-
 ployed (or employer) **Farmer**

9. BIRTHPLACE

(State or Country) **Kansas**

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country) **Penn**

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country) **Penn**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Ladie Engle**(Address) **Siler**

15.

Filed Dec. 30-22. 191....

John F. Langhorne
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 28 191**2**
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Dec 27 191**2** to **Dec 28** 191**2**
 that I last saw him alive on **Dec 28** 191**2**
 and that death occurred on the date stated above, at **12:45 P.M.**
 The CAUSE OF DEATH* was as follows:

Paralysis of pneumogastrie
 (Duration) Yrs. mos. **1 Mon. 15**
 Contributory (Secondary) **minutes**

(Duration) Yrs. mos. ds.
 (Signed) **D. A. Langhorne** M. D.
Dec 30 191**2**, (Address) **Siler**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
 of death yrs. mos. days, State yrs. mos. days

Where was disease contracted

If not at place of death?

Former or
 usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

2001 Cemetery 191**2**
 UNDERTAKER **J. H. Rusk** ADDRESS **Siler**

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

1. PLACE OF DEATH

County of *Twin Falls*

City of *"*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No. *37*

Primary Registration District No. *1085*

(No. *County Hospital* St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. *40687*

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female White

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-OWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

July 19
(Month) (Day) (Year)

7. AGE

39 Yrs. *4* Mos. *9* ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Nurse wife

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Id

10. NAME OF FATHER

Richard Scott

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Burgess Gee

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. O. Broning

(Address) *Twin Falls*

15.

Filed Dec. *1* 19*22*

John P. Boughlin
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov. 28 19*22*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov. 28 19*22*, to *Nov. 28* 19*22*

that I last saw h. *er* alive on *Nov. 28* 19*22*

and that death occurred on the date stated above, at *M.*

The CAUSE OF DEATH* was as follows:

*Septic endocarditis,
following childbirth*

(Duration) Yrs. *8* ds.

Contributory (Secondary)

(Duration) yrs. *1* mos. *8* ds.

(Signed) *H. W. Wilson* M. D.

Nov. 29 19*22* (Address) *Twin Falls Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Twin Falls, Ida

Dec. 1 19*22*

20. UNDERTAKER

ADDRESS

J. P. Grossman

Twin Falls Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

40688

1. PLACE OF DEATH

County of *Swain Falls*

Registration District No. *37*

City of *"*

Primary Registration District No. *1085*

(No. *66* County Hospital. St.)

File No. *40688*

Registered No. *132*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Irma Irene Letspeich

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

Nov
(Month)

28
(Day)

1895
(Year)

7. AGE

27
Yrs.

0
Mos.

18
ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Kan

10. NAME OF FATHER

C. D. Lechner

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Etta Webb

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

H. B. Letspeich

(Address)

Swain Falls, Ida

15.

Filed *Dec. 16* 19 *22*

John F. Coughlin
Local Registrar

16. DATE OF DEATH

Dec
(Month)

16
(Day)

1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov. 18 19 *22* to *Dec 16* 19 *22*

that I last saw her alive on *Dec. 16* 19 *22*

and that death occurred on the date stated above, at *1:00* AM.

The CAUSE OF DEATH* was as follows:

*Peritonitis
from ruptured fallopian tube*

(Duration)

Yrs.

mos.

ds.

Contributory (Secondary)

Gonorrhea

(Duration)

Yrs.

mos.

ds.

(Signed)

E. D. Weaver M. D.

19

(Address)

Swain Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

Yrs.

mos.

days.

In the

State

Yrs.

mos.

days

Where was disease contracted if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Swain Falls, Ida

12/18 19 *22*

20. UNDERTAKER

ADDRESS

P. J. Grossman

Swain Falls

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **40689**

Registered No. _____

1. PLACE OF DEATH

County of SanfellyRegistration District No. 37Primary Registration District No. 1085

City of _____

(No. County Hospital, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Andrew D. Dillon

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

MwhiteMarried
(Write the word.)

6. DATE OF BIRTH

aug 6
(Month) (Day) (Year)

7. AGE

74 Yrs.

Mos.

ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Farmer

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

not known

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

C. D. Dillon

(Address)

Kimberly, Ida.

15.

Filed Dec. 1- 1922John J. Coughlin
Local Registrar

16. DATE OF DEATH

Nov 28
(Month) (Day) (Year)1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 1922 to Nov 28 1922
that I last saw him alive on Nov 28 1922
and that death occurred on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:

Compounded Corrosive fracture of both bones of left arm - Hemorrhage - Septicemia

(Duration) Yrs. _____ mos. _____ ds.

Contributory (Secondary)

74 yrs old

(Duration) yrs. _____ mos. _____ ds.

(Signed)

Dr. John R. Morgan M. D.11-28-1922 (Address) Twice Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Twice Falls

DATE OF BURIAL

Nov 29 1922

20. UNDERTAKER

J. E. L. Watt

ADDRESS

Twice Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40690**

1. PLACE OF DEATH

County of JuniperRegistration District No. 37

City of _____

Primary Registration District No. 1085
(No. 1423 Poplar Ave. St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Dorid Herald Story

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Infant
(Write the word.)

6. DATE OF BIRTH

Dec 17 1922
(Month) (Day) (Year)

7. AGE

9 Yrs. 9 Mos. 9 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Infant

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Herald Story

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Wilma Zeller

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Harold Story

(Address)

Keybank Idaho

15.

Filed Dec 26 1922John F. Houghlin
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 25 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from 12-17 1922 to 12-25 1922that I last saw him alive on 12-25 1922
and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Purpura neonatorum

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) John F. Houghlin M. D.

19. (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Juniper Falls

DATE OF BURIAL

Dec 26 1922

20. UNDERTAKER

J. E. DeWitt

ADDRESS

Juniper Falls

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

Registration District No. 37.

County of Twin Falls

Primary Registration District No. 1085.

City of

(No. Addison Ave., N.

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Sue Rhoads

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 40691

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo E. Harriott

(Address) Twin Falls, Ida.

15.

Filed December 1 1922

John F. Coughlin
Local Registrar

16. DATE OF DEATH

11-8-22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from November 1922 to Nov-8th 1922

that I last saw her alive on Nov-8th 1922

and that death occurred on the date stated above, at 11 A. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Esophagus

(Duration) 3 Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) John F. Coughlin M. D.

11-8-1922 (Address) Twin Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Portland Ore

1922

20. UNDERTAKER

ADDRESS

J. F. Coughlin
Twin Falls

RECEIVED CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 40692

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

Registration District No. 37.
County of Twin Falls Primary Registration District No. 2085.
City of Hansen (N.C. 151) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

(2) Infant Patty

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Fe 4. COLOR OR RACE WT 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH

11 - 12 - 1922
(Month) (Day) (Year)

7. AGE

0 Yrs. 0 Mos. 0 ds.

IF LESS than 1 day
how many hrs. or min.?
30

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed Dec. 1 1922

Local Registrar

16. DATE OF DEATH

11 - 12 - 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 10 - 13 - 1922
that I last saw her alive on never 19
and that death occurred on the date stated above, at 2:48 P.M.

The CAUSE OF DEATH* was as follows:

Immature

(Duration) 0 Yrs. 0 mos. 0 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

11-13-1922 (Address) Twin Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 0 yrs. 0 mos. 0 days. In the State 0 yrs. 0 mos. 0 days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rochester

Oct 14, 1922

20. UNDERTAKER

ADDRESS

F. A. Dewitt

Twin Falls

RECEIVED
JAN 1 1923

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40693**

Registered No.

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

1. PLACE OF DEATH

County of Twin Falls Registration District No. 37.
City of Hansen Primary Registration District No. 2085.
(No.) (St.)

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

(3) Infant - Patty

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Fe

4. COLOR OR RACE

WT5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDSingle
(Write the word.)

6. DATE OF BIRTH

11 - 12 - 1922
(Month) (Day) (Year)

7. AGE

0 Yrs. 0 Mos. 0 ds.

IF LESS than 1 day
how many 3 hrs.
or 30 min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho10. NAME OF
FATHERJos. Ernest Patty11. BIRTHPLACE
OF FATHER

(State or Country)

Ark12. MAIDEN NAME
OF MOTHERAlthea Bouham13. BIRTHPLACE
OF MOTHER

(State or Country)

Ark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. J. A. Cator

(Address)

Hansen

15.

Filed Dec. 1 1922

John F. Bouham
Local Registrar

16. DATE OF DEATH

11 - 12 - 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

11 - 12 - 1922 to 11 - 12 - 1922
that I last saw h. e. alive on never 1922
and that death occurred on the date stated above, at 3:05 P.M.
The CAUSE OF DEATH* was as follows:

Immature

(Duration) 0 Yrs. 0 mos. 0 ds.

Contributory
(Secondary)

(Duration) 0 yrs. 0 mos. 0 ds.

(Signed) Edwan Cott M. D.

11 - 12 - 1922 (Address) Twin Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death 0 yrs. 0 mos. 0 days. In the State 0 yrs. 0 mos. 0 days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Idaho

DATE OF BURIAL

Mar 14, 1922

20. UNDERTAKER

J. E. DeWitt

ADDRESS

Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH
in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Twin Falls Registration District No. 37
City of Hansen Primary Registration District No. 2085
(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

(1) Infants - Patty

File No. **40694**
Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Fe 4. COLOR OR RACE Wt 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH

11 - 12 - 1922
(Month) (Day) (Year)

7. AGE

0 Yrs. 0 Mos. 0 ds.

IF LESS than 1 day
how many 0 hrs.
or 30 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Jos. Erast. Patty

11. BIRTHPLACE OF FATHER

(State or Country) Ark

12. MAIDEN NAME OF MOTHER

Alethe Bonham

13. BIRTHPLACE OF MOTHER

(State or Country) Ark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. J. A. Caton

(Address) Hansen

15.

Filed Dec. 1 1922

John J. Foxglin
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

11 - 12 - 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

10 to 10 - 13 1922
that I last saw h.e.r. alive on Dec 11 1922
and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

In - nature

(Duration) - Yrs. - mos. 0 ds.

Contributory
(Secondary)

(Duration) - yrs. - mos. 0 ds.

(Signed) E. Van Coten

11-13-22 (Address) Twin Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 0 yrs. 0 mos. 0 days. In the State 0 yrs. 0 mos. 0 days

Where was disease contracted if not at place of death? -

Former or usual residence -

19. PLACE OF BURIAL OR REMOVAL

Rochereek

DATE OF BURIAL

19

20. UNDERTAKER

F. E. C. Co.

ADDRESS

Twin Falls

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Jun. Falls Registration District No. 37
 City of JAN Primary Registration District No. 1085
 (No. 1085 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William B. Huntsman

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 40695
 Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
 (Write the word.)

6. DATE OF BIRTH

Oct 3 1840
 (Month) (Day) (Year)

7. AGE

82 Yrs. 2 Mos. 24 ds.

IF LESS than 1 day
 how many..... hrs.
 or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

Lumberman

9. BIRTHPLACE

(State or Country)

Ind

10. NAME OF FATHER

Lowell Huntsman

11. BIRTHPLACE OF FATHER

(State or Country)

Penn

12. MAIDEN NAME OF MOTHER

Berkie Ruppel

13. BIRTHPLACE OF MOTHER

(State or Country)

Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Albert Huntsman

(Address)

15.

Filed December 29 19 22

John Fleaughler
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 27 19 22
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 27 19 22, to Dec. 27 19 22 that I last saw him alive on Dec. 27 19 22 and that death occurred on the date stated above, at 10 P.M.
 The CAUSE OF DEATH* was as follows:

Apoplexy

..... (Duration) Yrs. mos. ds.

Contributory
 (Secondary)

..... (Duration) yrs. mos. ds.

(Signed)

J. R. Morgan

M. D.

Dec. 27 19 22

(Address) Jun Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Jun Falls

DATE OF BURIAL

Dec 28 19 22

20. UNDERTAKER

J. R. Morgan

ADDRESS

Jun Falls

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. County Hospital.) St.)

FULL NAME

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Dec. 1

19 22

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

9 PM. Nov. 10, 1922, to 10 PM. Nov. 10, 1922
that I last saw her alive on Nov. 10, 1922
and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Cancer of liver & stomach

(Duration) ? Yrs. ? mos. ? ds.

Contributory (Secondary)

(Duration) 15 minutes

(Signed)

11-1019.22 (Address) Twin Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH

Twin Falls

Registration District No. 37.

County of _____ Primary Registration District No. 1085.

City of _____ St. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John H. Grinstead

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 40697

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

Oct
(Month)26
(Day)1858
(Year)

7. AGE

64 yrs. 0 mos. 29 ds.

IF LESS than 1 day
how many hrs.
or min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Farmer

(b) General nature of industry, business or establishment in which employed (or employer).

Retired

9. BIRTHPLACE

(State or Country)

Ida.

10. NAME OF FATHER

Wm Grinstead

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Ester Armistead

13. BIRTHPLACE OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs J. H. Grinstead

(Address)

Twin Falls, Ida.

15.

Filed Dec. 1, 1922

John H. Grinstead
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov.
(Month)25
(Day)1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

1918, to July 1922

that I last saw him alive on July 1922

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Did not see him alive for several mos before death (chronic poisoning)
(Duration) several mosContributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

P. A. Emess

M.

19 (Address) Twin Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Twin Falls

DATE OF BURIAL

11/27/1922

20. UNDERTAKER

J. J. Grossman Twin Falls

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **40698**

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH *Juin Falls*
 County of *Juin Falls* Registration District No. *37*
 City of *Juin Falls* Primary Registration District No. *1085*
 (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Franklin P Dayton

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*

6. DATE OF BIRTH

Mar 7 1893
 (Month) (Day) (Year)

7. AGE

68 Yrs. *8* Mos. *26* ds. ***

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Id.

10. NAME OF FATHER

Lech Dayton

11. BIRTHPLACE OF FATHER

(State or Country)

Id.

12. MAIDEN NAME OF MOTHER

Lerain Walcott

13. BIRTHPLACE OF MOTHER

(State or Country)

Id.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs J P Dayton

(Address)

Juin Falls, Ida

15.

Filed *Dec. 6* 19*22*

Local Registrar

John J. Coughlin

16. DATE OF DEATH

Dec 3 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 1922, to *Dec. 1922*
 that I last saw him alive on *Dec. 2 1922*
 and that death occurred on the date stated above, at *3:45 P.M.*

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage(Duration) Yrs. mos. *1* ds.

Contributory (Secondary)

Arteriosclerosis

unknown (Duration) yrs. mos. ds.

(Signed)

*Hal Piels M. D.*Dec. 4, 1922: (Address) *Juin Falls, Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Juin Falls, Ida**12-6 1922*

20. UNDERTAKER

ADDRESS

*J. P. Crossman**Juin Falls Ida*

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 37.

County of Twin Falls

Primary Registration District No. 1085.

City of " " (No. County Hospital. St.)

File No. 40699

Registered No.

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Jacob H. Spainhower

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Male

White

Married (Write the word.)

6. DATE OF BIRTH

Sept - 8 1897
(Month) (Day) (Year)

7. AGE

65 3 5
Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.

Farmer

(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer).

Owner

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF
FATHER

John Spainhower

11. BIRTHPLACE
OF FATHER

(State or Country)

Ky.

12. MAIDEN NAME
OF MOTHER

Lucinda Murphy

13. BIRTHPLACE
OF MOTHER

(State or Country)

Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs JH Spainhower

(Address)

Buhl, Ida

15.

Filed

Dec. 13, 1922

John Houghlin

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 13 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 11 1922 to Dec 13 1922
that I last saw him alive on Dec 13 1922
and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Shock - Surgical
following late operation
for strangulated hernia
(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. H. Murphy M. D.

12/13/1922 (Address) Buhl, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Shanbury, Ida 1922

20. UNDERTAKER

ADDRESS

P. J. Grossman, Twin Falls, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

JAN 4 1923

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

40700

1. PLACE OF DEATH
County of Twin Falls Registration District No. 37
City of Twin Falls Primary Registration District No. 1085
(No. County Hospital St.)

File No. 40700
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Fern Simmons

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widow
(Write the word.)

6. DATE OF BIRTH Nov 26 1922
(Month) (Day) (Year)

7. AGE 5 yrs. 5 mos. 5 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

None

9. BIRTHPLACE Twin Falls Ida
(State or Country)

10. NAME OF FATHER John Simmons

11. BIRTHPLACE OF FATHER Kansas
(State or Country)

12. MAIDEN NAME OF MOTHER Gay Love

13. BIRTHPLACE OF MOTHER Mo.
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Simmons
(Address) Burke Ida

15. Filed Dec 4 - 1922 John F. Coughlin
Local Registrar

16. DATE OF DEATH Dec 1 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 26 1922, to Nov 30 1922
that I last saw him alive on Dec 1 1922,
and that death occurred on the date stated above, at 5 P.M.
The CAUSE OF DEATH* was as follows:
Premature Birth

(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) J. H. Murphy M. D.
12-1-1922 (Address) Burke Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Burke Ida DATE OF BURIAL 12-7-22

20. UNDERTAKER J. F. Coughlin ADDRESS Burke Ida

FORM V. S. No. 5-A—25 M. 1-19.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No. 37.

Primary Registration District No. 1085.

(No.

St.)

File No.

40701

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed Dec. 1 - 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

10-7-22 to 11-3-22

that I last saw him alive on 11-2-22

and that death occurred on the date stated above, at 4:00 P.M.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. T. Murphy M. D.

11-3-22 (Address) Buffalo, N. Y.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40703**
Registered No. _____

1. PLACE OF DEATH
County of Lewin Registration District No. 37
City of Buhl Primary Registration District No. 1085
(No. County Hospital) _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED ✓
(Write the word.)

16. DATE OF DEATH

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many 8 hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed Dec. 1 -- 1922

Local Registrar

17. I HEREBY CERTIFY, That I attended deceased from 10-30-1922 to 10-31-1922
that I last saw him alive on 10-31-1922
and that death occurred on the date stated above, at 4 a. M.

The CAUSE OF DEATH* was as follows:

Probably incomplete closure of foramen ovale of heart.
(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.(Signed) Geo. Jennings M. D.10/31/1922 (Address) Buhl, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 37.

1085.

File No.

40704

County of

Primary Registration District No.

City of

(No. County hospital.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED
married
(Write the word.)

6. DATE OF BIRTH

7. AGE

46 Yrs. 1 Mos. 28 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed Dec. 1 --- 19 22

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 10 19 22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 4 19 22 to Nov 10 19 22

that I last saw h. or alive on Nov 10 19 22

and that death occurred on the date stated above, at 10:20 AM.

The CAUSE OF DEATH* was as follows:

Acute dilatation
of heart - Myocardial
degenerative
(Duration) Yrs. mos. 2 ds.Contributory
(Secondary)Abrasion in left
pelvis - fractured ribs
(Signed) R. J. McKinley M. D.

11/10 19 22 (Address) Buhl Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. 2 days. In the State yrs. 2 mos. days

Where was disease contracted if not at place of death? Don't know

Former or usual residence Portland Ore

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Buhl Ida Nov 11 19 22

20. UNDERTAKER

ADDRESS

L. J. Johnson Buhl Ida

1. PLACE OF DEATH

Registration District No. 37.
 County of Jim F. Clark Primary Registration District No. 1085.
 City of STATISTICAL 227 7th Ave., N. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Janet Rogerson

CERTIFICATE OF DEATH

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. **40705**

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX fe 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED Infant
 (Write the word.)

6. DATE OF BIRTH

March 8 1921
 (Month) (Day) (Year)

7. AGE

Yrs. 21 Mos. 5 ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

Infant

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Robert Rogerson

11. BIRTHPLACE OF FATHER

(State or Country) Seattle

12. MAIDEN NAME OF MOTHER

Ethel Clark

13. BIRTHPLACE OF MOTHER

(State or Country) Georgie

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. R. H. Rogerson
 (Address) 227-7th Ave. North

15.

Filed Dec. 14-22 19

John F. Coughlin
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec. 13 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 5 1921, to Dec. 13 1922
 that I last saw him alive on Dec. 8 1922
 and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Hydrocephalus

(Duration) 1 Yrs. 8 mos. ds.

Contributory
 (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. W. Wilcox M. D.

Dec. 13 1922 (Address) Swan Falls, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Swan Falls

DATE OF BURIAL

12-14 1922

20. UNDERTAKER

J. C. DeWitt

ADDRESS

Swan Falls

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

40706

1. PLACE OF DEATH

County of *Lewin Teller*City of *Lewin Teller*

If death occurs away from usual residence, give facts called for under special information.

Registration District No. *37*Primary Registration District No. *1085*(No. *37* County Hospital. St.)

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Louisa Meeks

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

Feb 28 1863
(Month) (Day) (Year)

7. AGE

88 Yrs. *9* Mos. *4* ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

Housewife

9. BIRTHPLACE

(State or Country)

Michigan

10. NAME OF FATHER

John Rector

11. BIRTHPLACE OF FATHER

(State or Country)

Don't know

12. MAIDEN NAME OF MOTHER

Don't know

13. BIRTHPLACE OF MOTHER

(State or Country)

Don't know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

L. D. Meeks
Buhl, Ida

15.

Filed

*Dec. 4-22**John F. Coughlin*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec. 2 (Friday) 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov. 24 1922 to *Dec. 2 1922*that I last saw her alive on *Dec. 2 1922*and that death occurred on the date stated above, at *12* M.

The CAUSE OF DEATH* was as follows:

Uraemia (Chronic interstitial nephritis) following cholecystectomy.(Duration) *?* Yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

H. Wilson M. D.(Address) *Lewin Teller, Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Buhl - Ida**12/6 1922*

20. UNDERTAKER

ADDRESS

*L. Johnson**Buhl Ida*

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Franklin* JANRegistration District No. *37*

City of

Primary Registration District No. *1085*(No. *Addison Ave.* St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Frances Bryant*State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *40707*

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *fe* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *married*
(Write the word.)

6. DATE OF BIRTH

May 21 18*85*
(Month) (Day) (Year)

7. AGE

67 Yrs. *6* Mos. *3* ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)*House wife*

9. BIRTHPLACE

(State or Country)

New York

10. NAME OF FATHER

Egra Keller

11. BIRTHPLACE OF FATHER

(State or Country)

New York

12. MAIDEN NAME OF MOTHER

Emonetta Beech

13. BIRTHPLACE OF MOTHER

(State or Country)

New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

George E. Bryant

(Address)

Twins Falls, Ida

15.

Filed *Dec. 1* 19*22**John T. Conklin*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 28 19*22*
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *Nov 16* 19*22*, to *Nov. 27* 19*22*, that I last saw h*er* alive on *Nov. 27* 19*22* and that death occurred on the date stated above, at *8:30* P.M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia(Duration) Yrs. mos. *21* ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

H. W. Wilcox M. D.*Dec. 1* 19*22* (Address) *Twins Falls, Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Twins Falls, Ida

DATE OF BURIAL

Dec. 1 19*22*

20. UNDERTAKER

J. E. Dwyer

ADDRESS

Twins Falls

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40708**

1. PLACE OF DEATH
County of Travis Falls
City of "
Registration District No. 37
Primary Registration District No. 1085
(No. 10860, Harrison St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME W. H. Henry Shohoney

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married

6. DATE OF BIRTH Jan 27
(Month) (Day) (Year)

7. AGE 55 Yrs. 10 Mos. 24 ds.
IF LESS than 1 day how many... hrs. or... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Lab.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE Mo.
(State or Country)

10. NAME OF FATHER John T. Shohoney

11. BIRTHPLACE OF FATHER Mo.
(State or Country)

12. MAIDEN NAME OF MOTHER Mary Cherry

13. BIRTHPLACE OF MOTHER Mo.
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. James B. Lewis
(Address) Harrison

15. Filed Dec. 23- 1922
John F. Houghton
Local Registrar

16. DATE OF DEATH Dec. 21 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 10, 1922 to Dec 21, 1922
that I last saw him alive on Dec 21, 1922
and that death occurred on the date stated above, at 8:15 P.M.
The CAUSE OF DEATH* was as follows:

Ulcers of Stomach
(Duration) 2 Yrs. mos. ds.
Contributory (Secondary) Cancer of Stomach
(Duration) 6 yrs. mos. ds.
(Signed) W. H. Leete M. D.
12/23/1922 (Address) Travis Falls, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death... yrs... mos... days. In the State... yrs... mos... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Travis Falls
20. UNDERTAKER J. F. Houghton
ADDRESS Travis Falls

CERTIFICATE OF DEATH

1. PLACE OF DEATH JAN 4
 County of Twin Falls Registration District No. 37
 Primary Registration District No. 1085
 City of " (No. County Hospital, St.)

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 40709
 Registered No. "

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Vera May Van Eaton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED Single
 (Write the word.)

6. DATE OF BIRTH Sept 22 1920
 (Month) (Day) (Year)

7. AGE 7 Yrs. 1 Mos. 29 ds.
 IF LESS than 1 day
 how many..... hrs.
 or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho.

10. NAME OF FATHER

Frank Van Eaton

11. BIRTHPLACE OF FATHER

(State or Country)

Calif.

12. MAIDEN NAME OF MOTHER

Jaqueta Willis

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank Van Eaton
 (Address) Rogers, Ida.

15. Filed Dec. 1-- 19 22

John F. Coughlin
 Local Registrar

16. DATE OF DEATH

Nov - 21 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 16 19 22 to Nov. 21 19 22
 that I last saw h. ex. alive on Nov. 20 19 22
 and that death occurred on the date stated above, at 5 A.M.
 The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) Yrs. mos. 7 ds.
 Contributory (Secondary)

(Duration) yrs. mos. ds.
 (Signed) C. S. Weaver M. D.
 19..... (Address) Twin Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Twin Falls, Ida. DATE OF BURIAL 11-22-1922

20. UNDERTAKER J. F. Grossman ADDRESS Twin Falls, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

Urener
State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40710**
Registered No.

1. PLACE OF DEATH *Swain Falls*
County of *Swain* Registration District No. *37*
City of *"* Primary Registration District No. *1085*
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Henry Clay Parker

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*

6. DATE OF BIRTH *Dec 5 1881*
(Month) (Day) (Year)

7. AGE *87* Yrs. *11* Mos. *9* ds. IF LESS than 1 day how many..... hrs. or..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. *Retired*
(b) General nature of industry, business or establishment in which employed (or employer) *Farmer.*

9. BIRTHPLACE *Ohio.*
(State or Country)

10. NAME OF FATHER *David Parker.*

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER *Starks.*

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *Mrs. H. C. Parker*
(Address) *Swain Falls, Ida.*

15. Filed *Dec. 1* 19*22*
John I. Bughlin
Local Registrar

16. DATE OF DEATH *Nov 14 1922*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *4/16 1922* to *5/31 1922*
that I last saw him alive on *11/14 1922*
and that death occurred on the date stated above, at *5 A.M.*

The CAUSE OF DEATH* was as follows:
Organic Heart Disease
(hypertension mitral regurgitation)
(Duration) Yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) *E. S. Weaver*, M. D.
..... 19..... (Address).....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Swain Falls, Ida.* DATE OF BURIAL *Nov 15 1922*

20. UNDERTAKER *J. J. Grossman* ADDRESS *Swain Falls, Ida.*

Clouchbeck

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

Registration District No. 37

Primary Registration District No. 1083

City of

(No.)

St.)

File No.

40711

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Wm N Clark

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

N

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

Dec 10 1848
(Month) (Day) (Year)

7. AGE

73 Yrs. *11* Mos. *20* ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Farmer

(b) General nature of industry, business or establishment in which employed (or employer)

Retired

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

Not Known

11. BIRTHPLACE OF

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Not Known

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

G. J. Weiss

(Address)

Twinn Falls, Ida.

15.

Filed *Dec 1 - 1922*

John Houghton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov - 30 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 26 1922 to *Nov 29 1922*

that I last saw h..... alive on..... 19.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Acute dilatation of heart

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

Geo Clouchbeck M. D.
Twinn Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Twinn Falls, Ida

12 - 2 1922

20. UNDERTAKER

ADDRESS

R. J. Grossman

Twinn Falls Ida

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Twin FallsRegistration District No. 37Primary Registration District No. 1085City of Idaho

(No. _____ St.)

File No. 40712

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ruby Juaneta Brownfield

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female white

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

June 10 1920
(Month) (Day) (Year)

7. AGE

2 Yrs. 5 Mos. 9 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

E. Brownfield

11. BIRTHPLACE OF FATHER

(State or Country)

Missouri

12. MAIDEN NAME OF MOTHER

Lillian M. Chandler

13. BIRTHPLACE OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. Brownfield(Address) Twin Falls, Ida.

15.

Filed Dec. 1 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

19

16. DATE OF DEATH

Nov 18 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 11 1922 to Nov 18 1922that I last saw him alive on Nov 18 1922

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Peritonitis following enteritis

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W. L. Chandler M. D.19 (Address) Twin Falls, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Twin Falls, Ida.11-20-1922

20. UNDERTAKER

ADDRESS

J. J. GrossmanTwin Falls, Idaho

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Twin Falls*Registration District No. *37*

City of

Primary Registration District No. *1085*(No. *South Park Addition* St.)State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *40713*

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Harold Hansing (Twin)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

*Male White**Single*
(Write the word.)

6. DATE OF BIRTH

Aug 16 1922
(Month) (Day) (Year)

7. AGE

3 Yrs. *20* Mos. *20* ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Okech

10. NAME OF FATHER

A. N. Hansing

11. BIRTHPLACE OF FATHER

(State or Country)

Kan

12. MAIDEN NAME OF MOTHER

Stella McCall

13. BIRTHPLACE OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. N. Hansing

(Address)

Twin Falls

15.

Filed *Dec-9* *1922*

Local Registrar

16. DATE OF DEATH

December 6 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 1 1922 to *Dec 6 1922*that I last saw him alive on *Dec 5 1922*

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Thrombosis poisoning(Duration) Yrs. mos. *10* ds.Contributory
(Secondary)(Duration) yrs. mos. *10* ds.

(Signed)

John R. Morgan M. D.*12-6-1922* (Address) *Twin Falls, Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Twin Falls**Dec 7 1922*

20. UNDERTAKER

ADDRESS

J. R. Morgan *Twin Falls*

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED

JAN 4 1922

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Union Falls* Registration District No. *37.*
Primary Registration District No. *1085.*
City of *"* (No. County Hospital. *"* St.)State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *10714*Registered No. *"*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Gottfried Weckert

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

16. DATE OF DEATH

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

17. I HEREBY CERTIFY, That I attended deceased from

Dec. 2 - 1922 to *Dec 3 - 1922*that I last saw him alive on *Dec. 2 - 1922*and that death occurred on the date stated above, at *"* M.

The CAUSE OF DEATH* was as follows:

Obstruction of Bowel(Duration) Yrs. mos. *1* ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. R. Morgan M. D.
12-4-1922 (Address) *Union Falls Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Union Falls *12-5-1922*

20. UNDERTAKER

ADDRESS

R. Brassneau *Union Falls*

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

40715

1. PLACE OF DEATH

County of *Juin Falls*Registration District No. *37*City of *"*Primary Registration District No. *1085*(No. *South Park Addition*. St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Hausung

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Aug 16 19*22*
(Month) (Day) (Year)

7. AGE

3 Yrs. *14* Mos. *14* ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Okla.

10. NAME OF FATHER

A. H. Hausung

11. BIRTHPLACE OF FATHER

(State or Country)

Kan

12. MAIDEN NAME OF MOTHER

Stella McCall

13. BIRTHPLACE OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. H. Hausung

(Address)

Juin Falls, Id.

15.

Filed *December 4* 19*22*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 30 19*22*
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *Nov. 30* 19*22* to *Nov. 30* 19*22*that I last saw h..... alive on..... 19.....
and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Pneumonia secondary due to food

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. R. Morgan

M. D.

12-4-1922 (Address) *Juin Falls, Idaho.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Juin Falls, Ida

DATE OF BURIAL

Dec 4, 1922

20. UNDERTAKER

R. G. Brown

ADDRESS

Juin Falls.

FORM V. S. No. 5-A-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

40716

1. PLACE OF DEATH

County of Twin Falls Registration District No. 37
Primary Registration District No. 1085
City of " (No. 108 St.)File No. 40716
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Charles Morgan Ambrose

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male white Married
(Write the word.)

6. DATE OF BIRTH

June 5
(Month) (Day) (Year)

7. AGE

55 Yrs. 6 Mos. 11 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

Collector for Idaho Power Co.

9. BIRTHPLACE

(State or Country)

N.Y.

10. NAME OF FATHER

Not known

11. BIRTHPLACE OF FATHER

(State or Country)

"

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. C. M. Ambrose
(Address) Twin Falls, Ide

15.

Filed Dec. 16- 19 22

Local Registrar

John J. Laughlin

16. DATE OF DEATH

Dec - 16 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 1st 1921 to Dec 16 1922that I last saw him alive on Dec 16 1922and that death occurred on the date stated above, at 3 A.M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory Alcoholism Chronic nephritis(Secondary) Chronic nephritis
(Duration) 2 yrs. _____ mos. _____ ds.(Signed) S. H. Francis M. D.Dec 16 19 22 (Address) Twin Falls, Ide

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Twin FallsDATE OF BURIAL 12-17-192220. UNDERTAKER GrossmanADDRESS Twin Falls

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD.
N. B.-Every item of information should be classified EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH
County of Elmore JAN 4 1923 Registration District No. 37.
City of Twin Falls Idaho Primary Registration District No. 1085.
County Hospital. (St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 40717
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robert Hayward Stevenson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH July 27 1869
(Month) (Day) (Year)

7. AGE 53 Yrs. 4 Mos. 7 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. News Paper Man
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE
(State or Country) Georgetown Ohio

10. NAME OF FATHER Samuel Hamilton Stevenson

11. BIRTHPLACE OF FATHER
(State or Country) Ohio

12. MAIDEN NAME OF MOTHER Sarah Higgins

13. BIRTHPLACE OF MOTHER
(State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Hellie J. Stevenson
(Address) Twin Falls, Idaho

15. Filed Dec. 11 1922
John T. Loughlin
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 5 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 4th 1922, to Dec 5th 1922
that I last saw him alive on Dec 5th 1922
and that death occurred on the date stated above, at 5 P.M.
The CAUSE OF DEATH* was as follows:

Heart Disease, Heart - Myocarditis Chronic
(Duration) ✓ Yrs. mos. ds.
Contributory Gauger Base Bladder
(Secondary) Perforation of duodenum
(Duration) yrs. mos. ds.
(Signed) Samuel J. Stevenson M. D.
Dec 6, 1922 (Address) Twin Falls Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Twin Falls DATE OF BURIAL Dec. 8 1922

20. UNDERTAKER J. J. Foreman ADDRESS Twin Falls

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of win. FallsRegistration District No. 37.
Primary Registration District No. 1085.City of Winfield(No. 1085)

St.)

Registered No. 40718

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Winfield Campbell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

M

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married

(Write the word.)

6. DATE OF BIRTH

Nov 5 1842

(Month)

(Day)

(Year)

7. AGE

80 Yrs.Mos. 1

ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Attorney

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ind

10. NAME OF FATHER

James.Campbell

11. BIRTHPLACE OF FATHER

(State or Country)

S. Carolina

12. MAIDEN NAME OF MOTHER

Precila Mick

13. BIRTHPLACE OF MOTHER

(State or Country)

S. Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. E. Mann

(Address)

15.

Filed

Dec. 1 - 1922John F. Goughlin

Local Registrar

16. DATE OF DEATH

Nov 6 1922

(Month)

(Day)

19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 3rd 1921, to Nov 6th 1922that I last saw him alive on Nov 6 1922and that death occurred on the date stated above, at 11 45 M.

The CAUSE OF DEATH* was as follows:

Memoria(Duration) Yrs. 6 mos. 6 ds.

Contributory

Nephritis Chronic Interstitial

(Secondary)

General Arteriosclerosis(Duration) 3 yrs. 1 mos. 1 ds.

(Signed)

Stewart L. Alexander M. D.Nov 1922 (Address) Win Falls Id

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. 1 mos. 1 days. In the State Yrs. 1 mos. 1 days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Morteno Ill

DATE OF BURIAL

19

20. UNDERTAKER

J.F. Dewitt

ADDRESS

Win Falls

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No. 37.

Primary Registration District No. 1085.

(No. County Hospital. St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 40719

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed Dec. 1, 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

Nov 11th 1922, to Nov 18th 1922that I last saw her alive on Nov 18th 1922and that death occurred on the date stated above, at 10⁰⁰ M.

The CAUSE OF DEATH* was as follows:

Acute dilatation of Heart

(Duration) Yrs. mos. ds.

Contributory Septicemia + Hemorrhage

(Secondary) following confinement + high fever

(Duration) yrs. mos. ds.

(Signed) Bureau RPH + family M. D.

Nov 18 1922 (Address) Twin Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rock Creek, Ida

11-19-1922

20. UNDERTAKER

ADDRESS

J. P. Crossman

Twin Falls, Ida.

This case delivered by midwife.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Twin Falls*Registration District No. *37*Primary Registration District No. *1085*

City of " " (No. County Hospital, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Ray L. Rumsey*File No. *40720*

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Male

4. COLOR OR RACE

*White*5. SINGLE, MARRIED, WID-
OWED OR DIVORCED*Married*
(Write the word.)

6. DATE OF BIRTH

Jan 7

(Month)

(Day)

1876
(Year)

7. AGE

46 Yrs.*10* Mos.*21* ds.

IF LESS than 1 day

how many _____ hrs.

or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Farmer

(b) General nature of industry, business or establishment in which employed (or employer).

Owner

9. BIRTHPLACE

(State or Country)

Ida

10. NAME OF FATHER

O.S. Rumsey

11. BIRTHPLACE OF FATHER

(State or Country)

N.Y.

12. MAIDEN NAME OF MOTHER

J.A. Watson

13. BIRTHPLACE OF MOTHER

(State or Country)

N.Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs R.A. Rumsey

(Address)

Eden 2da

15.

Filed *Dec. 1-**1922**John F. Coughlin*
Local Registrar

16. DATE OF DEATH

Nov - 28

(Month)

(Day)

1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

*Nov 25th**1922*

to

*Nov 28**1922*that I last saw him alive on *Nov 28th* *1922*and that death occurred on the date stated above, at *4:30 P.* M.

The CAUSE OF DEATH* was as follows:

*Acute dilation Heart following
Traumatic Pneumonia*(Duration) _____ Yrs. _____ mos. *2* ds.Contributory *Fracture (Bull) Fracture S 9th R.*
(Secondary) *G.S. Clonal Left Perforation Long R.*(Duration) _____ yrs. _____ mos. *3* ds.(Signed) *Samuel L. H. M.D.**Nov 29 1922* (Address) *Twin Falls Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Twin Falls Ida

DATE OF BURIAL

11-29-22

20. UNDERTAKER

S. J. Grossman

ADDRESS

Twin Falls Ida

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **40722**
Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Blaine Registration District No. 37
City of _____ Primary Registration District No. 1085
(No. County General Hosp St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Thomas L. Jackson

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

May 13 1865
(Month) (Day) (Year)

7. AGE

57 Yrs. 7 Mos. 16 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Laborer

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Mo.

10. NAME OF FATHER

Geo. Jackson

11. BIRTHPLACE OF FATHER

(State or Country)

Not Known

12. MAIDEN NAME OF MOTHER

Haney Warren

13. BIRTHPLACE OF MOTHER

(State or Country)

Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Fred Greun

(Address)

Blaine Falls, Ida.

15.

Filed Jan. 2-23 1923

Local Registrar

John F. Coughlin

16. DATE OF DEATH

Dec 29 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Oct 31, 1922 to Dec 29, 1922that I last saw him alive on Dec 29, 1922and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(Duration) 3 Yrs. - mos. - ds.Contributory
(Secondary)(Duration) - yrs. - mos. - ds.

(Signed)

Joseph Sygal M. D.1/2 1923 (Address) Blaine Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Blaine Falls, Ida. Jan. 2, 1923

20. UNDERTAKER

ADDRESS

P. J. Grossman Blaine Falls, Ida.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

40723

File No.
Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

Registration District No. 39
County of Swain Falls Primary Registration District No. 2087
City of Buhl Idaho (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Johnson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widowed

6. DATE OF BIRTH

Aug 29 1847
(Month) (Day) (Year)

7. AGE

75 Yrs. 3 Mos. 28 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Farmer

9. BIRTHPLACE

(State or Country)

Sweden

10. NAME OF FATHER

Not known

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME OF MOTHER

Not known

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Fred Johnson

(Address)

Buhl Idaho

15.

Filed Dec 27 1922J. H. Murphy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

12-26-22
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from 12-9- 1922, to 12-26- 1922that I last saw him alive on 12-26- 1922,
and that death occurred on the date stated above, at 10 P M.

The CAUSE OF DEATH* was as follows:

Cancer of Lower Jaw(Duration) 3 Yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Geo. Jennings M. D.12-27-22 (Address) Buhl, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Osleams Herb.

DATE OF BURIAL

12/27/22

20. UNDERTAKER

Lawville Drugg.

ADDRESS

Buhl, Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
40725

1. PLACE OF DEATH

County of Valley Registration District No.
City of Cascade Primary Registration District No.
(No., St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Charles William Parks

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widowed

(Write the word.)

6. DATE OF BIRTH

Aug 24 1860
(Month) (Day) (Year)

7. AGE

62 Yrs. 4 Mos. 1 ds.

IF LESS than 1 day
how many... hrs.
or... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

huntsman and

(b) General nature of industry, business or establishment in which employed (or employer)

farmer

9. BIRTHPLACE

(State or Country)

Illinois

10. NAME OF FATHER

Samuel Parks

11. BIRTHPLACE OF FATHER

(State or Country)

Illinois

12. MAIDEN NAME OF MOTHER

Rachel Dunlap

13. BIRTHPLACE OF MOTHER

(State or Country)

Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Dr. J. F. Rutledge

(Address)

Cascade, Idaho

15.

Filed

19

Stella Cain

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 25 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 24 1922 to Dec 25 1922

that I last saw him alive on Dec 25 1922

and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Paralytic ileus

(Duration) ... Yrs. ... mos. 4 ds.

Contributory
(Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) J. F. Rutledge M. D.

12/25 1922 (Address) Cascade Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40726**

1. PLACE OF DEATH

County of Valley

Registration District No. 15

City of Emmett

(No. 15)

St. Idaho

Registered No. 40726

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

James Leonard Phillips

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married

(Write the word.)

6. DATE OF BIRTH

July 10 1897
(Month) (Day) (Year)

7. AGE

25 Yrs. 5 Mos. 20 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

hogger

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Emmett, Idaho

10. NAME OF FATHER

James Leonard Phillips

11. BIRTHPLACE OF FATHER

(State or Country)

Missouri

12. MAIDEN NAME OF MOTHER

Matilda Elizabeth Perkins

13. BIRTHPLACE OF MOTHER

(State or Country)

Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Dr. J. F. Rutledge

(Address)

Cascade, Idaho

15.

Filed 19

Stella Cain
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 1 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

HT 19— to 19—

that I last saw him alive on 19—

and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Fractured Skull.
Dead when seen by me.
Reported killed instantly.

(Duration) — Yrs. — mos. — ds.

Contributory
(Secondary)

(Duration) — yrs. — mos. — ds.

(Signed) J. F. Rutledge M. D.

12/1 19 22 (Address) Cascade, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death — yrs. — mos. — days. In the State — yrs. — mos. — days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

40727

1. PLACE OF DEATH

Registration District No. 15

County of Valley

Primary Registration District No.

City of 2 miles east of Arling

No.

St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mrs. Ester Mary Johnson Luoma

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White Finnish

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

married
(Write the word.)

6. DATE OF BIRTH

March 9 1900
(Month) (Day) (Year)

7. AGE

22 Yrs. 7 Mos. 27 ds.

IF LESS than 1 day
how many — hrs.
or — min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

House wife

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Wyoming.

10. NAME OF FATHER

John S. Johnson

11. BIRTHPLACE OF FATHER

(State or Country)

Finland.

12. MAIDEN NAME OF MOTHER

Hannah Siemonen

13. BIRTHPLACE OF MOTHER

(State or Country)

Finland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Dr. J. F. Rutledge

(Address)

Cascades Idaho.

15.

Filed

19

Stella Cain

Deputy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

November 4 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 31 1922 to Nov 4 1922

that I last saw her alive on Nov. 4 1922

and that death occurred on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH* was as follows:

Puerperal sepsis, following labor on October 26, 1922

(Duration) — Yrs. — mos. 5+ ds.

Contributory
(Secondary)

(Duration) — yrs. — mos. — ds.

(Signed)

J. F. Rutledge

M. D.

19

(Address) Cascade Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death — yrs. — mos. — days. In the State — yrs. — mos. — days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40728**
Registered No. _____

1. PLACE OF DEATH

County of ValleyCity of CascadeRegistration District No. 15

Primary Registration District No. _____

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alma C. M. Sawyer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

married

(Write the word.)

6. DATE OF BIRTH

May

(Month)

10

(Day)

1922

(Year)

7. AGE

46 Yrs. 6 Mos. 8 ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Harness Maker

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Ogden, Utah.

10. NAME OF FATHER

William Sawyer

11. BIRTHPLACE OF FATHER

(State or Country)

England.

12. MAIDEN NAME OF MOTHER

Annie Cohen

13. BIRTHPLACE OF MOTHER

(State or Country)

England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Dr. J. F. Rutledge

(Address)

Cascade, Idaho

15.

Filed _____ 19 _____

Stella Cain

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov

(Month)

18

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov. 15 1922 to Nov. 18 1922that I last saw him alive on Nov. 18 1922and that death occurred on the date stated above, at 8:30 A.M.

The CAUSE OF DEATH* was as follows:

Bright's Disease.(Duration) about 6 mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. F. Rutledge M. D.11/18 1922 (Address) Cascade, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40729**

1. PLACE OF DEATH

Registration District No. 15
County of Valley
Primary Registration District No. _____
City of 2 miles north of Smith's Ferry (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Leonard Leroy Crawford.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED single
(Write the word.)

6. DATE OF BIRTH

Dec 18 1922
(Month) (Day) (Year)

7. AGE

— Yrs. — Mos. 5 ds.IF LESS than 1 day
how many 1 hrs.
or 0 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. None
(b) General nature of industry, business or establishment in which employed (or employer) _____9. BIRTHPLACE 2 miles north of Smith's Ferry, Idaho.
(State or Country)10. NAME OF FATHER Joe Crawford.11. BIRTHPLACE OF FATHER Texas.
(State or Country)12. MAIDEN NAME OF MOTHER Mabel Elizabeth Haskins.13. BIRTHPLACE OF MOTHER Washington
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dr. J. F. Rutledge
(Address) Cascade, Idaho.15. Stella Cain
Filed 19 _____ Local Registrar
DeputyMEDICAL CERTIFICATE OF DEATH 151-a

16. DATE OF DEATH

Dec 18 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Dec 13 1922 to Dec 18 1922
that I last saw him alive on Dec 18 1922
and that death occurred on the date stated above, at 2:30 P.M.
The CAUSE OF DEATH* was as follows:Premature birth(Duration) _____ Yrs. _____ mos. _____ ds.
Contributory Internal Neuronium
(Secondary)(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) J. F. Rutledge M. D.12/18/1922 (Address) Cascade, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **40730**
Registered No. _____

1. PLACE OF DEATH

County of Washington
City of Madison

Registration District No. 87
Primary Registration District No. _____
(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Louisa Elizabeth Rodgers

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widowed
(Write the word.)

6. DATE OF BIRTH

Aug. 17 1893
(Month) (Day) (Year)

7. AGE

67 Yrs. 2 Mos. 22 ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

House Wife

9. BIRTHPLACE

(State or Country) Mo.

10. NAME OF FATHER

Wm. Lorton

11. BIRTHPLACE OF FATHER

(State or Country) Kentucky

12. MAIDEN NAME OF MOTHER

Mary Laker

13. BIRTHPLACE OF MOTHER

(State or Country) Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ed Rodgers
(Address) Madison, Ida

15.

Filed 2-10-1922 F. A. Schmitt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

74

16. DATE OF DEATH

Dec. 9 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1 - 1920, to Dec. 9 - 1922 that I last saw her alive on Dec. 8 - 1922 and that death occurred on the date stated above, at 24 M.

The CAUSE OF DEATH* was as follows:

Tuberculosis of right kidney

(Duration) 5 Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) F. A. Schmitt M. D.

12-9-1922 (Address) Madison, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Cambridge, Idaho DATE OF BURIAL Dec. 10, 1922

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Washington
City of Madras

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 87
Primary Registration District No. _____
(No. _____, St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 40731
Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robert D. Pratt Vancil

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED widowed
(Write the word.)

6. DATE OF BIRTH Oct. 6 1871
(Month) (Day) (Year)

7. AGE 81 Yrs. 2 Mos. 12 ds. IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Farmer
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Ill.

10. NAME OF FATHER

Geo. Vancil

11. BIRTHPLACE OF FATHER

(State or Country) _____

12. MAIDEN NAME OF MOTHER

Cassie

13. BIRTHPLACE OF MOTHER

(State or Country) _____

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) R. H. Vancil
(Address) Madras, Idaho

15. Filed 12-19 1922 F. Schmitt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 18 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 1 - 1922 to Dec. 18 - 1922
that I last saw him alive on Dec. 12 - 1922
and that death occurred on the date stated above, at 10 P. M.
The CAUSE OF DEATH* was as follows:

similarity
arteriosclerosis

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) F. Schmitt M. D.

12-19-22 (Address) Madras, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF ~~BURIAL~~ OR REMOVAL DATE OF BURIAL

Joseph, Oregon 19

20. UNDERTAKER ADDRESS

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

Shirley
State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
40732
File No.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

JAN 4 1923

Registration District No.

Primary Registration District No.

(No.)

St.)

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED
(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

19 22

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

19 22 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Signed)

12/21/1922

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

40733

1. PLACE OF DEATH

County of WashingtonCity of WeiserRegistration District No. 76Primary Registration District No. 2112

(No. _____)

(St. _____)

File No. _____

Registered No. 29

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John B Clabby

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

March171854

(Month)

(Day)

(Year)

7. AGE

68Yrs. 8Mos. 28

ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Wisconsin

10. NAME OF FATHER

John Clabby

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Elizabeth Keenan

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Joe F Clabby

(Address)

Weiser Ida

15.

Filed Dec 18th 1922J R Hamilton

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec1522

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19....., to

19.....

that I last saw him alive on Nov 28 1922and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

General Scurvyseveral

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

J M Waterhouse

M. D.

(Address)

Weiser Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Hullerist Cemetery

DATE OF BURIAL

12-18 1922

20. UNDERTAKER

Northrup McCann

ADDRESS

Weiser Ida

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
JAN 1 1923
CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of

City of

Registration District No.

Primary Registration District No.

(No.)

(St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:

Type: Undetermined

Contributory
(Secondary)

(Signed)

1922 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH

JAN 4 1923

Registration District No.

86

County of

Washington

Primary Registration District No.

1010

City of

Weiser

(No.

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Bernardus Lafayette Bragg

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
40735

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

Wht

5. SINGLE, MARRIED, WIDOWED OR DIVORCED
~~Married~~
(Write the word.)

6. DATE OF BIRTH

Oct

30th1857
(Month) (Day) (Year)

7. AGE

71

Yrs.

1

Mos.

11

ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

Retired Farmer

9. BIRTHPLACE

(State or Country)

Mo.

10. NAME OF FATHER

B.S. Bragg

11. BIRTHPLACE OF FATHER

(State or Country)

Don't Know

12. MAIDEN NAME OF MOTHER

Don't Know

13. BIRTHPLACE OF MOTHER

(State or Country)

Don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Alva Bragg

(Address)

Ponca City Okla.

15.

Filed

Dec 14th

1922

Dr. R. Hummel

Local Registrar

MEDICAL CERTIFICATE OF DEATH

79

16. DATE OF DEATH

December

10th1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
11/29/22 19 to 12/10/22 19

that I last saw him alive on 12/10/22 19

and that death occurred on the date stated above, at 5 A. M.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart and
Valvular Incompetency.

(Duration)

Yrs.

mos.

1

ds.

Contributory
(Secondary)

Myocarditis

(Duration)

3

yrs.

mos.

ds.

(Signed)

Emanuel Finney, M. D.

12/14/22

(Address)

Weiser Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Ponca City. Okla

19

20. UNDERTAKER

ADDRESS

Northrup McLean

Weiser Id.

FORM V. S. No. 5-25 M. 1-19.

RECORDED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

40736

1. PLACE OF DEATH

JAN

Registration District No.

76

County of Washington

Primary Registration District No.

1010

City of Wenatchee

(No.

St.)

File No.

Registered No. 23

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Tueller

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male WhiteSingle

(Write the word.)

6. DATE OF BIRTH

Nov 5 1922
(Month) (Day) (Year)

7. AGE

— Yrs. 5 Mos. — ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ida

10. NAME OF FATHER

Albert Tueller

11. BIRTHPLACE OF FATHER

(State or Country)

Switzerland

12. MAIDEN NAME OF MOTHER

Margaret Herzog

13. BIRTHPLACE OF MOTHER

(State or Country)

Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Margaret Tueller

(Address)

Wenatchee Ida

15.

Filed Nov 12 1922Dr R. R. Rasmussen

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

11 11 22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

11/5 1922 to 11/11 1922that I last saw him alive on 11/10 1922and that death occurred on the date stated above, at 9a M.

The CAUSE OF DEATH* was as follows:

Congenital Achromic Jaundice

(Duration)

Yrs. — mos. 5 ds.Contributory
(Secondary)Seamstress

(Duration)

Yrs. — mos. 2 ds.

(Signed)

Ernest H. Frumey, M. D.10-12 1922 (Address) Wenatchee Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. — mos. — days. In the State Yrs. — mos. — days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hillcrest Cemetery11-12 1922

20. UNDERTAKER

ADDRESS

Marshall McCannWenatchee Ida

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Washington
City of WenatcheeRegistration District No. 86Primary Registration District No. 1010File No. 40737Registered No. 26

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Russel Burnette Clark

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Sept 29 1906
(Month) (Day) (Year)

7. AGE

16 Yrs. 2 Mos. 10 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).School Boy

9. BIRTHPLACE

(State or Country)

Wash.

10. NAME OF FATHER

Harry Clark

11. BIRTHPLACE OF FATHER

(State or Country)

No. Carolina

12. MAIDEN NAME OF MOTHER

Mary Cable

13. BIRTHPLACE OF MOTHER

(State or Country)

Tenn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Harry Clark

(Address)

Wenatchee Ida

15.

Filed Dec 10th 1922Dr. R. Samuel

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 9th 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Nov 25th 1922, to Dec 9th 1922that I last saw him alive on Dec 8th 1922and that death occurred on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:

Thrombosis (Post Operation)
(Cause)

(Duration) Yrs. mos. ds.

Contributory (Secondary) Appendicitis

(Duration) yrs. mos. ds.

(Signed) W. R. Samuel M. D.12/10 1922 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wenatchee Cemetery

19

20. UNDERTAKER

ADDRESS

Northrup McCann Wenatchee Ida

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

40738

1. PLACE OF DEATH

County of Washington
City of WenatcheeRegistration District No. 96Primary Registration District No. 1010

(No. _____ St.)

File No. _____
Registered No. 25

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Fay Walker

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female White

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

July 5 1906
(Month) (Day) (Year)

7. AGE

16 Yrs. 4 Mos. 24 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).School Girl

9. BIRTHPLACE

(State or Country)

Colorado

10. NAME OF FATHER

Bert C Walker

11. BIRTHPLACE OF FATHER

(State or Country)

Ind.

12. MAIDEN NAME OF MOTHER

Don't Know

13. BIRTHPLACE OF MOTHER

(State or Country)

Don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Fred Mullin

(Address)

Wenatchee, Ida.

15.

Filed Nov 30th 1922Dr. R. H. Hume

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 29 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Nov 29 1922 to 1922that I last saw her alive on Nov 29 1922
and that death occurred on the date stated above, at 109 M.

The CAUSE OF DEATH* was as follows:

Don't know. She was dead when I arrived at house. Probably heart.

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory (Secondary)

Acute bronchitis

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

G. M. WalkerNov 30 1922 (Address) Wenatchee, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Killcrest CemeteryNov 1 1922

20. UNDERTAKER

ADDRESS

Northrup McCallum

RECEIVED

CERTIFICATE OF DEATH

Shirley
State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

40739

1. PLACE OF DEATH

County of Washington
City of WeiserRegistration District No. 86Primary Registration District No. 1010

(No. _____)

(St.) _____

File No. _____

Registered No. 24

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Sallie French Kimball

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female whiteWidow
(Write the word.)

6. DATE OF BIRTH

May 26 1844
(Month) (Day) (Year)

7. AGE

78 Yrs. 5 Mos. 20 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

New York

10. NAME OF FATHER

Don't know

11. BIRTHPLACE OF FATHER

(State or Country)

Don't know

12. MAIDEN NAME OF MOTHER

Don't know

13. BIRTHPLACE OF MOTHER

(State or Country)

Don't know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Liebert French Kimball

(Address)

Weiser, Idaho

15.

Filed

Nov 20th 1922W. R. Samuelson

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

11 (Month) 19 (Day) 1922 (Year)17. I HEREBY CERTIFY, That I attended deceased from July 1 1922 to November 18 1922that I last saw her alive on November 18 1922and that death occurred on the date stated above, at 7:00 M.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Le R. Shirts M. D.11-21 1922 (Address) Weiser, Idaho

*State the Disease Causing Death; or in deaths from violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hillman Cemetery11 21 1922

20. UNDERTAKER

ADDRESS

Northam M'CamyWeiser, Idaho

RECEIVED JAN 11 1923 STATE OF IDAHO

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Kootenai
City of Rathdrum

Registration District No. 30Primary Registration District No. 1051File No. 402840Registered No. 1102

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Glenn J. Waldecker

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

single
(Write the word.)

6. DATE OF BIRTH

July 6 1922
(Month) (Day) (Year)

7. AGE

0 Yrs. 3 Mos. 29 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF
FATHER

Joe Waldecker

11. BIRTHPLACE
OF FATHER

(State or Country) Mich.

12. MAIDEN NAME
OF MOTHER

Carrie Davis

13. BIRTHPLACE
OF MOTHER

(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address) Rathdrum Idaho

15.

Filed 1-7 1923

J. J. Brennan
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Novbr. 3rd 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 6 1922, to Novbr. 3 1922,
that I last saw him alive on Nov. 2 1922,
and that death occurred on the date stated above, at 11:30 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Indigestion and
resulting inanition
since birth
(Duration) Yrs. mos. ds.

Contributory congenital weakness
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Frank Wenz M. D.

11/7 1922 (Address) Rathdrum Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Rathdrum Idaho

DATE OF BURIAL

11/7 1922

20. UNDERTAKER

E. L. Carrel

ADDRESS

Rathdrum Idaho

40796

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 57

Registered No. 3992

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH
 County of *San Juan*
 City of *Pocahontas*
 Registration District No. *28*
 Primary Registration District No. *2161*
 (No. *1014* for *Arthur*)
 St. *Idaho*

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
 FEB 8 1923
 BUREAU OF VITAL STATISTICS

2. FULL NAME *Fred Barnes*

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *married*
 (Write the word.)

6. DATE OF BIRTH *Dec 4 1893*
 (Month) (Day) (Year)

7. AGE *29* Yrs. *27* Mos. *27* ds.
 IF LESS than 1 day
 how many hrs. or min.?

8. OCCUPATION
 (a) Trade, profession or particular kind of work *Retired*
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE *Switzerland*
 (State or Country)

10. NAME OF FATHER */*

11. BIRTHPLACE OF FATHER */*
 (State or Country)

12. MAIDEN NAME OF MOTHER */*

13. BIRTHPLACE OF MOTHER */*
 (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Frank E. Barnes*
 (Address) *Pocahontas*

15. Filed *1/1* 1923
J. J. Young
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *Dec 31 1922*
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Dec 17 1922*, to *Dec 31 1922*, that I last saw him alive on *Dec 30 1922*, and that death occurred on the date stated above, at *4 a. m.*

The CAUSE OF DEATH* was as follows:
chronic nephritis (acute exacerbation)

History dating back about 20 years
 (Duration) Yrs. mos. ds.

Contributory *Senility*
 (Secondary) (Duration) Yrs. mos. ds.

(Signed) *J. J. Young* M. D.
12/31 1922 (Address) *Pocahontas, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *St. Lawrence Cemetery* DATE OF BURIAL *Jan 1 1923*

20. UNDERTAKER *W. W. Racker* ADDRESS *Pocahontas*

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH

County of Bannock
City of Pocatello

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William Leroy Riggs

RECEIVED CERTIFICATE OF DEATH

Registration and Disposition No. 1923BUREAU OF VITAL STATISTICS District No. 2161(No. STATISTICS St.)BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 57Registered No. 3993

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Dec 16 1922
(Month) (Day) (Year)

7. AGE

no Yrs. no Mos. 15 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

None

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Pocatello Ida.

10. NAME OF FATHER

Claude L. Riggs

11. BIRTHPLACE OF FATHER

(State or Country) Minnesota

12. MAIDEN NAME OF MOTHER

Ella Hawkes

13. BIRTHPLACE OF MOTHER

(State or Country) Salt Lake City Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Claude L. Riggs

(Address)

328 So. Johnson

15.

Filed 1/1 1923J. H. Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 31 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Dec. 27 1922 to Dec. 31 1922that I last saw him alive on Dec. 31 1922and that death occurred on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis(Duration) Yrs. mos. 14 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

M. D.1922 (Address) Pocatello, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Pocatello Ida.

DATE OF BURIAL

Jan 1, 1923

20. UNDERTAKER

W. H. McHan

ADDRESS

Pocatello
Ida.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Blaine* Registration District No. *2161*City of *Pocahontas* (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Frank M. Watson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

(Write the word.)

6. DATE OF BIRTH

Aug 13 1922
(Month) (Day) (Year)

7. AGE

4 Yrs. *15* Mos. *15* ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

Baby

9. BIRTHPLACE

(State or Country)

Pocahontas Ida.

10. NAME OF FATHER

Frank Watson

11. BIRTHPLACE OF FATHER

(State or Country)

Wyo.

12. MAIDEN NAME OF MOTHER

Jimmy Thompson

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Frank M. Watson

(Address)

#326 S. 9th

15.

Filed

1/2 19*23*

Local Registrar

16. DATE OF DEATH

December 31st 19*22*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec. 28th 19*22* to *Dec. 31st* 19*22*that I last saw him alive on *Dec. 31st* 19*22*and that death occurred on the date stated above, at *10:00 A.M.*

The CAUSE OF DEATH* was as follows:

Pulmonary edema(Duration) Yrs. mos. *4* mos. *4* mos.
Contributory (Secondary) *Croupous Pneumonia*(Duration) Yrs. mos. *2* mos. *2* mos.(Signed) *W. A. Wright* M. D.*7/7 19 22* (Address) *Pocahontas, Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mountain View *Jan 2 19 23*

20. UNDERTAKER

ADDRESS

Schumacher, W. A. Wright

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

40810

1. PLACE OF DEATH

County of Bingham Registration District No. 121
City of Shelly Primary Registration District No. 2194
St. _____File No. _____
Registered No. 1

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

George Alvin McBride

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widower
(Write the word.)6. DATE OF BIRTH Feb. 4 1874
(Month) (Day) (Year)7. AGE 48 Yrs. 10 Mos. 21 ds. IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Farmer
(b) General nature of industry, business or establishment in which employed (or employer) ✓

9. BIRTHPLACE

(State or Country) Wah

10. NAME OF FATHER

Wm Alvin McBride

11. BIRTHPLACE OF FATHER

(State or Country) Wah

12. MAIDEN NAME OF MOTHER

Cynthia S. Benson

13. BIRTHPLACE OF MOTHER

(State or Country) Wah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) G. E. McBride
(Address) Shelly Idaho15. Filed Jan 7 1923 Mr. Walter E. Paine
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 25 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Dec 25 1922 to Dec 25 1922
that I last saw him alive on Dec 21 1922
and that death occurred on the date stated above, at 9 P M.

The CAUSE OF DEATH* was as follows:

Mr McBride fell while descending stairs - was picked up immediately dead. Cause believed to be "heart failure" due to the shock of the fall
(Duration) 7 yrs. 5 mos. 27 ds.(Signed) F. E. G. G. G. M. D.Dec 27 1922 (Address) Shelly Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL

DATE OF BURIAL

Calvary Cemetery12-26-1922

20. UNDERTAKER

ADDRESS

None employed

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

FEB 8 1923

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bingham District No. 121
 City of Frank Registration District No. 2194
 (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

BUREAU OF VITAL STATISTICS

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 40811
 Registered No. 2

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Keva Clawson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Infant
 (Write the word.)

6. DATE OF BIRTH

Dec. 15 1922
 (Month) (Day) (Year)

7. AGE

Yrs. ✓ Mos. ✓ ds. ✓
 IF LESS than 1 day how many 4 hrs. or ✓ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

Infant

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Ray Clawson

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Keva Harker

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ray Clawson
 (Address) Frank, Idaho

File Dec 10 1922 Mo. Harker
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 15 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 15 1922 to Dec 15 1922 that I last saw him ✓ alive on Dec 15 1922 and that death occurred on the date stated above, at 89 M. The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) F. E. Ricketts M. D.

Dec 16 1922 (Address) Shelley Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Frank, Idaho Dec 16 1922

20. UNDERTAKER

ADDRESS

None employed

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH

County of Canyon
City of Nampa

If death occurs away from usual residence, give facts called for under special information.

RECEIVED

FEB 7 1923

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

215 Locust

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

40844

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elizabeth A. Jones

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Fem

White

Widow (the word.)

6. DATE OF BIRTH

Unknown

(Month)

(Day)

(Year)

7. AGE

70

Yrs.

Mos.

ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

William Gammon

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Feb 6 1923

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sep. 23

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 13 1922, to Sept 23 1922
that I last saw her alive on Sept 22, 1922
and the death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration)

Yrs.

mos.

12 ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

Hos. E. Mangum M. D.

9/23/22

(Address)

Nampa Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Nampa Ida. Kohlerlawn

DATE OF BURIAL

9/25 22

20. UNDERTAKER

Fred K. Robinson

ADDRESS

Nampa, Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

40848

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Idaho*City of *Idaho*

If death occurs away from usual residence, give facts called for under special information.

Registration District No. *12*Primary Registration District No. *217*

(No. 123)

St.)

File No. *XVII*Registered No. *20*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Seniors

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.) *single*

6. DATE OF BIRTH

November 9 1922
(Month) (Day) (Year)

7. AGE

Yrs. Mos. da.

IF LESS than 1 day

how many hrs. min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Calvin Seniors

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Ruth Hess

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Calvin Seniors

(Address)

Idaho

15.

Filed

*Nov 10 1922**W. J. Nelson*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 8 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 8 1922 to *Nov 8 1922*
that I last saw him alive on *Nov 8 1922*
and that death occurred on the date stated above, at *20* M.

The CAUSE OF DEATH* was as follows:

Premature Child

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed)

W. J. Nelson M. D.*Nov 8 1922* (Address) *Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Idaho

DATE OF BURIAL

Nov 10 1922

20. UNDERTAKER

Ep. Cannon

ADDRESS

Idaho

CERTIFICATE OF DEATH

40849

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. *XV 111*
Registered No. *26*
If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

1. PLACE OF DEATH

County of *Cassia* Registration District No. *130*
City of *Oakley* Registration District No. *2196217*
If death occurs away from
usual residence, give facts
called for under special
information.

2. FULL NAME *Clarence E. Harper*

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

*White*5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.*Married* (Write the word.)

6. DATE OF BIRTH.

Nov.
(Month)*5*
(Day)*1885*
(Year)

7. AGE

36 Yrs. *10* Mos. *9* ds.IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of in-
dustry, business, or estab-
lishment in which em-
ployed (or employer)

Laborer & Farmer

9. BIRTHPLACE

(State or Country)

*Rexford Kansas*10. NAME OF
FATHER*George M. Harper*11. BIRTHPLACE
OF FATHER

(State or Country)

*Iowa*12. MAIDEN NAME
OF MOTHER*Anna Salzman*13. BIRTHPLACE
OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Hellie J. Harper

(Address)

Goodland Kansas

15.

Filed

Jan 10 1923

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

91

16. DATE OF DEATH

Sept.
(Month)*17*
(Day)*1922*
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

*Sept. 11**1922**to Sept. 14**1922*that I last saw him alive on *Sept. 14* *1922*and that death occurred on the date stated above, at *8:30 P.M.*

The CAUSE OF DEATH* was as follows:

*Bronchial Pneumonia*Contributory
(Secondary)

(Duration)

Yrs. mos. ds.

(Signed) *A. J. C. Nelson*

M. D.

9/17/1922 (Address) *Oakley Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place

In the

of death yrs. mos. days, State yrs. mos. days

Where was disease contracted

if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Goodland Kansas

DATE OF BURIAL

Sept. 27 1922

20. UNDERTAKER

L. L. Gallagher

ADDRESS

Oakley Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

40850

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *XV. III*
Registered No. *25*
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of *Cassia*City of *Cable*

If death occurs away from usual residence, give facts called for under special information.

Registration District No. *120*Primary Registration District No. *2197*

2. FULL NAME

Peter Johnson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married

6. DATE OF BIRTH.

Unknown

(Month)

(Day)

(Year)

7. AGE

58 Yrs.

Mos.

ds.

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Miner & Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Unknown

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

L. B. Talley - Coroner

(Address)

Burley, Ida.

15.

Filed

Jan 10 1923

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

92

16. DATE OF DEATH

Sept.

(Month)

7

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191

to

*191*that I last saw him alive on *191*and that death occurred on the date stated above, at *M.*

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration)

Yrs.

mos.

ds.

Contributory

(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

*L. B. Talley - Coroner**9/9/1922*

(Address)

Burley, Idaho

*State the Disease Causing Death or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death *...* yrs. *...* mos. *...* days. State *...* yrs. *...* mos. *...* days

Where was disease contracted

if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

Burley, Ida.

DATE OF BURIAL

9/16/1922

20. UNDERTAKER

L. B. Talley

ADDRESS

Burley, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

40851

State of Idaho
BOARD OF HEALTH

Bureau of Vital Statistics

File No. 4447Registered No. 2

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of CassiaCity of Oakley

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 170Primary Registration District No. 219

BUREAU OF VITAL STATISTICS

St.)

2. FULL NAME Leage W. Cannon

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single (Write the word.)

6. DATE OF BIRTH.

Unknown

(Month) (Day) (Year)

7. AGE

57 Yrs. Mos. ds.IF LESS than 1 day
how many hrs. or
.... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)Miner

9. BIRTHPLACE

(State or Country)

Unknown

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) B. W. Cannon(Address) So. 2d. L. R. City, Utah

15.

Filed Jan 10 1923

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept. 14 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 12 1922 to Sept 14 1922
that I last saw him alive on Sept 14 1922and that death occurred on the date stated above, at 7 A M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) R. E. Nelson M. D.Sept 14 1922 (Address) Oakley, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days, State yrs. mos. daysWhere was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Burley Ida.

DATE OF BURIAL

Sept. 15 1922

20. UNDERTAKER

L. B. Tallogly

ADDRESS

Burley Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-1-13

COUNTY OF Lincoln CERTIFICATE OF DEATH.

1. PLACE OF DEATH RECEIVED Registration District No. 76
 County of Lincoln JAN 31 1923 Registration District No. 2153
 City of Darlington BUREAU OF VITAL STATISTICS (St.)

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 40852

Registered No. _____
 If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME M. W. Brown

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widowed

6. DATE OF BIRTH.

April 1 1853
 (Month) (Day) (Year)

7. AGE

67 Yrs. 7 Mos. 13 ds.

IF LESS than 1 day
 how many hrs. or
 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
 (b) General nature of industry, business, or establishment in which employed (or employer).....

Farmer

9. BIRTHPLACE

(State or Country)

Ill

10. NAME OF FATHER

Richard Brown

11. BIRTHPLACE OF FATHER

(State or Country)

Ill

12. MAIDEN NAME OF MOTHER

Elizabeth Barker.

13. BIRTHPLACE OF MOTHER

(State or Country)

Ken.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Miss. Edna E Brown

(Address)

Darlington

15.

Filed

1/271923Rose Nowack

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov. 14 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 7 1922, to Nov 13 1922, that I last saw him alive on Nov 13 1922, and that death occurred on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:

Gastric Ca

(Duration) Yrs. mos. ds.

Contributory hypertrophic prostatic
glandular hypertrophy
 (Duration) Yrs. mos. ds.

(Signed) W. H. Jayell M. D.1923 (Address) Markey Idh

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

191

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

40871

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Idaho
City of Cottonwood

Registration District No. 105
Primary Registration District No. 2183
(No. _____ St.)

File No. 22
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Loretta Rosina Holthaus

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH Oct 12 1922
(Month) (Day) (Year)

7. AGE _____ Yrs. 1 Mos. 24 ds.
IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work _____
(b) General nature of industry, business or establishment in which employed (or employer) _____

9. BIRTHPLACE Cottonwood
(State or Country)

10. NAME OF FATHER Florian Holthaus

11. BIRTHPLACE OF FATHER Iowa
(State or Country)

12. MAIDEN NAME OF MOTHER Marie Fiedler

13. BIRTHPLACE OF MOTHER Minnesota
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Florian Holthaus
(Address) _____

15. Filed Feb. 2 1923 W.F. Orr.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

91

16. DATE OF DEATH Dec. 7 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 2 1922 to Dec. 7 1922
that I last saw her alive on Dec. 7 1922
and that death occurred on the date stated above, at 9 P. M.
The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia

(Duration) _____ Yrs. _____ mos. 5 ds.
Contributory (Secondary) _____

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) Wesley F. Orr M. D.
Dec. 7 1922 (Address) Cottonwood, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days
Where was disease contracted if not at place of death? _____
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Cottonwood DATE OF BURIAL Dec. 9 1922

20. UNDERTAKER W. F. Orr ADDRESS Cottonwood

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of IdahoCity of Kosciusko

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 106Primary Registration District No. 2184(No. 106 St.)

2. FULL NAME

Edward BreezeState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 40873Registered No. 123

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

(Write the word.)

6. DATE OF BIRTH

Dec

(Month)

22

(Day)

1922

(Year)

7. AGE

Yrs.

Mos.

9 ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Infant

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho Co. Idaho

10. NAME OF FATHER

Albert Breeze

11. BIRTHPLACE OF FATHER

(State or Country)

Missouri

12. MAIDEN NAME OF MOTHER

Bertha Tinney

13. BIRTHPLACE OF MOTHER

(State or Country)

Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Albert Breeze

(Address)

Kosciusko Idaho

15.

Filed

Jan 3 1923

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

December 31

(Month)

(Day)

1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19

to

19that I last saw him..... alive on..... 19

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Probably congenital heart defect.

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

J. M. Kuberku M. D.

Jan 2 1923

(Address) Kosciusko Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Harris Ridge

DATE OF BURIAL

Jan 2 1923

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of IdahoRegistration District No. 106City of KootenaiPrimary Registration District No. 2184File No. 40874Registered No. 132

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Dec 8 1922
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many 2 hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Infant

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Hugh M. Keith

11. BIRTHPLACE OF FATHER

(State or Country)

Illinois

12. MAIDEN NAME OF MOTHER

Mildred Whyman

13. BIRTHPLACE OF MOTHER

(State or Country)

Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Geo. Hanson

(Address)

Kootenai - Idaho

15.

Filed

Dec 10 1922 J M Weber
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 8 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

.....19....., to19.....

that I last saw him alive on19.....

and that death occurred on the date stated above, atM.

The CAUSE OF DEATH* was as follows:

No medical attendance, consultation on phone.Premature birth

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J M Weber M. D.Dec 10 1922 (Address) Kootenai - Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Kootenai - Idaho

DATE OF BURIAL

Dec 10 1922

20. UNDERTAKER

ADDRESS

FORM No. 5-25 M.

CERTIFICATE

OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

40901

1. PLACE OF DEATH

Registration District No.

County of *Latah*

Primary Registration District No.

City of *Kendrick* (So. _____ St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Samuel H. Hager, M. Smith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male *White**Married*
(Write the word.)

6. DATE OF BIRTH

May 12 1847
(Month) (Day) (Year)

7. AGE

75 Yrs. *21* Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

Retired Farmer

9. BIRTHPLACE

(State or Country)

Penn

10. NAME OF FATHER

Benjamin Smith

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Eliza Snicks

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

E. O. Stuart
*Julia Ida*Filed *Nov. 3* 19*22*

19

R. D. Apple

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

November 1 19*22*
(Month) (Day) (Year)

17. - I HEREBY CERTIFY, That I attended deceased from

19..... to 19.....

that I last saw him alive on *Nov. 1* 19*22*.and that death occurred on the date stated above, at *12:30* M.

The CAUSE OF DEATH was as follows:

Accidentally killed by a falling timber

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *Andrew C. Hager, M. D.**11/2* 19*22* (Address) *Kendrick, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

John J. Pickens *Fry Ida*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

RECEIVED
FEB 20 1923
CERTIFICATE OF DEATH

1. PLACE OF DEATH. Registration District No. 100
County of Madison Primary Registration District No. 2178
City of Boylston (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harvey G. Hinchley

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 40905
Registered No. 50

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Bate
(Write the word.)

6. DATE OF BIRTH Aug 13 - 1919
(Month) (Day) (Year)

7. AGE 3 yrs. 4 mos. 17 ds. IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Baby
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE Boylston
(State or Country)

10. NAME OF FATHER Ira W. Hinchley

11. BIRTHPLACE OF FATHER Utah
(State or Country)

12. MAIDEN NAME OF MOTHER Emma Kippner

13. BIRTHPLACE OF MOTHER Idaho
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ira H. Hinchley
(Address) R 3

15. Filed 1/5 19123 J. P. Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 12 30 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-30 1922 to 12-30 1922
that I last saw him alive on 12-30 1922
and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Acute intestinal intoxication

(Duration) yrs. mos. 10 ds.
Contributory Acute Bronchitis
(Secondary)

(Duration) yrs. mos. 7 ds.
(Signed) W. L. Gutherland M. D.
1-6 1923 (Address) Boylston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Boylston 1/3 1923
20. UNDERTAKER J. P. Young ADDRESS Boylston

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Madison* Registration District No. *100*
City of *Reeseburg* Primary Registration District No. *2178*
St. *Idaho*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Alice R. Wright*File No. *40910*
Registered No. *86*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *F* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*
(Write the word.)

6. DATE OF BIRTH

Aug 27 1881
(Month) (Day) (Year)

7. AGE

41 Yrs. *4* Mos. *27* ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)*Housewife*

9. BIRTHPLACE

(State or Country)

Illinois

10. NAME OF FATHER

Albert Langorth

11. BIRTHPLACE OF FATHER

(State or Country)

Vermont

12. MAIDEN NAME OF MOTHER

Ellen Studdard

13. BIRTHPLACE OF MOTHER

(State or Country)

Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

James R. Wright
Reeseburg

15.

Filed *1/23/23* 19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

January 23 1923
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *Jan. 10 - 1922* to *Jan. 23 1922*
that I last saw her alive on *Jan. 23 1922*
and that death occurred on the date stated above, at *11:06 P.M.*

The CAUSE OF DEATH* was as follows:

Cerebral embolism(Duration) Yrs. *3* mos. *3* ds.

Contributory (Secondary)

Phlebitis(Duration) *7* yrs. *7* mos. *7* ds.

(Signed)

1/23 1922 (Address) *Reeseburg Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Reeseburg *1-27-1923*

20. UNDERTAKER

ADDRESS

John R. Phelps *Reeseburg*

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

JAN 3 1923

CERTIFICATE OF DEATH

1. PLACE OF DEATH *Shoshone* Registration District No. *7*
 County of *Wallace* Primary Registration District No. *104*
 City of *Wallace* (No. *Interstate Mine*)
 If death occurs away from usual residence, give facts called for under special information.
 2. FULL NAME *Alex Stod*
 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. **40928**
 Registered No. *117*
 If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *male* 4. COLOR OF RACE *white* 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED *single*
 (Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

32

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer)

Miner

9. BIRTHPLACE

(State or Country)

Poland

10. NAME OF FATHER

not given

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Ray Kingsburg
Wallace

15.

Filed

19

Local Registrar

16. DATE OF DEATH

(Month)

(Day)

19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

.....19..... to19.....

that I last saw *him* alive on19.....

and that death occurred on the date stated above, atM.

The CAUSE OF DEATH was as follows:

Crushed between the
logs & wall

(Duration)

Yrs.

Mos.

ds.

Contributory
(Secondary)

(Duration)

Yrs.

Mos.

ds.

(Signed)

R. Mowry
26-19-22 (Address) *Wallace, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state
 (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of deathyrs.....mos.....days. In the Stateyrs.....mos.....days

Where was disease contracted
 if not at place of death?

Former or
 usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Wallace, Idaho**12-27-22*

20. UNDERTAKER

ADDRESS

*R. Mowry**Wallace*

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

1922 Union District No.

Registration District No.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19

19

that I last saw him alive on 19

and that death occurred on the date stated above, at 11:00 M.

The CAUSE OF DEATH was as follows:

Multiple Contusions of head

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

12/9/22

(Address)

State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

JAN 30 1923

Registration District No.

70

County of

Shoshone

Registration District No.

(No.)

City of

Tullock

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Dorothy G. Bangs

File No.

40930

Registered No.

111

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

male white

(Write the word.)

6. DATE OF BIRTH

Nov

22

1899

(Month)

(Day)

(Year)

7. AGE

23

Yrs. 13 ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

at home

9. BIRTHPLACE

(State or Country)

No. Dakota

10. NAME OF FATHER

Thomas Cochrane

11. BIRTHPLACE OF FATHER

(State or Country)

Wisconsin

12. MAIDEN NAME OF MOTHER

Barnett

13. BIRTHPLACE OF MOTHER

(State or Country)

Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Geo. Bangs

(Address)

Buck 3da

15.

File

Dec 10 22 F L 2nd

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 5

22

(Month)

(Day)

1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 1 22 to Dec 2 22

that I last saw him alive on Dec 4 22

and that death occurred on the date stated above, at 2:45 A.M.

The CAUSE OF DEATH* was as follows:

Septicemia Gravid
Eclampsia. Toxic

(Duration)

Yrs.

mos.

ds.

Contributory (Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

Dr. M. B. Wallace

1922

(Address) Wallace Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL
Wallace IdaDATE OF BURIAL
12-10-22UNDERTAKER
Bruce G. MottADDRESS
Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

40931

1. PLACE OF DEATH

JAN 30 1923

Registration District No. 70

County of Shoshone

Palmer Registration District No.

City of Wallace

(No. 12444444 Idaho St.)

File No.

Registered No. 104

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Jean Armstrong

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female white

(Write the word.)

6. DATE OF BIRTH

Sept. 27 1922

7. AGE

0 Yrs. 4 Mos. 16 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

none

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Nelson Armstrong

11. BIRTHPLACE OF FATHER

(State or Country)

N. Y.

12. MAIDEN NAME OF MOTHER

Helen Garner

13. BIRTHPLACE OF MOTHER

(State or Country)

N. Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

C. W. Newton

(Address)

Wallace, Id.

Nov 14 1922 F. L. Dundy

Local Registrar

16. DATE OF DEATH

Nov 13 1922

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19 that I last saw her alive on 19 and that death occurred on the date stated above, at 12 noon

The CAUSE OF DEATH* was as follows:

premature

(Duration) Yrs. Several ds.

Contributory (Secondary)

Prematurity

(Duration) yrs. mos. ds.

(Signed)

H. Mowbray Cooper

1922 (Address) Wallace, Id.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Wallace Id

DATE OF BURIAL

Nov 14 1922

20. UNDERTAKER

B. Moutell

ADDRESS

Wallace, Id.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

1923
Registration District No.

Primary Registration District No.

(No.)

St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

19

Local Registrar

16. DATE OF DEATH

17. I HEREBY CERTIFY That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Signed)

1923 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs mos days In the State yrs mos days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
JAN 30 1922

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
40933

1. PLACE OF DEATH

Registration District No. 70

County of Shoshone
City of Malheur

Primary Registration District No. 1011
(No. Providence Hospital)

File No.

Registered No. 119

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Merence Leube

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WID-OWED OR DIVORCED
married
(Write the word.)

6. DATE OF BIRTH

Sept 7 1893
(Month) (Day) (Year)

7. AGE

29 Yrs. 3 Mos. 20 ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

At Home

9. BIRTHPLACE

(State or Country)

Maine

10. NAME OF FATHER

Joe Babini

11. BIRTHPLACE OF FATHER

(State or Country)

Prov. Quebec

12. MAIDEN NAME OF MOTHER

Amelia Lavecourt

13. BIRTHPLACE OF MOTHER

(State or Country)

Mass

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Claude Babini

(Address)

Malheur Idaho

15.

Filed

Dec 30 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 27 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 10 1922 to Dec 27 1922 that I last saw him alive on Dec 27 1922 and that death occurred on the date stated above, at 4 M.

The CAUSE OF DEATH* was as follows:

Colomplex

(Duration) Yrs. mos. ds.
Contributory (Secondary) Septic Pseudotuberculosis

(Duration) yrs. mos. ds.
(Signed) Dr. M. W. Smith M. D.

(Address) Malheur Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

New Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Malheur Idaho

Dec 30 1922

20. UNDERTAKER

ADDRESS

Malheur Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
40934

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No.

Primary Registration District No.

(No.)

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

1922 to 1922

that I last saw him alive on 1922

and that death occurred on the date stated above, at 37 M.

The CAUSE OF DEATH* was as follows:

encephalitis, septic

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Shoshone Registration District No. 70
City of Wallace (No. 1041 St.)
BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Harold A. Reynolds

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

married
(Write the word.)

6. DATE OF BIRTH

Dec. 6 1922
(Month) (Day) (Year)

7. AGE

36 Yrs. — Mos. — ds.IF LESS than 1 day
how many... hrs.
or... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Timber Man

(b) General nature of industry, business or establishment in which employed (or employer)

Steela Mine

9. BIRTHPLACE

(State or Country)

Washington

10. NAME OF FATHER

Isaac Reynolds

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Kate Highberger

13. BIRTHPLACE OF MOTHER

(State or Country)

Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Emma Reynolds
(Address) Deer Park Wash

15. Filed

Dec 16 1922 + 2 min

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 14 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 8 1922 to Dec 14 1922
that I last saw him alive on Dec 14 1922
and that death occurred on the date stated above, at 2:45 P.M.

The CAUSE OF DEATH* was as follows:

Emphysema, Lethargia

(Duration)

Yrs. several mos. — ds.

Contributory (Secondary)

(Duration)

Yrs. — mos. — ds.

(Signed)

Dr. Mowry M. D.

(Address)

Wallace, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. — mos. — days. In the State Yrs. — mos. — days

Where was disease contracted if not at place of death?

Former or usual residence Wallace 2 day

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Spokane Wash. Dec 16 1922

20. UNDERTAKER

ADDRESS

Ward & Co. Wallace

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JAN 30 1923 BUREAU OF VITAL STATISTICS			CERTIFICATE OF DEATH		State of Idaho BOARD OF HEALTH Bureau of Vital Statistics	
1. PLACE OF DEATH Shoshone			Registration District No. 70		File No. 40936	
County of Shoshone			Registration District No. 184		Registered No. 108	
City of Wallace			Sister Mine Addition		If death occurred in a hospital, institution or camp, give its NAME instead of street and number.	
If death occurs away from usual residence, give facts called for under special information.			2. FULL NAME Greenbury Taylor Walters			
PERSONAL AND STATISTICAL PARTICULARS						
3. SEX Male	4. COLOR OR RACE White	5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widowed (Write the word.)				
6. DATE OF BIRTH Dec. 25 1852 (Month) (Day) (Year)						
7. AGE 70		IF LESS than 1 day how many hrs. or min.?				
8. OCCUPATION (a) Trade, profession or particular kind of work. minister (b) General nature of industry, business or establishment in which employed (or employer). United Brethren						
9. BIRTHPLACE (State or Country) Iowa						
10. NAME OF FATHER Eliza Walters						
11. BIRTHPLACE OF FATHER (State or Country) Not known						
12. MAIDEN NAME OF MOTHER " "						
13. BIRTHPLACE OF MOTHER (State or Country) " "						
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) C. N. Walters (Address) Wallace Idaho						
15. Filed 4 1922 Local Registrar						
MEDICAL CERTIFICATE OF DEATH 28						
16. DATE OF DEATH Dec 3 1922 (Month) (Day) (Year)						
17. I HEREBY CERTIFY, That I attended deceased from 19 to 19 that I last saw him alive on Nov 25 1922 and that death occurred on the date stated above, at 3 A. M. The CAUSE OF DEATH* was as follows: Tuberculosis Pulmonary (Duration) Several mos. ds. Contributory (Secondary) (Duration) yrs. mos. ds. (Signed) Dr. Mowery M. D. 1922 (Address) Wallace Idaho						
*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.						
18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) At place of death yrs. mos. days. In the State yrs. mos. days. Where was disease contracted if not at place of death? Former or usual residence						
19. PLACE OF BURIAL OR REMOVAL Farmington Wm						
DATE OF BURIAL Dec 4 1922						
20. UNDERTAKER Bruce G. Morrell						
ADDRESS Wallace						

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH **RECEIVED**
 County of Shoshone Registration District No. 70
 City of Wallace Primary Registration District No. 104
 If death occurs away from usual residence, give facts called for under special information. County Infirmary St.)

File No. **40937**
 Registered No. 109

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Thompson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED not given
 (Write the word.)

6. DATE OF BIRTH
 (Month) (Day) (Year)

7. AGE 66 Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE Ohio
 (State or Country)

10. NAME OF FATHER not known

11. BIRTHPLACE OF FATHER ☒ ☒
 (State or Country)

12. MAIDEN NAME OF MOTHER ☒ ☒

13. BIRTHPLACE OF MOTHER ☒ ☒
 (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) County Infirmary
 (Address) Wallace, Idaho

15. Dec 5 1922
 Filed Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 3 22
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1920 to Dec 3 1922
 that I last saw h. m. alive on Dec 2 1922
 and that death occurred on the date stated above, at 9:30 A.M.
 The CAUSE OF DEATH* was as follows:

Cerebrae apoplexy

(Duration) Yrs. mos. 5 ds.
 Contributory (Secondary) epilepsy
 (Duration) Yrs. mos. years ds.

12/4 (Signed) James R. Belton M. D.
 Address Wallace

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL Wallace Idaho DATE OF BURIAL 12-5 1922

20. UNDERTAKER Bruce G. Mott ADDRESS Wallace

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH
in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH **RECEIVED**
County of *Shoshone* JAN 30 1923
City of *Mace* **BUREAU OF VITAL STATISTICS** Registration District No. *161*
Mace Idaho

File No. **40938**
Registered No. *110*

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Elvin Otis Wellman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Mr* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *married*
(Write *married*)

6. DATE OF BIRTH

Oct 25 1871
(Month) (Day) (Year)

7. AGE

51 Yrs. *1* Mos. *9* ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Miner

9. BIRTHPLACE

(State or Country)

Illinois

10. NAME OF FATHER

E C Wellman

11. BIRTHPLACE OF FATHER

(State or Country)

Indiana

12. MAIDEN NAME OF MOTHER

Joanna Hines

13. BIRTHPLACE OF MOTHER

(State or Country)

Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Herbert Wellman

(Address)

15. *Dec 6 1922*
Filed *7* Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 22 19 *22*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

8/22/20 19 *20* to *11/4/22* 19 *22*
that I last saw him alive on *10/15/22* 19 *22*
and that death occurred on the date stated above, at *8:30 A.M.*

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(Duration) *4* yrs. *1* mos. *28* ds.

Contributory (Secondary)

(Duration) *1* yrs. *1* mos. *28* ds.

(Signed)

Leonard E. Hanson, M.D.

DEC 4 1922 LEONARD E. HANSON, M.D.
Address) *WALLACE, IDAHO*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Wallace

DATE OF BURIAL

Dec 6, 22

20. UNDERTAKER

B. G. Warner

ADDRESS

1. PLACE OF DEATH

County of *Shoshone*City of *Burke*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Matthew Battick

CERTIFICATE OF DEATH

Registration District No. *70*Primary Registration District No. *1041*St.) *Idaho*State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *40939*Registered No. *113*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

*white*5. SINGLE, MARRIED, WID-
OWED OR DIVORCED*married*
(Write the word.)

6. DATE OF BIRTH

*Feb.**14**1867*

(Month)

(Day)

(Year)

7. AGE

54 Yrs.*9*Mos. *10* ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

miner

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Austria

10. NAME OF FATHER

Nick Battick

11. BIRTHPLACE OF FATHER

(State or Country)

Austria

12. MAIDEN NAME OF MOTHER

Lora Battick

13. BIRTHPLACE OF MOTHER

(State or Country)

Austria

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Nurse Anna Battick

(Address)

Burke 2da

15.

Filed

*Dec 18**19**22**5**7*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec

(Month)

14

(Day)

22
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 22 to *Dec 14* *1922*that I last saw him alive on *Nov 9* *1922*and that death occurred on the date stated above, at *6:30* M.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver

(Duration)

yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

Dr. W. W. M. D.

(Address)

Wallace

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death..... yrs..... mos..... days

In the

State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

Burke 2da

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Spokane Wash**Dec 18* *1922*

20. UNDERTAKER

ADDRESS

*Wardell Co**Wallace*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Herman Bergman

MEDICAL CERTIFICATE OF DEATH

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WID- OWED OR DIVORCED
male	white	single (Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work..... **Plumber**

(b) General nature of industry, business or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

**13. BIRTHPLACE
OF MOTHER:**

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15. *Dec 21 1922* *F L Jung*

Local Registrar

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from
 Orla 1 19 22 to Dec 17 19 22
 that I last saw him alive on Dec 17 19 22
 and that death occurred on the date stated above, at 6 a.m.
 The CAUSE OF DEATH was as follows:

Contributory...
(Secondary)

.....(Duration)

(Signed)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

**18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)**

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted
if not at place of death?.....

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL
Murray, Idaho.

DATE OF BURIAL
12- 21st. 22

20 UNDERTAKER

ADDRESS

WRITE PLAINLY. WITH UNFADING INK -- THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Shoshone Registration District No. 20
City of Wallace Primary Registration District No. 104
(No. Providence Hospital St.)File No. 40941
Registered No. 116

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
(Write the word.)

16. DATE OF DEATH

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15. File

Local Registrar

17. I HEREBY CERTIFY, That I attended deceased from Dec 23 1922 to Dec 23 1922
that I last saw him alive on Dec 23 1922
and that death occurred on the date stated above, at 1200 A.M.
The CAUSE OF DEATH was as follows:
Chorea
Chorea
Chorea
(Duration) Yrs. mos. ds.
Contributory (Secondary) Chorea
(Duration) Yrs. mos. ds.
(Signed) W. H. Wallace M.D.
(Address) Wallace

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
40942

1. PLACE OF DEATH

County of Shoshone Registration District No. 20
City of Malace Princeton Hospital

If death occurs away from usual residence, give facts called for under special information.

JAN 30 1922
BUREAU OF VITAL STATISTICS

2. FULL NAME

Mae Babin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

single
(Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many 6 hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

none

9. BIRTHPLACE

(State or Country) Malace Idaho

10. NAME OF FATHER

Philip Babin

11. BIRTHPLACE OF FATHER

(State or Country) Prov. Quebec

12. MAIDEN NAME OF MOTHER

Mae Babin

13. BIRTHPLACE OF MOTHER

(State or Country) Minn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Claude Babin

(Address) Malace Idaho

15. FILED

Dec 30 1922 J L Lumsden

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 27 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 26 1922 to Dec 27 1922 that I last saw him alive on Dec 27 1922 and that death occurred on the date stated above, at 7 A. M. The CAUSE OF DEATH* was as follows:
Congestive atelectasis

(Duration) Yrs. Mos. ds.
Contributing (Secondary) Strenuous physical effort

(Signed) Dr. J. L. Lumsden M. D.
(Address) Malace Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence none

19. PLACE OF BURIAL OR REMOVAL

Malace Ida

DATE OF BURIAL

Dec 30 1922

20. UNDERTAKER

Harding Co

ADDRESS

Malace
Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B. - Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH

County of Shoshone
City of Mullan

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Best Charles Hartwell

RECEIVED CERTIFICATE OF DEATH

Registered District No. 7
Primary Registration District No. 104
(No. Mullan Ida St.)State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 40943
Registered No. 102

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-OWED OR DIVORCED married
(Write the word)

6. DATE OF BIRTH

December 22 1874
(Month) (Day) (Year)

7. AGE

47 Yrs. 10 Mos. 15 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Mill Shifter
Concentrating Mill

9. BIRTHPLACE

(State or Country)

Fairport, Mo.

10. NAME OF FATHER

Marion Hartwell

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Mary Pierce

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs Marie Hartwell

(Address)

Mullan, Idaho

15.

Filed

Nov 10 1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 7 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov. 7 1922, to Nov. 7 1922that I last saw him alive on Nov. 7 1922and that death occurred on the date stated above, at 10:30 P.The CAUSE OF DEATH* was as follows: 10 min to 1 P.M.Injured in a fall
while at work at the National Mill
a possible embolism. Absolutely
no contagious disease
(Duration) Yrs. 2 mos. 2 ds.Contributory
(Secondary)(Duration) Yrs. 2 mos. 2 ds.(Signed) Dr. F. W. Rolfs M. D.Nov 8 1922 (Address) Mullan, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

Mullan, Ida

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Fairport Missouri Nov 10 1922

20. UNDERTAKER

ADDRESS

Ward and Tate Co Mullan, Ida

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No.

Primary Registration District No.

(No.)

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19

to

19

that I last saw him alive on

19

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

(Duration)

Yrs.

ds.

Contributory
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

19 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Statistics

1. PLACE OF DEATH

County of *Shoshone* Registration District No. *10*
City of *Malheur* Secondary Registration District No. *1011*
City of *Malheur* *Alley* St.)File No. *40945*
Registered No. *107*

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Eric John Malheur

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-OWED OR DIVORCED

M *white* *single*
(Write the word.)

6. DATE OF BIRTH

June *16* *1898*
(Month) (Day) (Year)

7. AGE

44 Yrs. *5* Mos. *10* ds.
IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)*miner*

9. BIRTHPLACE

(State or Country)

Finland

10. NAME OF FATHER

Matt Malheur

11. BIRTHPLACE OF FATHER

(State or Country)

Finland

12. MAIDEN NAME OF MOTHER

Margaret Johnson

13. BIRTHPLACE OF MOTHER

(State or Country)

Finland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mrs. Anna L. Anderson*
(Address) *Malheur Idaho*Filed *Nov 30* *1922*
19

Local Registrar

16. DATE OF DEATH

Nov *26* *1922*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 1st *1922* to *19*
that I last saw h..... alive on *19*
and that death occurred on the date stated above, at *12* M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *Wm. T. Smith* M. D.*11/29/22* (Address) *Malheur Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence *Malheur Idaho*

19. PLACE OF BURIAL OR REMOVAL

Malheur Idaho

DATE OF BURIAL

Nov 30 1922

20. UNDERTAKER

Hardwood Co

ADDRESS

Malheur Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

40946

1. PLACE OF DEATH **RECEIVED**
County of Shoshone Registration District No. 70
City of Wallace Primary Registration District No. 1961
(No. Wallace Hospital St.)

File No.

Registered No. 107

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Dean

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED unknown
(Write the word.)

6. DATE OF BIRTH Oct 14 1869
(Month) (Day) (Year)

7. AGE 53 Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION Miner
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE Pennsylvania
(State or Country)

10. NAME OF FATHER Fred Dean

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER Georgia Buringer

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wallace Hospital
(Address) Wallace, Idaho

15. Nov 11 1922
Filed Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 30 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 26 1922 to Nov 30 1922
that I last saw him alive on Nov 30 1922
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) Wm. T. Smith M. D.

12/2 19 22 (Address) Wallace Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Wallace Ida DATE OF BURIAL 12-11 1922

20. UNDERTAKER B. G. Horstall ADDRESS Wallace

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **40950**Registered No. *One*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of *Latah*
City of *Victor*Registration District No. *77*Registration District No. *2176*

BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Drum Stigg Keatley

MEDICAL CERTIFICATE OF DEATH

19

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Widower*
(Write the word.)6. DATE OF BIRTH *Sept. 7 1856*
(Month) (Day) (Year)7. AGE *66 Yrs 2 Mos 21 ds.* IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)*Farmer*
Farming

9. BIRTHPLACE

(State or Country)

Penn
Indiana

10. NAME OF FATHER

Thomas Keatley
Mont Know

11. BIRTHPLACE OF FATHER

(State or Country)

Penn
about know

12. MAIDEN NAME OF MOTHER

about know

13. BIRTHPLACE OF MOTHER

(State or Country)

about know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Loy A Keatley
Victor, Idaho

15.

Filed *1/10/**1923**Martha Marker*
Local Registrar

16. DATE OF DEATH

November 28 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to *19*
that I last saw him alive on *19*
and that death occurred on the date stated above, at *M.*
The CAUSE OF DEATH* was as follows:*We surmise that the cause of death was heart failure.*

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

Hiles Pearson
Coroner.*11-28-22.* (Address) *Box 58 R.D. 1 Victor Idaho.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Victor Cemetery**12-1-1922*

20. UNDERTAKER

ADDRESS

*W. W. W. W.**W. W. W. W.*

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **41025**

Registered No.

1. PLACE OF DEATH

County of Butte
City of MooreRECEIVED
MAR 2 1923
BUREAU OF VITAL
STATISTICSRegistration District No. 76
Primary Registration District No. 2153 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Eva Elizabeth Montgomery Fry

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

Caucasian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married

6. DATE OF BIRTH

August 2nd 1856
(Month) (Day) (Year)

7. AGE

66 yrs. 4 mos. 29 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Housewife

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Leon Decatur Co. Iowa

10. NAME OF FATHER

Thomas Montgomery

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Elizabeth Ann Riddle

13. BIRTHPLACE OF MOTHER

(State or Country)

Highland Co. Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Florence Fry

(Address)

Moore, Idaho.

15.

Filed

2/261923Roe Nowalki

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 31 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Oct 28 1922, to Dec 31 1922that I last saw her..... alive on Dec 31 1922and that death occurred on the date stated above, at 9:00 P.M.

The CAUSE OF DEATH* was as follows:

Nephritis + cardiac insufficiency

(Duration) Yrs. mos. ds.

Contributory (Secondary)

Tuberc pneumonia.

(Duration) yrs. mos. ds.

(Signed)

1/31923

(Address)

M. H. Farrell M. D.
Mackay Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 28 yrs. 3 mos. 16 days. In the State 29 yrs. 3 mos. 16 days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Jan 3, 1923

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully applied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. **41041**

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of *Latah*
City of *Mackay*

Registration District No. *76*Primary Registration District No. *2153*

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Stanford Earl Petersen

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single

(Write the word.)

6. DATE OF BIRTH.

December 27 1914
(Month) (Day) (Year)

7. AGE

7 Yrs. *11* Mos. *17* ds.

IF LESS than 1 day
how many hrs. or
..... min.

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...

Student.

9. BIRTHPLACE

(State or Country)

Mackay Idaho

10. NAME OF FATHER

Samuel Petersen

11. BIRTHPLACE OF FATHER

(State or Country)

Danmark

12. MAIDEN NAME OF MOTHER

Carrie Marie Jorgensen

13. BIRTHPLACE OF MOTHER

(State or Country)

Danmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Sam Petersen

(Address)

Mackay Idaho

15.

Filed

2/26 1923 R. E. Nowack
Local Registrar

16. DATE OF DEATH

Dec 14 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 8 1922 to *Dec 14 1922*

that I last saw him alive on *Dec 12 1922*

and that death occurred on the date stated above, at *2:30 A. M.*

The CAUSE OF DEATH* was as follows:

Peritonitis(Duration) Yrs. mos. *7* ds.

Contributory (Secondary)

Appendicitis
(Duration) yrs. mos. *7* ds.

(Signed) *M. H. J. J. J.* M. D.*1923* (Address) *Mackay Idaho*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

191.....

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

1. PLACE OF DEATH.

County of Custer
City of Maxey

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED
MAY 13 1923
BUREAU OF VITAL STATISTICS

Registration District No. 76
Primary Registration District No. 2153
St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 41042

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

Caucasian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widowed

6. DATE OF BIRTH.

June 22 1844
(Month) (Day) (Year)

7. AGE

78 Yrs. 7 Mos. 13 ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

Miner

9. BIRTHPLACE

(State or Country)

Ireland

10. NAME OF FATHER

John McKelvey

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Nora O'Donne

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Mrs. H. E. McElroy
Maxey, Ida

15.

Filed

2/261923

Rae Nowalk
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov. 9 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov. 2 1922 to Nov. 9 1922,

that I last saw him alive on Nov 9 1922,

and that death occurred on the date stated above, at 2.20 M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) Yrs. mos. 7 ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) H. E. McElroy M. D.

19 (Address) Maxey, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

191

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **41043**

1. PLACE OF DEATH

County of Custer Registration District No. 76
City of Mackay Registration District No. 2153 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED
MAR 2 1922
BUREAU OF VITAL STATISTICS
Robert Martin Davidson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)6. DATE OF BIRTH Jan 31 1840
(Month) (Day) (Year)7. AGE 82 Yrs. 10 Mos. 8 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

Rancher-Mining

9. BIRTHPLACE

(State or Country)

Penn.

10. NAME OF FATHER

Beng. C. Davidson

11. BIRTHPLACE OF FATHER

(State or Country)

Scotland.

12. MAIDEN NAME OF MOTHER

Fanny Martin

13. BIRTHPLACE OF MOTHER

(State or Country)

Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

B. C. Davidson
Mackay, Idaho.

15.

Filed 2/26 1923 Rose Nowalki
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

12 - 8 - 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from 11-27-22 19 to 12-8-22 19, that I last saw him alive on 12-2-22 19, and that death occurred on the date stated above, at 3:15 P. M.
The CAUSE OF DEATH* was as follows:myocarditis(Duration) Yrs. mos. ds.
Contributory (Secondary) Bronchial asthma(Duration) yrs. mos. ds.
(Signed) Carroll A. Jensen M. D.12/8 1922 (Address) Mackay Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

RECEIVED

FORM V. S. No. 5-25 M. 1-19.

FEB 28 1923 CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **41091**1. PLACE OF DEATH
County of *Payette* Registration District No. *57*
City of *Grinnland* (No. St.)
Primary Registration District No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Minnie Hatson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*
(Write the word.)

6. DATE OF BIRTH

June 15 1887
(Month) (Day) (Year)

7. AGE

*35 Yrs 6 Mos 7 ds.*IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)*Housewife*

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

M. H. Ford

11. BIRTHPLACE OF FATHER

(State or Country)

Tenn

12. MAIDEN NAME OF MOTHER

Not Known

13. BIRTHPLACE OF MOTHER

(State or Country)

Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

a. g. Matson
Grinnland

(Address)

15.

Filed

Jan 23 1923 *C. C. Paxton*
Local Registrar

16. DATE OF DEATH

Dec 22 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *Dec 19 1922*, to *Dec 22 1922*, that I last saw her alive on *Dec 22 1922*, and that death occurred on the date stated above, at *8:00 P.M.*

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) Yrs. ds.

Contributory *Cholecystitis Recent Myocarditis*
(Secondary)(Duration) *Indefinite* mos. ds.(Signed) *C. H. Avery M. D.*19. (Address) *Payette Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Payette Idaho *Dec 24 1922*

20. UNDERTAKER

ADDRESS

St. Adair Payette Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

RECEIVED
FEB 28 1928
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Washington District No. 88
County of Washington Registration District No. 1
City of Bernadine (St.)

File No. 41128

Registered No. 154
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Samuel R Denney

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH Jan 13 1888
(Month) (Day) (Year)

7. AGE 42 yrs. 3 mos. 27 ds.
IF LESS than 1 day how many hrs. or mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmers
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE Ohio
(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. J. Denney
(Address)

15. Filed 2-1-23 191 W. H. Lewis
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH May 10 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191 to 191, that I last saw him alive on 191, and that death occurred on the date stated above, at M.
The CAUSE OF DEATH* was as follows:

(Duration) yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) M. D.
19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Asubue DATE OF BURIAL May 11 1922
20. UNDERTAKER J. A. Henderson ADDRESS Bernadine

FORM V. S. No. 5-A-25 M. 1-19.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed 2-20-23 19

Local Registrar

RECEIVED
FEB 23 1923
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No.

Registration District No.

(No.)

(St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

19 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH Washington District No. 98
 County of Washington Registration District No. 98
 City of Cambridge (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

George Lucile Myers

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 41130

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED Single

6. DATE OF BIRTH

May 11 1922
 (Month) (Day) (Year)

7. AGE

4 Yrs. 7 Mos. 7 ds.

IF LESS than 1 day
 how many _____ hrs.
 or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

NA

9. BIRTHPLACE

(State or Country)

Cambridge Id

10. NAME OF FATHER

E. L. Myers

11. BIRTHPLACE OF FATHER

(State or Country)

Cambridge Id

12. MAIDEN NAME OF MOTHER

Edith Evans

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

G. L. Myers

(Address)

15.

Filed

2-20-23

19

M. W. Tutelman

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 18 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 1 - 22 to Aug 10 1922

that I last saw him alive on Aug 10 1922

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Marasmus.

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed)

M. W. Tutelman

M. D.

(Address) Cambridge Id

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

RECEIVED
FEB 23 1923

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. **41131**

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Adams

City of Indian Valley

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Rosella Embles

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Oct 29 1897
(Month) (Day) (Year)

7. AGE

54 yrs. 7 mos. 23 ds.

IF LESS than 1 day
how many hrs. or
..... mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Indiana

10. NAME OF FATHER

John Decker

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Jane Decker

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

H. J. Smiley

15.

Filed 2-20-23 191

R. H. Steina
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 22 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 20 1922, to June 22 1922

that I last saw her alive on June 22 1922

and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Peritonitis
Hurt

(Duration) yrs. mos. 1 ds.

Contributory Gun shot
(Secondary)

(Duration) yrs. mos. 2 ds.

(Signed) E. A. Wilson M. D.

19. (Address) Cambria, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

191

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH.

FILED FEB 23 1923 District No.

County of

Adams

BUREAU OF VITAL STATISTICS

District No.

City of

Woodstock

(No.)

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ida May Elcock

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 41132

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female

White

Married
(Write the word.)

6. DATE OF BIRTH

March 12 1874
(Month) (Day) (Year)

7. AGE

28 yrs. 1 mos. 22 ds.

IF LESS than 1 day
how many hrs. or
..... mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

House Wife

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Lane County Oregon

10. NAME OF FATHER

J. T. Baston

11. BIRTHPLACE OF FATHER

(State or Country)

Henry County Illinois

12. MAIDEN NAME OF MOTHER

Etta May Kitchner

13. BIRTHPLACE OF MOTHER

(State or Country)

Lane County Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. T. Baston

(Address)

Cambridge Idaho

15.

Filed

2-20-23

191

W. H. McQuinn

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 4 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

5/2 1923 to 5/4 1923

that I last saw him alive on May 3 1923

and that death occurred on the date stated above, at 2 A.M.

The CAUSE OF DEATH* was as follows:

Heart failure following
Influenza

(Duration) 3 or 4 yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) E. W. Wisner M. D.

19. (Address) Cambridge Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wesley

May 5 1923

20. UNDERTAKER

ADDRESS

J. A. Hudson

Cambridge

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

RECEIVED CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
41138

1. PLACE OF DEATH. Workmen's
County of Washington Registration District No. 88
City of Cambridge (No. 10 St.)

File No. _____

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ruth I Kirschner

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH Sept 16 1894
(Month) (Day) (Year)

7. AGE 28 yrs. 7 mos. 16 ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Minnesota

10. NAME OF FATHER W E Smiley

11. BIRTHPLACE OF FATHER (State or Country) Mass

12. MAIDEN NAME OF MOTHER Henson

13. BIRTHPLACE OF MOTHER (State or Country) Minnesota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Robert O Kirschner

(Address) _____

15. Filed 2-20-23 191 White Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 1 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 17 1912 to April 1 1912, that I last saw him alive on April 1 1912, and that death occurred on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:

Scarlet Fever

(Duration) yrs. mos. 14 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) E. A. Johnson M. D.

41 19 22 (Address) Cambridge, Ma

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Cambridge Apr 2 1922

20. RECOR ADDRESS Cambridge

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADEING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

FEB 23 1923

Registration District No.

County of *Washington*

BUREAU OF VITAL STATISTICS

Registration District No.

City of *Cambridge*

(No.

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *James M Childers*

File No. **41134**

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Oct 27 1897
(Month) (Day) (Year)

7. AGE

84 yrs 5 mos 23 ds.

IF LESS than 1 day
how many hrs. or
..... mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

North Carolina

10. NAME OF FATHER

Wm A Childers

11. BIRTHPLACE OF FATHER

(State or Country)

Tennessee

12. MAIDEN NAME OF MOTHER

Grimesley

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

George Childers

(Address)

15.

Filed

2-25-23 *W. H. White*
191 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 20 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *April 19 1922* to *April 20 1922*

that I last saw him alive on *" 20 1922*

and that death occurred on the date stated above, at *11 P. M.*

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) *6* yrs. mos. ds.

Contributory (Secondary)

Senility

(Duration) *1* yrs. mos. ds.

(Signed)

W. H. White M. D.

19. (Address) *Cambridge*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cambridge

Apr 24 1922

20. UNDERTAKER

ADDRESS

J. A. Hudson

Cambridge

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED
FEB 23 1923

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **41136**

1. PLACE OF DEATH
County of Washington District No. 88
City of Cambridge (No. St.)
Registration District No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William H. Thompson

Registered No.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH Apr 6 1869
(Month) (Day) (Year)

7. AGE 53 Yrs. 8 Mos. 5 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION Farmer
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE Massena
(State or Country)

10. NAME OF FATHER John Thompson

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER Mollie Stevenson

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) T. H. Thompson
(Address) Cambridge, Idaho

15. Filed 2-20-23 19...
Local Registrar R. M. White

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 11 1927
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-1-27 to 2-11-27
that I last saw him alive on Feb 10 1927
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:
Coccarina Gase
1. Bleeding
(Duration) Yrs. mos. ds.

Contributory (Secondary) Yes
(Duration) Yrs. mos. ds.
(Signed) W. H. Steiner M. D.
19... (Address) Cambridge, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED
FEB 23 1923
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **41137**
Registered No.

1. PLACE OF DEATH
County of Washington Registration District No. 88
City of Cambridge Registration District No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph Elmer Craddock

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH Aug 19 1908
(Month) (Day) (Year)

7. AGE 14 Yrs. 25 Mos. 25 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. No
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE Cambridge Id
(State or Country)

10. NAME OF FATHER A L Craddock

11. BIRTHPLACE OF FATHER California
(State or Country)

12. MAIDEN NAME OF MOTHER Mary Woods

13. BIRTHPLACE OF MOTHER Oregon
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. C. Craddock
(Address) Cambridge Idaho

15. Filed 2-20-23 19 1923
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 12 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 19 to 19
that I last saw him alive on Sept 10 1922
and that death occurred on the date stated above, at 11 M.
The CAUSE OF DEATH* was as follows:

Diabetes
(Duration) 1 Yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) E. W. Wisniam M. D.
9/12/22 19 22 (Address) Cambridge Id

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Cambridge DATE OF BURIAL Sept 14 1922

20. UNDERTAKER La. H. H. H. ADDRESS Cambridge

FORM V. S. No. 5-A—25 M. 1-19.

1. PLACE OF DEATH

County of AdamsCity of Mesa

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
FEB 23 1923
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 88

Registration District No. _____

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 41138

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Robert Deane Teem

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDSingle
(Write the words)

6. DATE OF BIRTH

May
(Month)11
(Day)1922
(Year)

7. AGE

7 Yrs. 21 Mos. 21 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)No

9. BIRTHPLACE

(State or Country)

Adams Co Idaho

10. NAME OF FATHER

J H Teem

11. BIRTHPLACE OF FATHER

(State or Country)

Colorado

12. MAIDEN NAME OF MOTHER

May Beck

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Anne Knibb

(Address)

Cambridge Ida

15.

Filed 2-20-23 19 23W M Teem

Local Registrar

MEDICAL CERTIFICATE OF DEATH

92

16. DATE OF DEATH

Sept
(Month)1
(Day)1922
(Year)17. I HEREBY CERTIFY, That I attended deceased from Aug 30 1922 to Aug 30 1922that I last saw him alive on Aug 30 1922

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed)

W M Teem
Cambridge Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Council

DATE OF BURIAL

Sept 2 1922

20. UNDERTAKER

J A Anderson

ADDRESS

Cambridge

FORM V. S. No. 5-A-25 M. 1-19.

RECEIVED

FEB 23 1923

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Washington
City of Cornbridge
Registration District No. 88
BUREAU OF VITAL STATISTICSFile No. 41139

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edgar Owen Boone

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male White Single
(Write the word.)

6. DATE OF BIRTH

Mos 29 1910
(Month) (Day) (Year)

7. AGE

12 Yrs. 4 Mos. 25 ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

No

9. BIRTHPLACE

(State or Country)

Okla

10. NAME OF FATHER

J. O. Boone

11. BIRTHPLACE OF FATHER

(State or Country)

Texas

12. MAIDEN NAME OF MOTHER

Minnie B. Peters

13. BIRTHPLACE OF MOTHER

(State or Country)

Texas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. O. Boone

15. 2-23 1922
Filed

M. A. White

Local Registrar

16. DATE OF DEATH

Aug 23 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Apr 3 1922 to Aug 23 1922
that I last saw him alive on Aug 22 1922
and that death occurred on the date stated above, at 4:30 A.M.

The CAUSE OF DEATH* was as follows:

Hemorrhage from disease

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) E. W. Winkler M. D.

8/24/1922 (Address) Cambridge, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cambridge Aug 24 1922

20. UNDERTAKER

ADDRESS

J. C. Hedelorn Cambridge, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Washington Registration District No. 88
County of Washington Registration District No. 88
City of Cambridge (No. St.)

File No. 41140

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elmer W. Cable

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-OWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Nov 20 1810
(Month) (Day) (Year)

7. AGE 11 yrs 7 mos 20 ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Ontario Oregon

10. NAME OF FATHER Elmer W. Cable

11. BIRTHPLACE OF FATHER (State or Country) Massachusetts

12. MAIDEN NAME OF MOTHER Elenor Martin

13. BIRTHPLACE OF MOTHER (State or Country) Massachusetts

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Elmer W. Cable
(Address)

15. Filed 1-20-23 191 Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH July 10 1912
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 2 1912 to July 10 1912, that I last saw him alive on July 10 1912, and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

General Peritonitis
(Duration) yrs. 3 mos. 3 ds.
Contributory Perforating ulcer
(Secondary)
(Duration) yrs. 3 mos. 3 ds.
(Signed) E. A. Winters M. D.
7/10 1912 (Address) Cambridge, Mass.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Calvary DATE OF BURIAL July 12 1912
20. UNDERTAKER J. A. Hendricks ADDRESS Cambridge

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping-cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

77 # 6

FORM V. S. No. 5-A—25 M. 1-19.

1. PLACE OF DEATH

County of WashingtonCity of Cambridge

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Blane Wininger

CERTIFICATE OF DEATH

Registration District No. 88Primary Registration District No. 88

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 41141Registered No. 41141

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Dec 4 1922
(Month) (Day) (Year)

7. AGE

7 Yrs. 7 Mos. 7 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)None

9. BIRTHPLACE

(State or Country)

Washington Co. Ca

10. NAME OF FATHER

Charley B Wininger

11. BIRTHPLACE OF FATHER

(State or Country)

Virginia

12. MAIDEN NAME OF MOTHER

Ruth Taylor

13. BIRTHPLACE OF MOTHER

(State or Country)

Mont

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Maggie Wells

(Address)

15.

Filed 1-20-23 19 23W. H. Wininger

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 10 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Dec 10 1922 to Dec 10 1922that I last saw him alive on 19and that death occurred on the date stated above, at 19 M.

The CAUSE OF DEATH* was as follows:

Pneumonia(Duration) Yrs. mos. 6 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) E. H. Wininger M. D.1910 1922 (Address) Cambridge, Id.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

RECEIVED

FEB 23 1923

BUREAU OF VITAL
STATISTICS

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of

City of

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

District No.

Registration District No.

(No.

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

41142

Registered No.

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Female

White

Married
(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

1891
(Year)

7. AGE

IF LESS than 1 day
how many..... hrs
or..... min.?

81 Yrs 4 Mos 3 ds.

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF
FATHER

Wesley Coats

11. BIRTHPLACE
OF FATHER

(State or Country)

12. MAIDEN NAME
OF MOTHER13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Manuel Silvers
Durkee Ave.

(Address)

15.

File

1-20-23

19

M. W. Intema

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

1922
(Year)17. I HEREBY CERTIFY, That I attended deceased from
Jan 1 1922, to Dec 24 1922

that I last saw him alive on Dec 24 1922

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration)

Yrs.

mos.

ds.

Contributor
(Secondary)

Arterio-sclerosis

(Duration)

Yrs.

mos.

ds.

(Signed)

M. W. Intema M. D.

19

(Address)

Cambridge, Va.

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)At place
of death..... yrs..... mos..... days

In the

State..... yrs..... mos..... days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cambridge, Va.

19

20. UNDERTAKER

ADDRESS

J. H. Hudelson

RECEIVED CERTIFICATE OF DEATH

MAR 13 1923

1. PLACE OF DEATH

County of *Bannock*City of *Lava Hot Springs*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

BUREAU OF VITAL STATISTICS

STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **41193**

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1923

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

12
(Month)22
(Day)1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

12-21-1922 to 10-21-1922

that I last saw him alive on 10-21-1922

and that death occurred on the date stated above at 2:30 P. M.

The CAUSE OF DEATH* was as follows:

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

M. D.

19

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Ben Loh*City of *Montpelier*

If death occurs away from usual residence, give facts called for under special information.

RECEIVED

Registration District No. *52*Primary Registration District No. *2136*

BUREAU OF VITAL STATISTICS

State of Idaho
BUREAU OF HEALTH
Bureau of Vital StatisticsFile No. *41208*

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Maria B Schuur

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widow
(Write the word.)

6. DATE OF BIRTH

Sept.
(Month)*7*
(Day)*1852*
(Year)

7. AGE

Dec 70
Yrs. *2* Mos. *24* ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)*Housewife*

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

John G. Henke

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Anna Maria Henginger

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Fred Schuur

(Address)

Montpelier Idaho

15.

Filed

3-1-

19

*23**H. H. Kueg*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec
(Month)*1*
(Day)*22*
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 27 19____ to *Dec 1* 19____
that I last saw him alive on *Nov 30* 19____
and that death occurred on the date stated above, at *10 P.* M.

The CAUSE OF DEATH* was as follows:

(Duration) _____ Yrs. _____ mos. _____ ds.
Contributory (Secondary) *Old age*(Signed) *W. H. Schley* M. D.*12-4* 19____ 22 (Address) *Montpelier*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Montpelier Idaho**Dec 5* 19____ 22

20. UNDERTAKER

ADDRESS

*J. M. Williams**Montpelier Idaho*

RECEIVED
MAR 12 1923

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **41209**

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Berg Lake Registration District No. 52
City of Montpelier Primary Registration District No. 2136
(No.) (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Gottfried Seiler

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Nov 8 1884
(Month) (Day) (Year)

7. AGE

38 Yrs. 1 Mos. - ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

Tailor

9. BIRTHPLACE

(State or Country)

Switzerland

10. NAME OF FATHER

Fredrick Seiler

11. BIRTHPLACE OF FATHER

(State or Country)

Switzerland

12. MAIDEN NAME OF MOTHER

Elizabeth Aemmer

13. BIRTHPLACE OF MOTHER

(State or Country)

Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

John Jacob Messerli
Idaho Falls Idaho

15.

Filed 3-1- 1923H. H. King
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 8 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 10 1922 to Dec 8 1922
that I last saw him alive on Oct 10 1922
and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) Ernst C. Schuler M. D.12-12-1922 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Montpelier Idaho Dec 10 1922

20. UNDERTAKER

ADDRESS

F. M. Williams Montpelier Idaho

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of FremontCity of St. Anthony

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hilda Johnson

RECEIVED

APR 7 1923

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 99Registration District No. 2177

(No. _____, _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 41368Registered No. 11

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH

June 19th, 1852
(Month) (Day) (Year)

7. AGE

70 Yrs. 6 Mos. 22 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country) Sweden

10. NAME OF FATHER

Not Known Lawrence

11. BIRTHPLACE OF FATHER

(State or Country) Sweden

12. MAIDEN NAME OF MOTHER

Not Known

13. BIRTHPLACE OF MOTHER

(State or Country) Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John F. Johnson(Address) St. Anthony, Idaho R.F.D. 1

15.

Filed Dec. 10th, 19 22W. M. Hansen
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

December 10th, 19 22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on _____ 19 _____

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed) Frank Watkins

M. D.

12/12 1922

(Address) St. Anthony

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Wilford

DATE OF BURIAL

Dec. 14th 22

20. UNDERTAKER

W. M. Hansen

ADDRESS

St. Anthony, Ida

RECEIVED
MAR 19 1923

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Jefferson*City of *Reilly*
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No. *98*BUREAU OF VITAL STATISTICS
Registration District No. *2176*

(No. _____ St.)

File No. *41402*Registered No. *15*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed *3/10*

1923

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw her alive on *Dec 1* 19*22*and that death occurred on the date stated above, at *9* A. M.

The CAUSE OF DEATH* was as follows:

Artio-sclerosis (Senility)

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

M. D.

19

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Jefferson* Registration District No. *98*
 City of *Minneapolis* Registration District No. *2176*
 (No. *10123*) (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Dean W Lake

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
41403

File No.

Registered No. *17*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

June 21 1920
 (Month) (Day) (Year)

7. AGE

IF LESS than 1 day
 how many..... hrs.
 or..... min.?

.....Yrs.Mos.ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work.....
 (b) General nature of industry, business or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country)

Plano Idaho

10. NAME OF FATHER

Geo Lake

11. BIRTHPLACE OF FATHER

(State or Country)

Tairview Id

12. MAIDEN NAME OF MOTHER

Magdeline Westler

13. BIRTHPLACE OF MOTHER

(State or Country)

Colorado

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

George Lake

(Address)

Idaho

15.

Filed

3/10 1923

Ray H Fisher

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec. 16 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Dec 16 1922* to *Dec 16 1922*
 that I last saw him alive on *Dec 16 1922*
 and that death occurred on the date stated above, at *8 P. M.*
 The CAUSE OF DEATH* was as follows:

Pulmonary edema.

(Duration) Yrs. mos. ds.

Contributory (Secondary)

Smoke from burning
hand.

(Duration) yrs. mos. ds.

(Signed)

Chas. S. Moody M. D.

Dec 17 1922

(Address)

Meran, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos..... In the days. State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Ed Lake

12/16 1922

20. UNDERTAKER

ADDRESS

Idaho

Idaho

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Jefferson
City of Pike

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED
CERTIFICATE OF DEATH
 Registration District No. 98
 Primary Registration District No. 2176
BUREAU OF VITAL STATISTICS

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
41404
 File No. _____
 Registered No. 100

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Boy 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH

November 17 1922
(Month) (Day) (Year)

7. AGE

6 weeks
Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Wm B Clark

11. BIRTHPLACE OF FATHER

(State or Country) Idaho

12. MAIDEN NAME OF MOTHER

Virginia Opal Summers

13. BIRTHPLACE OF MOTHER

(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm B Clark(Address) Pike Idaho

15.

Filed 3/10 1923

Local Registrar

16. DATE OF DEATH

Dec 31 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 26 1922, to Dec 31 1922,
 that I last saw him alive on Dec 31, 1922,
 and that death occurred on the date stated above, at 9 P. M.
 The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) Sam F. Price M. D.19 (Address) Pike Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Jefferson
City of Corvallis

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
MAR 19 1923
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 98
Administrative District No. 2176State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
41405
File No. _____
Registered No. 12

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Anna Drake

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widowed
(Write the word.)

6. DATE OF BIRTH

Jan 3 1851
(Month) (Day) (Year)

7. AGE

72 Yrs. — Mos. — ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Retired housewife

9. BIRTHPLACE

(State or Country) Sweden

10. NAME OF FATHER

Don't know

11. BIRTHPLACE OF FATHER

(State or Country) Sweden

12. MAIDEN NAME OF MOTHER

Don't know

13. BIRTHPLACE OF MOTHER

(State or Country) Stockholm

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Arthur Drake(Address) Corvallis, Idaho

15.

Filed 3 / 10 1923 Ray H. Fisher
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 31 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from June 1st 1922 to Dec 3rd 1922
that I last saw him alive on Dec 3rd 1922
and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Coronary Arteriosclerosis

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) A. Anderson

M. D.

19 _____ (Address) Regt Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Anna's 1-3 1923

20. UNDERTAKER

ADDRESS

Edw. G. Gibson Regt Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

41406

1. PLACE OF DEATH

County of *Jefferson*
City of *Rehby*

RECEIVED
MAR 19 1923

Registration District No. *2176*

File No.

Registered No. *11*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John T. Jones

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male White Married

6. DATE OF BIRTH

June 23 1854
(Month) (Day) (Year)

7. AGE

68 Yrs. *5* Mos. *3* ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. *Farmer*
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) *Wales*

10. NAME OF FATHER

David D. Jones

11. BIRTHPLACE OF FATHER

(State or Country) *Wales*

12. MAIDEN NAME OF MOTHER

Ann Jones

13. BIRTHPLACE OF MOTHER

(State or Country) *Wales*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Harry A. Watts*
(Address) *Rehby Ida*

15. Filed *3/10* 19*23* *Ray H. Fisher*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

November 26 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Oct 1 1921*, to *Nov 26 1922*

that I last saw him alive on *Nov 24 1922*
and that death occurred on the date stated above, at *8:30 P.M.*

The CAUSE OF DEATH* was as follows:

Cardio Renal Insufficiency

(Duration) *2* Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) *J. C. Case* M. D.

Nov 19 1922 (Address) *Rehby Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Rehby *11-28 1922*

20. UNDERTAKER ADDRESS

D. W. Sullivan *Rehby*

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Jefferson Registration District No. 9
City of Lowrey Registration District No. 176 St.)File No. 41407
Registered No. 10

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

BUREAU OF VITAL STATISTICS

Joseph M Strong

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

March 4 1876
(Month) (Day) (Year)

7. AGE

46 Yrs 7 Mos 23 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Springville
Utah Co. Utah

10. NAME OF FATHER

Ozias Strong

11. BIRTHPLACE OF FATHER

(State or Country)

Pennsylvania

12. MAIDEN NAME OF MOTHER

Mary E. Mendenhall

13. BIRTHPLACE OF MOTHER

(State or Country)

Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Strong
Springville Utah

15.

Filed

3/10 1923 Ray Fisher
Local Registrar

MEDICAL CERTIFICATE OF DEATH

28

16. DATE OF DEATH

November 27 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 22 1922, to Nov 27 1922that I last saw him alive on Nov 27 1922and that death occurred on the date stated above, at 7 AM

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosisabout 10 Yrs. mos. ds.
(Duration)Contributory
(Secondary)

(Duration) yrs. mos.

(Signed) O. H. Leach M. D.

19. (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. 4 days. In the State yrs. mos. daysWhere was disease contracted if not at place of death? Bonvilleville UtahFormer or usual residence Springville Utah

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lucie's 11-27-1922

20. UNDERTAKER

ADDRESS

E. W. Gilman Rich

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

41445

File No.

Registered No. 7

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

Registration District No. 30 46

County of Kootenai

Primary Registration District No. 1030 2123

City of Worley, Idaho

(No. 1030)

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Charles E. Bragott.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male

White

Widower

(Write the word.)

6. DATE OF BIRTH

June

25th

1835

(Month)

(Day)

(Year)

7. AGE

87 yrs. 4 mos. 22 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

Charles E. Bragott.

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Don't know.

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

John E. Bragott
Worley, Idaho

15.

Filed

Dec 21

1922

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov

17th

1922

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 26th 1922, to Nov 17th 1922

that I last saw him alive on Nov 15th 1922

and that death occurred on the date stated above, at 2:45 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Brights

(Duration)

yrs.

mos.

ds.

Contributory Hemorrhage from kidneys
(Secondary) Bladder "Sant Illness"

(Duration)

yrs.

mos.

ds.

(Signed)

J. J. Hemminger

M. D.

19

(Address)

Worley, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

yrs.

mos.

days

In the

State

yrs.

mos.

days

Where was disease contracted if not at place of death?

Worley, Idaho. Place of death

Former or usual residence

With Sam John Bragott.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Greenwood Cemetery

Nov 20 1922

20. UNDERTAKER

ADDRESS

Spokane, Wn.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No.

Registration District No.

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

19

E. D. Piper

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw her alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

Hypotaxia (exhaustion of
Lungs.

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) E. D. Piper M. D.

(Address) Jerome

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Jerome Cemetery

10-17-22

20. UNDERTAKER

ADDRESS

D. D. Harrison Jerome

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED
APR 21 1923

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **41730**
Registered No. **9**

1. PLACE OF DEATH

County of *Munich*
City of *Rupert*

Registration District No. *19*
Statistical Registration District No. *2015*
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Carl Titus

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *married*
(Write the word.)

6. DATE OF BIRTH *July 23 1878*
(Month) (Day) (Year)

7. AGE *44* Yrs. *2* Mos. *17* ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION *Farmer*
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE *Iowa*
(State or Country)

10. NAME OF FATHER *L. B. Titus*

11. BIRTHPLACE OF FATHER *Ohio*
(State or Country)

12. MAIDEN NAME OF MOTHER *Marah Jakway*

13. BIRTHPLACE OF MOTHER *Vermont*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *L. B. Titus*
(Address) *Twin Falls Idaho*

15. Filled *Mar 6 1923* *E. E. E. E. E.*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

92

16. DATE OF DEATH *Oct 10 1922*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Oct 8 - 1922* to *Oct 10 - 1922* that I last saw him alive on *Oct 10 1922* and that death occurred on the date stated above, at *2:30 P.M.*

The CAUSE OF DEATH* was as follows:
Pneumonia, Lobar, Lower lobes Bilateral

(Duration) Yrs. mos. *9* ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) *Leona Frazier* M. D.

19. (Address) *Rupert Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Rupert Cemetery* DATE OF BURIAL *19*

20. UNDERTAKER *W A Goodman* ADDRESS *Oct 11*

RECEIVED
APR 21 1923
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Minidoka*City of *Paul*Registration District No. *19*Primary Registration District No. *2015*

(No. _____)

(St. _____)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Doris Edwards

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. *41731*Registered No. *8*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

6. DATE OF BIRTH

Mar 5 1915
(Month) (Day) (Year)

7. AGE

7 Yrs. 4 Mos. 21 ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

Child

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

John Edward

11. BIRTHPLACE OF FATHER

(State or Country)

Wyoming

12. MAIDEN NAME OF MOTHER

Maud Blake

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Maud Edwards
Paul Idaho

(Address)

15.

Filed *Mar 6 1923* *E. E. Edwards*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

9

16. DATE OF DEATH

July 26 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 24 1922 to *July 26 1922*
that I last saw her alive on *July 26 1922*

and that death occurred on the date stated above, at *12:20 P.M.*

The CAUSE OF DEATH* was as follows:

Diphtheria

(Duration) _____ Yrs. _____ mos. *5* ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) *Leland Frazier* M. D.

19. (Address) *Rupert Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Burley Cemetery *July 27 1922*

20. UNDERTAKER

ADDRESS

Rodney Goodman *Rupert Idaho*

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
APR 21 1923
BUREAU OF VITAL STATISTICS
STATE OF IDAHO

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **41732**
Registered No. **5**

1. PLACE OF DEATH

County of **Minidoka**
City of **Rupert**

Registration District No.

Primary Registration District No.

(No.

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

George Montgomery

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widower

(Write the word.)

6. DATE OF BIRTH

Nov
(Month)**I**
(Day)**1837**
(Year)

7. AGE

86Yrs. **I**Mos. **24**

ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Farmer

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

Canada

(State or Country)

10. NAME OF FATHER

Dent Know

11. BIRTHPLACE OF FATHER

" "

(State or Country)

12. MAIDEN NAME OF MOTHER

" "

13. BIRTHPLACE OF MOTHER

" "

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Mar. 6 1923**Ed E. Elmore**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec
(Month)**25**
(Day)**1922**
(Year)17. I HEREBY CERTIFY, That I attended deceased from **Mar. 13 1922** to **Dec. 25 1922**that I last saw him alive on **Dec. 25 1922** and that death occurred on the date stated above, at **3 P. M.**

The CAUSE OF DEATH* was as follows:

apoplexy(Duration) Yrs. **9** mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. B. Kennedy

M. D.

3-5 1923(Address) **Rupert Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

I O O F Cemetry

DATE OF BURIAL

Dec 28 1922

20. UNDERTAKER

W A Goodman

ADDRESS

Rupert Idaho

2. FULL NAME Alvin E. Baker

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

Maude White

Nov 14 1920
(Month) (Day) (Year)

1 Yrs. 9 Mos. 28 ds

IF LESS than 1 day
how many..... hrs.
or.....min.?

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business or establishment in which employed (or employer).....

Child

(State or Country) *India*

Dionigio Grisenti

(State or Country) Italy

Marie Donasi

(State or Country) Italy

(Informant) Asnig's Friends

(Address) Jackson Idaho

15. Filed Mar. 6th 1923 Edt Elmore

Local Registrar

16. DATE OF DEATH Sept 12 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Sept 12 19 22 to Sept 12 19 22
 that I last saw her alive on Sept-12 19 22
 and that death occurred on the date stated above, at 6²⁵ P.M.

The CAUSE OF DEATH* was as follows:

Foreign body (Leish) in trochlea.

.. (Duration) Yrs. mos. / ds.

Contributory (Secondary)

(Duration) yrs. mos. ds

(Signed) Richard Trezuer M. D.

19 (Address) Rupert Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted
if not at place of death?.....

Former or
usual residence

[illegible]

20. UNDERTAKER	ADDRESS
----------------	---------

W. G. Goodenough Report

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Blaine Registration District No. 19
 City of Reupert Registration District No. 2013
 St. Idaho

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Sarah E Crawford

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 41734Registered No. 2

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

A White Widowed

6. DATE OF BIRTH

Apr 1 1866
 (Month) (Day) (Year)

7. AGE

56 Yrs. 9 Mos. 26 ds.

IF LESS than 1 day
 how many..... hrs.
 or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

House wife

9. BIRTHPLACE

(State or Country)

Kentucky

10. NAME OF FATHER

E Richardson

11. BIRTHPLACE OF FATHER

(State or Country)

Kentucky

12. MAIDEN NAME OF MOTHER

Malinda Chrail

13. BIRTHPLACE OF MOTHER

(State or Country)

Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. H. Harris

(Address)

Reupert Idaho

15.

Filed

Mar. 6 1923

E. H. E. Harris

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 27 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 25 1922 to Dec 27 1922

that I last saw him alive on Dec 27 1922

and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Exhaustion of urinary bladder.

(Duration) Yrs. mos. ds.

Contributory
 (Secondary)

(Duration) Yrs. mos. ds.

(Signed)

3/6/23

(Address)

Reupert Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Reupert Cemetery

Dec 31, 1922

20. UNDERTAKER

ADDRESS

W. G. Goodman

Reupert

MARGIN USED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLATE OF DEATH

County of *Shoshone*

City of *Wallace*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Bert Anderson

CERTIFICATE OF DEATH

Registration District No. *70*

Primary Registration District No. *1011*

No. *41774*

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. *41774*

Registered No. *2*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male white

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Married
(Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

69 Yrs. — Mos. — ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Common laborer

9. BIRTHPLACE

(State or Country)

Norway

10. NAME OF FATHER

not given

11. BIRTHPLACE OF FATHER

(State or Country)

" "

12. MAIDEN NAME OF MOTHER

" "

13. BIRTHPLACE OF MOTHER

(State or Country)

" "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

County Registrar
Wallace

(Address)

15. Filed

Jan 5 1923

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 21 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 18 1918 to *Dec 21 1922*
that I last saw him alive on *12/21 1922*
and that death occurred on the date stated above, at *7:30 P* M.
The CAUSE OF DEATH* was as follows:

apoplexy

(Duration) Yrs. mos. ds.

Contributory (Secondary)

Locomotor Ataxia

(Duration) Yrs. mos. ds.

(Signed)

James R Bean M. D.
12/27 1922 (Address) *Wallace Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL

Wallace Id

DATE OF BURIAL

1-5-1923

UNDERTAKE

W B Morrell *Wallace*

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Shoshone Registration District No. 70
City of Wallace Registration District No. 10 11
Idaho St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Edna Fay Bernice GayFile No. 41775
Registered No. 3

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

female whitesingle
(Write the word.)

6. DATE OF BIRTH

Aug 1 1919
(Month) (Day) (Year)

7. AGE

3 Yrs. 4 Mos. 30 ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).none

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Alvin C. Gay

11. BIRTHPLACE OF FATHER

(State or Country)

Oregon

12. MAIDEN NAME OF MOTHER

Ava Baltzer

13. BIRTHPLACE OF MOTHER

(State or Country)

Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Alvin C. Gay
Idaho

15. Filed

Jan 2 1923 1 L Jundy

Local Registrar

16. DATE OF DEATH

Dec. 30 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec. 28 1922 to Dec. 30 1922that I last saw him alive on Dec. 30 1922and that death occurred on the date stated above, at 2 P.

The CAUSE OF DEATH* was as follows:

Croup Membranous
choking of suppurative
failure to expectorate(Duration) Yrs. mos. 4 ds.Contributory suppuration
(Secondary)

(Duration) yrs. mos. ds.

(Signed) R. B. Lundy, R.C.D.19 (Address) Wallace, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wallace Id. Jan 2 1923

20. UNDERTAKER

ADDRESS

R. B. Lundy WallaceWRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **41776**Registered No. **1**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of **Shoshone** Registration District No. **70**
City of **Wallace** Primary Registration District No. **1011**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

August Peterson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **male** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

90

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed; (or employer)

miner

9. BIRTHPLACE

(State or Country)

Sweden

10. NAME OF FATHER

not given

11. BIRTHPLACE OF FATHER

(State or Country)

4 4

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

4 7

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

**County Infirmary
Wallace**15. **Jan 5 1923** **F L Zumpf**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 19 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from **Apr 18 1922** to **Dec 19 1922**
that I last saw him alive on **Dec 19 1922**
and that death occurred on the date stated above, at **2:30 PM**.

The CAUSE OF DEATH* was as follows:

apoplexy

Contributory (Secondary)

(Duration) Yrs. Mos. ds. **8**
(Signed) **James R. Bran** M. D.1922 (Address) **Wallace**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **Wallace Id**DATE OF BURIAL **1-5-1923**

20. UNDERTAKER

W. J. Morrell

ADDRESS

Wallace

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Shoshone*City of *Wallace*

If death occurs away from usual residence, give facts called for under special information.

Registration District No. *70*Primary Registration District No. *10 11*(No. *10 11*)

File No.

Registered No. *37*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Eliza Marshall Walker Stahl

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

married
(Write the word.)

6. DATE OF BIRTH

Nov
(Month)*9th*
(Day)*1858*
(Year)

7. AGE

63 Yrs. *11* Mos. *26* ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

at home

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Joseph Milton Walker

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Indiana Marshall

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Indian Pierce

(Address)

St. Mary's 2 dda

15. Filed

*Nov 8**1923**JL J. J. J.*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov
(Month)*5*
(Day)*22*
(Year)17. I HEREBY CERTIFY, That I attended deceased from *Oct 13* 19*22* to *Nov 3* 19*22*that I last saw him alive on *Nov 3* 19*22*and that death occurred on the date stated above, at *10:25* P.M.

The CAUSE OF DEATH* was as follows:

*Chromic ulcer of stomach & duodenum
at every autopsy*

(Duration)

Yrs.

mos.

ds.

Contributory (Secondary)

none

(Duration)

yrs.

mos.

ds.

(Signed)

Dr. M. W. M. W.

M.D.

(Address)

Wallace Id

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

Wallace 2 dda

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Moscow 2 dda**Nov 8* 19*22*

20. UNDERTAKER

ADDRESS

*Hardy & Co**Wallace 2 dda*

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M, 6-15-1

41839

1. PLACE OF DEATH **MAY 9 1923** CERTIFICATE OF DEATH
County of *Bonneville* Division District No. *75*
City of *Morton (rural)* Registration District No. *2155*
If death occurs away from usual residence, give facts called for under special information. (No. St.)
2. FULL NAME *P. H. Nass*

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. *41839*
Registered No.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. *Widowed*
(Write the word.)

6. DATE OF BIRTH. *January 6th 1827*
(Month) (Day) (Year)

7. AGE *96* Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work *Minister*
(b) General nature of industry, business, or establishment in which employed (or employer) *Farming*

9. BIRTHPLACE
(State or Country) *Denmark*

10. NAME OF FATHER *Barthel Nass*

11. BIRTHPLACE OF FATHER
(State or Country) *Denmark*

12. MAIDEN NAME OF MOTHER *Gunnar*

13. BIRTHPLACE OF MOTHER
(State or Country) *Denmark*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *Sara Nass*
(Address) *Morton Idaho*

15. Filed *May 4 1923* *Viola Allen*
Deputy Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *Dec 10 1922*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Didn't attend*
Signed on information from relatives
that I last saw him alive on M.
and that death occurred on the date stated above at
The CAUSE OF DEATH* was as follows:
Senility

(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) Yrs. mos. ds.
(Signed) *Floyd G. Siddle* M. D.
4-28-23 (Address) *CH. O. Sandpoint, Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days, State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Senyoguateen Cemetery* DATE OF BURIAL *Dec 12 1923*

20. UNDERTAKER *Neighbors* ADDRESS *Morton, Ida.*

RECEIVED
MAY 19 1922
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Blaineville
City of Idaho FallsRegistration District No. 73Primary Registration District No. 2140

(No. _____)

St. _____

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 41939Registered No. 21

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Reynold Junior Andrew

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Infant
(Write the word.)

6. DATE OF BIRTH

Nov. 15 1922
(Month) (Day) (Year)

7. AGE

0 Yrs. 0 Mos. 6 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho Falls

10. NAME OF FATHER

Fred Andrew

11. BIRTHPLACE OF FATHER

(State or Country)

Salt Lake, Utah

12. MAIDEN NAME OF MOTHER

Mina Thirkill

13. BIRTHPLACE OF MOTHER

(State or Country)

Logan, Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Fred Andrew

(Address)

Idaho Falls

15.

Filed Mar 6 19 23W. J. Mendenhall
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 21 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Nov. 18, 1922 to Nov. 21, 1922that I last saw h. _____ alive on _____ 19 _____
and that death occurred on the date stated above, at 5 a M.

The CAUSE OF DEATH* was as follows:

Unknown

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

John O. Melton M. D.
11/21/22 (Address) Idaho Falls, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Idaho Falls

DATE OF BURIAL

11/22/22

20. UNDERTAKER

B. E. Deemwoodey

ADDRESS

Idaho Falls

RECEIVED CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No.

Bureau Registration District No.

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1923

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from 11/27/1923, to 11/28/1923

that I last saw him alive on 19 and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Contributory (Secondary)

(Signed)

11/28/1923

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bonneville
City of Idaho FallsBUREAU OF VITAL STATISTICS
Registration District No. 73
Primary Registration District No. 214-0
(No. _____) (St. _____)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Benj. PageState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 41941Registered No. 19

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH

Apr 11 1894
(Month) (Day) (Year)

7. AGE

28 Yrs. 7 Mos. 27 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)Farming

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Alma Page

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Francis A Ashby

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah
England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Gundora Page

(Address)

Idaho Falls

15.

Filed

Mar 6 19 23 Idaho Falls

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept Dec 8 19 22
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 28 19 22 to Dec 8 19 22
that I last saw him alive on Dec 8 19 22

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis(Duration) Yrs. _____ mos. 14 ds.

Contributory (Secondary)

Chronic Articular Rheumatism(Duration) yrs. 5 mos. _____ ds.

(Signed)

James W. West M. D.178 19 22 (Address) Idaho Falls, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Idaho Falls, Ida

DATE OF BURIAL

12/11 19 22

20. UNDERTAKER

C. E. Woodward

ADDRESS

Idaho FallsArthur

CERTIFICATE OF DEATH

1. PLACE OF DEATH **RECEIVED**
 County of **Bonneville** Registration District No. **73**
 City of **Idaho Falls** Primary Registration District No. **2150**
 If death occurs away from usual residence, give facts called for under special information.
Verla Leola Cutler
 FULL NAME

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. **41914**
 Registered No. **10**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

2. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Infant**
 (Write the word.)

6. DATE OF BIRTH

Aug 16 1922
 (Month) (Day) (Year)

7. AGE

1 14 12
 Yrs. Mos. ds.

IF LESS than 1 day
 how many..... hrs.
 or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

J. A. Cutler

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Ruby Ball

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. A. Cutler
Idaho Falls

15.

Filed **Mar 6 1923** **Idaho Falls**
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 28 1922
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 18 1922 to **Dec 28 1922**
 that I last saw him alive on **Dec 28 1922**
 and that death occurred on the date stated above, at **7:00** M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

H. Ray Hatch M. D.1/29/1923 (Address) **Idaho Falls**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho Falls **12/31/1922**

20. UNDERTAKER

ADDRESS

Continuwoodey **Idaho Falls**

Hatch

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 41947
Registered No. 11

1. PLACE OF DEATH *Barre, Idaho*
County of *Blaine* Registration District No. *73*
City of *Barre* Primary Registration District No. *2150* St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jessie Reed Stilding

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Infant*
(Write the word.)

6. DATE OF BIRTH

Dec 10 1923
(Month) (Day) (Year)

7. AGE

0 Yrs. *0* Mos. *14* ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) *Idaho*

10. NAME OF FATHER

Joe A. Stilding

11. BIRTHPLACE OF FATHER

(State or Country) *Utah*

12. MAIDEN NAME OF MOTHER

Eliza A. Barnes

13. BIRTHPLACE OF MOTHER

(State or Country) *Idaho*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Joe A. Stilding*

(Address) *Highway R.D. 7, Sp. 10*

15. Filed *Dec 6* 19 *23* *W. J. Stilding*
Local Registrar

16. DATE OF DEATH

Dec 24 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Dec 10 1923*, to *Dec 24 1923*
that I last saw him alive on *Dec 10 1923*
and that death occurred on the date stated above, at *6:30* M.
The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) Yrs. mos. *6* ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) *O. F. Call*

17/10/23 (Address) *Reg. 1011*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Milo, Ida *12/26/23*

20. UNDERTAKER

ADDRESS

Beckwood *Idaho Falls*

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of BonnevilleCity of Idaho Falls

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No. 73Primary Registration District No. 21470

(No. _____)

(St. _____)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 11948Registered No. 10

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15. Filed

1923

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw her alive on

and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

12/4/1922

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully applied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED
MAY 12 1923
BUREAU OF VITAL STATISTICS
STATE OF IDAHO

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Camuel
City of Idaho Falls

Registration District No. 23
Primary Registration District No. 2150
No. 7

File No. 4195
Registered No. 7

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary C. Anderson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widow
(Write the word.)

6. DATE OF BIRTH Feb 9 1837
(Month) (Day) (Year)

7. AGE 86 Yrs. 0 Mos. 13 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION at Home
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE Sweden
(State or Country)

10. NAME OF FATHER Andrew Bergren

11. BIRTHPLACE OF FATHER Sweden
(State or Country)

12. MAIDEN NAME OF MOTHER ?

13. BIRTHPLACE OF MOTHER Sweden
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Andrew Anderson
(Address) Idaho Falls

15. Filled Mardik 19 23 W. Finmark
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 22 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1st 1920, to Feb 22 1923
that I last saw her alive on Feb 12 1923
and that death occurred on the date stated above, at 5:30 P. M.

The CAUSE OF DEATH* was as follows:

Endocarditis

(Duration) Yrs. mos. ds.
Contributory (Secondary)

(Duration) yrs. mos. ds.
(Signed) A. P. Soderquist M. D.
19 23 (Address) Idaho Falls Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Idaho Falls DATE OF BURIAL 7/27 1923

20. UNDERTAKER W. Finmark ADDRESS Idaho Falls

A. P. Soderquist

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

1. PLACE OF DEATH. **RECEIVED**
Registration District No. 27-1923
County of Goodhue Primary Registration District No. 27-1923
City of Wendell (St.)
BEAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Rebecca Bishop

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 42012

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED. Widowed
(Write the word.)

6. DATE OF BIRTH.

April 1 1840
(Month) (Day) (Year)

7. AGE

82 Yrs. 7 Mos. 20 ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

Housewife

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

Isaac Wickersham

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Eliza Lister

13. BIRTHPLACE OF MOTHER

(State or Country)

Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

J. C. Wickersham

(Address)

15. Filed

Nov 21 1922E. J. Sinton

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 21 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Nov 18 1922, to Nov 21 1922,
that I last saw h. or alive on Nov 18 1922,
and that death occurred on the date stated above, at 1 A. M.
The CAUSE OF DEATH* was as follows:

Inanition(Duration) Yrs. 4 mos. ds.Contributory Old age
(Secondary)

(Duration) yrs. mos. ds.

(Signed) _____ M. D.

19. (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Wendell

DATE OF BURIAL

Nov 22 1922

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED CERTIFICATE OF DEATH.

1. PLACE OF DEATH.

County of *Lethe*City of *Driggs*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

JUN 4 1922

BUREAU OF VITAL STATISTICS

Registration District No. *77*Registration District No. *2176*

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

*42115*Registered No. *17*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

*Female**White**Single*

6. DATE OF BIRTH.

*April 17 1922**Single*

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many... hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....*Infant.*

9. BIRTHPLACE

(State or Country)

Driggs, Ida.

10. NAME OF FATHER

Arthur Weston Smith

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Elvira Liddiard

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Arthur W. Smith

(Address)

Driggs, Ida.

15.

Filed

5/10/

1922

Martha Marker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

*April 17 1922**151a*

17. I HEREBY CERTIFY, That I attended deceased from

April 17 1922 to *April 17 1922*
that I last saw him alive on *April 17 1922*
and that death occurred on the date stated above, at *6:15 P.M.*

The CAUSE OF DEATH* was as follows:

Premature

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) *Chas. Martin* M. D.*4/17/1922* (Address) *Driggs, Ida.*

*State the DISEASE*CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Driggs, Ida**4/17/ 1922*

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

42136

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Shoshone*City of *Kellogg*

If death occurs away from usual residence, give facts called for under special information.

Registration District No. *123*

Primary Registration District No. _____

(No. _____ St.)

File No. *42136*Registered No. *9*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Geo. J. Savich

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-OWED OR DIVORCED

m. white single
(Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year) *1886*

7. AGE

36 Yrs. ____ Mos. ____ ds.IF LESS than 1 day
how many ____ hrs.
or ____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)*miner*

9. BIRTHPLACE

(State or Country)

Servia

10. NAME OF FATHER

No inf

11. BIRTHPLACE OF FATHER

(State or Country)

Servia

12. MAIDEN NAME OF MOTHER

No inf

13. BIRTHPLACE OF MOTHER

(State or Country)

Servia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

*M. P. Thornhill
Kellogg, Ida.*15. *June 30 / 1933*
Filed *E. E. Hardy*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 3 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____, 19____, to _____ 19____
that I last saw *him* alive on _____ 19____
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

*Household accident
died at 3:30 PM
of head injury
from fall from
ladder*Contributory
(Secondary)

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed)

_____, 19____ (Address)

*State the Disease Causing Death; or in deaths from violent causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Kellogg, Idaho *April 15 1923*

20. UNDERTAKER

ADDRESS

M. P. Thornhill *Kellogg, Ida*

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Washington
City of WenatcheeRegistration District No. 1010
Primary District No. 1010

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

George W. PhillipsState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 42584Registered No. 42584

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE WHR 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH

Oct. 15 1841
(Month) (Day) (Year)

7. AGE

75 Yrs. 11 Mos. 28 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Farmer

9. BIRTHPLACE

(State or Country)

Del.

10. NAME OF FATHER

Jerome Phillips

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

G. W. Phillips
Wenatchee

15.

Filed

10/17/1922H. G. Hamilton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

10 13 22
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from 8/13 1922 to 10/13 1922that I last saw him alive on 10/12 1922
and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris(Duration) _____ yrs. _____ mos. _____ ds.
Contributory (Secondary) Anterior Sclerosis(Duration) 3 yrs. 7 mos. _____ ds.(Signed) Guarino Fringer M. D.10/17/1922 (Address) Wenatchee, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL OF BURIAL

Durkee, Ore 1922

20. UNDERTAKER

ADDRESS

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED

CERTIFICATE OF DEATH

Registration District No.

BUREAU OF VITAL STATISTICS

No.

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 42596

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married

(Write the word.)

6. DATE OF BIRTH

Oct 16

(Month)

(Day)

1874

(Year)

7. AGE

47

Yrs.

11

Mos.

ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

House Wife

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Bd Boston

10. NAME OF FATHER

Jack Gibbs

11. BIRTHPLACE OF FATHER

(State or Country)

Pew

12. MAIDEN NAME OF MOTHER

Martha Baker

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs J. Gibbs

(Address)

15.

Filed

May 31 1923

Mrs E. S. Robinson

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 1

(Month)

18

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19

to

19

that I last saw him alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

19 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Placerville

DATE OF BURIAL

Oct 18 1922

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Portland District No. 45
City of Spirit Lake Registration District No. _____
St.)File No. 42951

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

James McWane

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH.

June 27 1837
(Month) (Day) (Year)

7. AGE

84 Yrs. 10 Mos. 28 ds.IF LESS than 1 day
how many _____ hrs. or
_____ min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).....Retired

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. A. Russell

(Address)

Spirit Lake

15.

Filed

7/251922

Local Registrar

16. DATE OF DEATH

May 21 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from May 15 1922 to May 21 1922that I last saw him alive on May 15 1922
and that death occurred on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:

Senile debility(Duration) several Yrs. _____ mos. _____ ds.Contributory
(Secondary)

(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed)

Earl J. Davis, M. D.5-24 1922 (Address) Spirit Lake, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Spirit Lake, Ida.5/21/22

20. BURIAL

ADDRESS

C. L. CassidyPathdown

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **42955**

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Kootenai
City of Spout LakeRegistration District No. 45RECEIVED
AUG 31 1922BUREAU OF VITAL
STATISTICS

2. FULL NAME

Warren Franklin Potter

If death occurs away from usual residence, give facts called for under special information.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

March
(Month)1
(Day)1856
(Year)

7. AGE

66 yrs. 6 mos. 29 ds.IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....Blacksmith

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

Sidney Potter

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MARRIAGE NAME OF MOTHER

Abel Gilden

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. W. F. Potter(Address) S. Lake Id.

15.

Filed 9/291922 Warren Idaho

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

9
(Month)29
(Day)1922
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept. 26 1922 to Sept. 29 1922that I last saw him alive on Sept. 26 1922and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration)

0 yrs. 0 mos. 3 ds.Contributory
(Secondary)Influenza

(Duration)

0 yrs. 14 mos. 14 ds.

(Signed)

E. W. Martin M. D.9-30-1922 (Address) Spout Lake Idaho

*State the DISEASE CAUSING DEATH; or in death from VIOLENT CAUSE, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Spout Lake CemeteryOct 1 1922

20. UNDERTAKER

ADDRESS

E. L. CassidyRathdrum Id.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

42957

1. PLACE OF DEATH
County of *Kootenai* Registration District No. *155*
City of *Spur Lake* (No. of VITAL STATISTICS) St.)

File No. *42957*
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Tredous Milton Jakobson*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. *Single*
(Write the word.)

6. DATE OF BIRTH. *Oct 15 1920*
(Month) (Day) (Year)

7. AGE *1 Yrs. 11 Mos. 23 ds.* IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Cora Jakobson*
(Address) *Spur Lake, Idaho*

15.

Filed *10/8 1922* Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *10 8 1922*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *191* to *191*, that I last saw him alive on *191* and that death occurred on the date stated above, at *M.* The CAUSE OF DEATH* was as follows:

(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) M. D.
19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED

CERTIFICATE OF DEATH.

1. PLACE OF DEATH.

SEP 6 1923
BUREAU OF VITAL STATISTICS

Registration District No. 87

County of WashingtonCity of Frederick

(No.)

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

MinnieRoeState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **43029**

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.FemaleWhiteSingle (No word.)

6. DATE OF BIRTH.

May71922

(Month)

(Day)

(Year)

7. AGE

Yrs. 12 Mos. 12 ds.IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work...
(b) General nature of in-
dustry, business, or estab-
lishment in which employ-
ed (or employer).....

9. BIRTHPLACE

(State or Country)

Idaho10. NAME OF
FATHERHerb Roe11. BIRTHPLACE
OF FATHER

(State or Country)

Idaho12. MAIDEN NAME
OF MOTHERGrace O'Leary13. BIRTHPLACE
OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Leonora Adams

(Address)

Weiser Idaho

15.

Filed

5-19-1922F. A. Schmidt

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May

(Month)

19

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 7 - 1922 to May 14, 1922that I last saw him alive on May 9, 1922and that death occurred on the date stated above, at 4 A. M.

The CAUSE OF DEATH* was as follows:

acute indigestion

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FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of **Donner**
City of **Laclede**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Theodore**Ahlkog**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WID-OWED OR DIVORCED

Single

(Write the word.)

6. DATE OF BIRTH

June 12

(Month)

(Day)

1906

(Year)

7. AGE

16

Yrs.

4

Mos.

14

ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

High school student

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho.

10. NAME OF FATHER

Matz Ahlskog

11. BIRTHPLACE OF FATHER

(State or Country)

Finland

12. MAIDEN NAME OF MOTHER

Marie Osterback

13. BIRTHPLACE OF MOTHER

(State or Country)

Finland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Bernard Ahlskog

(Address)

Laclede, Idaho

15.

Filed

Sept 20 1923**Viola Allen**

Local Registrar

DeputyRECEIVED
007-8-1923
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. **78**Primary Registration District No. **2155**

(No.)

(St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **43154**

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept

(Month)

26

(Day)

1922

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 2619 **22**to **Sept 26**19 **22**that I last saw him alive on **Sept 26**19 **22**and that death occurred on the date stated above, at **6:45 P.**

The CAUSE OF DEATH* was as follows:

Acute Dillitation of the Heart.

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

C. F. Getzloff

M. D.

Sept 27 1922

(Address)

Priest River, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho, Hach.**9/28 1922**

20. UNDERTAKER

ADDRESS

MOON & DALE Sandpoint, Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **43239**

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Boading District No. 22
City of Wendell Registration District No. 2018 St.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED
OCT 13 1922
BUREAU OF VITAL STATISTICSHerbert W Stickle

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

married
(With the world.)

6. DATE OF BIRTH

Apr 28 1852
(Month) (Day) (Year)

7. AGE

70 Yrs. 2 Mos. 26 ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Brick Mfg & farmer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

New York

10. NAME OF FATHER

Joshua

11. BIRTHPLACE OF FATHER

(State or Country)

New York

12. MAIDEN NAME OF MOTHER

Mary Ellis

13. BIRTHPLACE OF MOTHER

(State or Country)

New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J J Stickle
Wendell Ida

15. Filed

July 25 1922 E L Smanton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 24 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 11 1922 to July 24 1922that I last saw him alive on July 24 1922and that death occurred on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) E L Smanton M. D.7-25 1922 (Address) Wendell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Ripley Minn19

20. UNDERTAKER

ADDRESS

L. H. HirsmanJerome Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of CwyheeCity of Bruneau

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No. 44

(No. St.)

File No. 44202

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME David Brown Hyde

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH.

August 12 1853
(Month) (Day) (Year)

7. AGE

68 Yrs. 9 Mos. 1 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....Hotel proprietor

9. BIRTHPLACE

(State or Country)

Rome N. Y.

10. NAME OF FATHER

Jacob Hyde

11. BIRTHPLACE OF FATHER

(State or Country)

Alsace France

12. MAIDEN NAME OF MOTHER

Elizabeth Baker

13. BIRTHPLACE OF MOTHER

(State or Country)

Alsace France

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Michael Hyde(Address) Bruneau, Ida

15.

Filed June 13 1923 W. H. Becker

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 13 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 1921 to June 13 1922that I last saw him alive on June 11 1922and that death occurred on the date stated above, at 11:00 P. M.

The CAUSE OF DEATH* was as follows:

Cancer of face beginning in lower lip(Duration) 5 Yrs. mos. ds.Contributory Smoking & irritation of pipe stem
(Secondary)

(Duration) yrs. mos. ds.

(Signed) W. H. Becker M. D.19. (Address) Bruneau, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bruneau 6-15 1922

20. UNDERTAKER

ADDRESS

A. W. Conover Intn Home

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

46231

Registered No. 4

1 PLACE OF DEATH

County Nez Perce

State Idaho

Township

or Village

City Nez Perce Reservation

No.

St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Three Feathers

(a) Residence. No. Sweetwater, Idaho St., Ward.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE, MARRIED, WIDOWED,
OR DIVORCED (write the word)

Male

Indian

Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Yohoe

6 DATE OF BIRTH (month, day, and year)

1841

7 AGE

Years

Months

Days

If LESS than
1 day, --- hrs.
or --- min.

81

8 OCCUPATION OF DECEASED

Invalid

(a) Trade, profession, or
particular kind of work

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

Nez Perce Res.

(State or country)

Idaho

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant

(Address)

15

Filed

12, 19

Carbitt Langer

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13, 1922

17

I HEREBY CERTIFY, That I attended deceased from

_____, 19____, to _____, 19____,

that I last saw him _____ alive on _____, 19____,

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Old Age

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY

(SECONDARY)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) Carbitt Langer Lease Clerk
_____, 19 (Address) Lapwai, Idaho

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL

Indian Cemetery

DATE OF BURIAL

6-14-22

19

20 UNDERTAKER Wann-Lapwai, Idaho ADDRESS

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

16232 Registered No. 3

1 PLACE OF DEATH
County Nez Perce State Idaho
Township _____ or Village _____ or
City Nez Perce Reservation No. _____ St. _____ Ward _____
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Kah lu la son my (Mrs. John Miles)

(a) Residence. No. Cottonwood Creek, Idaho St. _____ Ward _____
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Indian 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5a If married, widowed, or divorced
HUSBAND of John Miles
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1851

7 AGE Years 71 Months _____ Days _____ If LESS than 1 day, ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House Invalid

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Ind. Res.
(State or country) Idaho

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) _____
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) _____
(State or country)

14 Informant _____
(Address)

15 Filed 10-4 1922 Lambert Langer
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 24, 1922

17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____,

that I last saw h_____ alive on _____, 19____,

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Old Age

CONTRIBUTORY
(SECONDARY)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) Lambert Langer Lease Clerk M. D.
, 19 (Address) Lapwai, Idaho

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Ind. Cemetery DATE OF BURIAL Oct. 25, 22 19

20 UNDERTAKER None ADDRESS _____

MARGIN RESERVED FOR BINDING

5-200 d

V. S. No. 98

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1 PLACE OF DEATH
County Nez Perce State Idaho
Township _____ or Village _____ or
City Nez Perce Reservation No. _____ St. _____ Ward _____
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Emma Ipnotkine

(a) Residence. No. Kamiah, Idaho St. _____ Ward _____
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Indian 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single
5a If married, widowed, or divorced HUSBAND of (or) WIFE of _____
6 DATE OF BIRTH (month, day, and year) 1834
7 AGE Years 88 Months _____ Days _____ If LESS than 1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Invalid
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9 BIRTHPLACE (city or town) Ind. Res.
(State or country) Idaho

10 NAME OF FATHER Unknown
11 BIRTHPLACE OF FATHER (city or town) _____
(State or country) _____
12 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (city or town) _____
(State or country) _____

14 Informant _____
(Address) _____
15 Filed 6/2/22, 19 Carbitt Lawyer
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1, 1922

17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____,

that I last saw h_____ alive on _____, 19____,
and that death occurred, on the date stated above, at _____m.

The CAUSE OF DEATH* was as follows:

Old Age

_____ (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(SECONDARY)

_____ (duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
if not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) Carbitt Lawyer Lease Clerk M. D.
, 19 (Address) Lapwai, Idaho

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Indian Cemetery DATE OF BURIAL 6-2-1922
20 UNDERTAKER C. J. Johnson - Kamiah, Ida. ADDRESS _____

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1 PLACE OF DEATH
County Nez Perce State Idaho Registered No. 2
Township _____ or Village _____
City Nez Perce Reservation No. _____ St., _____ Ward _____
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Susie Pe tal wa ta lote(a) Residence. No. Cottonwood Creek, Idaho Ward. _____
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Indian 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) 1841

7 AGE Years Months Days If LESS than 1 day, --- hrs. or --- min.
81

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Nez Perce Res.
(State or country) Idaho10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) _____
(State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) _____
(State or country)

14

Informant _____
(Address)

15

Filed 6/1/22 Cassitt Lawyer REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2, 1922

17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____,

that I last saw h_____ alive on _____, 19____,

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Old Age

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(SECONDARY)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) Cassitt Lawyer Lease Clerk
M. D. _____
, 19 (Address) La Pwai, Idaho

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL
Indian Cemetery - 6-3-2220 UNDERTAKER Wann-Lapwai, Idaho ADDRESS _____
19

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS10035
Registered No. 3

1 PLACE OF DEATH
County Nez Perce State Idaho
Township _____ or Village _____ or
City Nez Perce Reservation No. _____ St., _____ Ward _____
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Nelson Red Duck
(a) Residence. No. Lapwai, Idaho St., _____ Ward _____
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Indian 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1906
7 AGE Years 16 Months _____ Days _____ If LESS than 1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Invalid
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Nez Perce Res.
(State or country) Idaho

10 NAME OF FATHER Andrew Red Duck
11 BIRTHPLACE OF FATHER (city or town) Nez Perce Res.
(State or country) Idaho
12 MAIDEN NAME OF MOTHER Sophia Moore
13 BIRTHPLACE OF MOTHER (city or town) Nezperce Res
(State or country) Idaho

14 Informant _____
(Address) _____

15 Filed 4/1/22, 19 Leah L. Lawrence
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1, 1922 19

17 I HEREBY CERTIFY, That I attended deceased from

_____, 19_____, to _____, 19_____,
that I last saw h_____ alive on _____, 19_____,
and that death occurred, on the date stated above, at _____m.

The CAUSE OF DEATH* was as follows:

Tuberculosis

_____, (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(SECONDARY)

_____, (duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) Leah L. Lawrence Lease Clerk, M. D.
_____, 19 _____ (Address) Lapwai, Idaho

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Indian Cemetery DATE OF BURIAL 6-2-22

20 UNDERTAKER Wann-Lapwai, Idaho ADDRESS _____

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

40237 /
Registered No.

1 PLACE OF DEATH

County NezPerce

State Idaho

Township _____

or Village _____

City NezPerce Reservation

No. _____

St., _____

Ward _____

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME We yants kone my

(a) Residence. No. Lapwai, Idaho

St., _____

Ward. _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE, MARRIED, WIDOWED,
OR DIVORCED (write the word)

Female

Indian

Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1885

7 AGE

Years

Months

Days

IF LESS than
1 day, --- hrs.
or --- min.

37

8 OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work

Housekeeper

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

Ind. Res.

(State or country)

Idaho

PARENTS

10 NAME OF FATHER

Joe Albert

11 BIRTHPLACE OF FATHER (city or town)

Ind. Res.

(State or country)

Idaho

12 MAIDEN NAME OF MOTHER

Ahtims

13 BIRTHPLACE OF MOTHER (city or town)

Ind. Res.

(State or country)

Idaho

14

Informant

(Address)

15

Filed

10/1, 19

Leaheth Lawyer

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

12-9-22

19

17

I HEREBY CERTIFY, That I attended deceased from

_____, 19_____, to _____, 19_____,

that I last saw h_____ alive on _____, 19_____,

and that death occurred, on the date stated above, at _____m.

The CAUSE OF DEATH* was as follows:

Influenza

CONTRIBUTORY
(SECONDARY)

(duration) _____ yrs. _____ mos. _____ ds.

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis?

(Signed) Leaheth Lawyer, M. D.

, 19 (Address)

Lease Clerk

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL

Ind. Cemetery

DATE OF BURIAL

12-10-22

20 UNDERTAKER

Wann - Lapwai, Idaho

ADDRESS

MARGIN RESERVED FOR BINDING

8-200 d

V. S. No. 98

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

46238 Registered No. 2

1 PLACE OF DEATH
County Nez Perce State Idaho
Township _____ or Village _____ or
City NezPerce Reservation No. _____ St. _____ Ward _____
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME James Hayes
(a) Residence. No. Lapwai Idaho St. _____ Ward. _____
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Indian 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5a If married, widowed, or divorced
HUSBAND of Emma Williams
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE Years Months Days If LESS than 1 day, hrs. or min.
57

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Ind. Res.
(State or country) Idaho

PARENTS
10 NAME OF FATHER Thuslimhihi
11 BIRTHPLACE OF FATHER (city or town) Ind. Res.
(State or country) Idaho
12 MAIDEN NAME OF MOTHER Michsono
13 BIRTHPLACE OF MOTHER (city or town) Ind. Res.
(State or country) Idaho

14 Informant _____
(Address) _____

15 Filed 1-1-19 Carbott Langer REGISTRAR
11-3184

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 22, 1922 19

17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____,

that I last saw him alive on _____, 19____,

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

pneumonia

No physician

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) Carbott Langer, M. D.

, 19 (Address) Lease Clerk

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Ind. Cemetery - Dec. 23, 1922 DATE OF BURIAL 19

20 UNDERTAKER Wann-Lapwai, Idaho ADDRESS

MARGIN RESERVED FOR BINDING

8-220 d
V. S. No. 98

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

46239

Registered No. 3

1 PLACE OF DEATH
County Nez Perce State Idaho
Township Indian reservation or Village _____ or
City _____ No. _____ St. _____ Ward _____
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Louisa Pablo (minor)

(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Indian 1/4 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

5a If married, widowed, or divorced
HUSBAND of _____
(or) WIFE of _____

6 DATE OF BIRTH (month, day, and year) 1921

7 AGE Years 1 Months _____ Days _____ If LESS than 1 day, --- hrs. or --- min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Indian Reservation
(State or country) Idaho

10 NAME OF FATHER John Pablo
11 BIRTHPLACE OF FATHER (city or town) Ind Res
(State or country) Idaho
12 MAIDEN NAME OF MOTHER Julia Webb
13 BIRTHPLACE OF MOTHER (city or town) Indian Res
(State or country)

14 Informant J. J. GUYER
(Address) Kamiah, Ida

15 Filed 1-26-22 19 Carlott Sawyer
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-26-22 19

17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____,

that I last saw h----- alive on _____, 19____,

and that death occurred, on the date stated above, at _____m.

The CAUSE OF DEATH* was as follows:

unknown (no physician)

----- (duration) ----- yrs. ----- mos. ----- ds.

CONTRIBUTORY (SECONDARY)

----- (duration) ----- yrs. ----- mos. ----- ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) Carlott Sawyer Lease clk, M. D.
, 19 (Address) Lapwai, Idaho.

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Indian cemetery DATE OF BURIAL 1-27-22 19

20 UNDERTAKER Trennary, Kooskia, Idaho. ADDRESS

MARGIN RESERVED FOR BINDING

8-2009 d
V. 61, No. 98

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1 PLACE OF DEATH

County Nez Perce State Idaho
 Township Indian reservation or Village _____ or
 City _____ No. _____ St. _____ Ward _____
 (If death occurred in a hospital or institution, give its NAME instead of street and number)

46240
Registered No. 22 FULL NAME Frank Bronche

(a) Residence. No. _____ St. _____ Ward _____
 (Usual place of abode)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Indian 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5a If married, widowed, or divorced HUSBAND of Mary Ann Bronche (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1857

7 AGE Years Months Days If LESS than 1 day, --- hrs. or --- min.
65

8 OCCUPATION OF DECEASED Farmer

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Indian Reservation
 (State or country) Idaho

10 NAME OF FATHER Bronche (Frenchman)

11 BIRTHPLACE OF FATHER (city or town) unknown
 (State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) _____
 (State or country)

14 Informant Mary Ann Bronche
 (Address) Culdesac, Idaho.

15 Filed 1-8-22, 19 Carlott Sawyer
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-8-22 19

17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____,

that I last saw h----- alive on _____, 19____,

and that death occurred, on the date stated above, at _____m.

The CAUSE OF DEATH* was as follows:

Pneumonia

_____ (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
 (SECONDARY)

_____ (duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
 if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) Carlott Sawyer Lease Clerk, M. D.
 , 19 (Address) Lapwai, Idaho

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Indian cemetary DATE OF BURIAL 1-9-22 19

20 UNDERTAKER Wann, Lapwai, Idaho. ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1 PLACE OF DEATH
County Nez Perce State Idaho Registered No. 10244 1
Township Indian reservation or Village _____ or
City _____ No. _____ St. _____ Ward _____
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Weyaotwy Spaulding

(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Indian $\frac{3}{4}$ 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

5a If married, widowed, or divorced
HUSBAND of Thomas Spaulding
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years 77 Months _____ Days _____ If LESS than 1 day, — hrs. or — min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Indian reservation
(State or country) Idaho

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) unknown
(State or country)

14 Informant James Spaulding
(Address) Lenore, Idaho.

15 Filed 1-7-22 19 Carlott Sawyer
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-6-22 19 19

17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____,

that I last saw h----- alive on _____, 19____, and that death occurred, on the date stated above, at _____m.

The CAUSE OF DEATH* was as follows:

Pneumonia

_____ (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(SECONDARY)

18 Where was disease contracted (duration) _____ yrs. _____ mos. _____ ds.
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) Carlott Sawyer Lease Clerk, M. D.
, 19 (Address) Lapwai, Idaho.

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Indian cemetery DATE OF BURIAL 1-8-22 19 19

20 UNDERTAKER Wann, Lapwai, Idaho. ADDRESS _____

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1 PLACE OF DEATH
County Nez Perce State Idaho Registered No. 1
Township Indian Reservation or Village _____ or
City _____ No. _____ St. _____ Ward _____
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME ROSA PAUL

(a) Residence. No. _____ St. _____ Ward. _____
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX FEMALE 4 COLOR OR RACE Indian 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1905

7 AGE Years Months Days If LESS than 1 day, ---- hrs. or ---- min.
17

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Indian res
(State or country)

10 NAME OF FATHER Jesse Paul

11 BIRTHPLACE OF FATHER (city or town) Indian Res
(State or country) Idaho

12 MAIDEN NAME OF MOTHER Lydia Conditt

13 BIRTHPLACE OF MOTHER (city or town) Indian res
(State or country) Lapwai, Idaho

14 Informant Jesse Paul
(Address) Rebrens Idaho

15 Filed 2-12-22 10:11 AM 19 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-11-1922 19

17 I HEREBY CERTIFY, That I attended deceased from

_____, 19____, to _____, 19____,

that I last saw him alive on _____, 19____,

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

heart failure

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(SECONDARY)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) Lease Clk, M. D.
_____, 19 (Address) Lapwai, Idaho

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Indian cemetery DATE OF BURIAL 2-12-22 19
20 UNDERTAKER Wann, Lapwai, I ADDRESS _____

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

46246 Registered No. 1

1 PLACE OF DEATH
County Nez Perce State Idaho
Township _____ or Village _____ or
City NezPerce Reservation No. _____ St. _____ Ward _____
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Dorothy Henry
(a) Residence. No. Lapwai, Idaho St. _____ Ward. _____
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred _____ yrs. mos. ds. How long in U. S., if of foreign birth? _____ yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Indian 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

5a If married, widowed, or divorced
HUSBAND of _____
(or) WIFE of _____

6 DATE OF BIRTH (month, day, and year) 1918

7 AGE Years 4 Months _____ Days _____ If LESS than 1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Lapwai, Idaho
(State or country)

10 NAME OF FATHER John Henry
11 BIRTHPLACE OF FATHER (city or town) Nezperce Res
(State or country) Idaho
12 MAIDEN NAME OF MOTHER Tomnee James
13 BIRTHPLACE OF MOTHER (city or town) Nezperce Res
(State or country) Idaho

14 Informant _____
(Address) _____

15 Filed 9/6/22, 19 Carbeth Lawyer
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 5, 22 19

17 I HEREBY CERTIFY, That I attended deceased from

_____, 19_____, to _____, 19_____,

that I last saw h_____ alive on _____, 19_____,

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

_____, 19_____, (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(SECONDARY)

_____, 19_____, (duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) Carbeth Lawyer Lease Clerk

, 19 (Address) Lapwai, Idaho

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Indian Cemetery DATE OF BURIAL Sept. 6, 1922 19

20 UNDERTAKER Wann-Lapwai, Idaho ADDRESS _____

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1 PLACE OF DEATH
County Nez Perce State Idaho Registered No. 10247
Township _____ or Village _____ or
City Nez Perce Indian Reservation No. _____ St., _____ Ward _____
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Amelia John
(a) Residence. No. Stites, Idaho St., _____ Ward. _____
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Indian 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widow

5a If married, widowed, or divorced
HUSBAND of Divorced
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1890

7 AGE _____ Years _____ Months _____ Days _____ If LESS than 1 day, _____ hrs. or _____ min.
32

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Invalid

(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Nezperce Res.
(State or country) Idaho

PARENTS
10 NAME OF FATHER Moosmoos John
11 BIRTHPLACE OF FATHER (city or town) Nezperce Res
(State or country) Idaho
12 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (city or town) _____
(State or country)

14 Informant _____
(Address) _____

15 Filed 9/14/22, 19 Carbott Lawyer
REGISTRAR
11-3184

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 14, 1922

17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____,

that I last saw h_____ alive on _____, 19____,

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Did not recover from operation

CONTRIBUTORY (SECONDARY)

_____ (duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted

If not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) Carbott Lawyer Lease Clerk

, 19 (Address) Lapwai, Idaho

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

Indian Cemetery - Sept. 15, 1922

20 UNDERTAKER ADDRESS

Geo. W. T. renary - Kamiah, Ida

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1 PLACE OF DEATH
County Nez Perce State Idaho Registered No. 46248 3
Township _____ or Village _____ or
City Nez Perce Reservation No. _____ St. _____ Ward _____
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Lucy Bronche
(a) Residence. No. Culdesac, Idaho St. _____ Ward. _____
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Indian 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5a If married, widowed, or divorced
HUSBAND of James Eagle Boy
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE Years Months Days If LESS than 1 day, --- hrs. or --- min.
51

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Nez Perce Res.
(State or country) Idaho

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant
(Address)

15 Filled Sept. 29, 1922 Carbett Lawyer
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 28, 1922

17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____,

that I last saw h----- alive on _____, 19____,

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

CONTRIBUTORY
(SECONDARY)

(duration) ----- yrs. ----- mos. ----- ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? ----- Date of -----

Was there an autopsy? -----

What test confirmed diagnosis? -----

(Signed) Carbett Lawyer Lease Clerk

, 19 (Address) Lapwai, Idaho

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS and NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Indian Cemetery - Sept. 29, 1922 DATE OF BURIAL 19

20 UNDERTAKER Wann-Lapwai, Idaho.

ADDRESS

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

46249

Registered No. 4

1 PLACE OF DEATH
County Nez Perce State Idaho
Township _____ or Village _____ or
City Nez Perce Reservation St. _____ Ward _____
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME E we nun my (Mrs. Ned Webb)
(a) Residence. No. Sweetwater, Idaho St. _____ Ward _____
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Indian 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5a If married, widowed, or divorced
HUSBAND of Edward Webb
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE Years 58 Months _____ Days _____ If LESS than 1 day, hrs. _____ or min. _____

8 OCCUPATION OF DECEASED Housekeeper

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Nezperce Res.
(State or country) Idaho

10 NAME OF FATHER Halfmoon

11 BIRTHPLACE OF FATHER (city or town) Nezperce Res
(State or country) Idaho

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) _____
(State or country)

14 Informant _____
(Address) _____

15 Filed 11/11/22, 19 Carbott Lawyer
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 28, 1922

17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____,

that I last saw h_____ alive on _____, 19____,

and that death occurred, on the date stated above, at _____m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

_____ (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(SECONDARY)

_____ (duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

• What test confirmed diagnosis? _____

(Signed) Carbott Lawyer Lease, Clerk

, 19 (Address) Lapwai, Idaho

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Indian Cemetery DATE OF BURIAL 9-28-22 19

20 UNDERTAKER Wann - Lapwai, Idaho ADDRESS _____

MARGIN RESERVED FOR BINDING

8-200 d

V. S. No. 28

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

46259

Registered No. 1

1 PLACE OF DEATH

County Nez Perce

State Idaho

Township _____

or Village _____

City Nez Perce Reservation

St. _____ Ward _____

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Mary Ann Tababoo

(a) Residence. No. Webb, Idaho

St. _____ Ward _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Indian

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1913

7 AGE

Years

Months

Days

If LESS than
1 day, --- hrs.
or --- min.

10

8 OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

Nez Perce Res.

(State or country)

Idaho

10 NAME OF FATHER

John Alexis Tababoo

11 BIRTHPLACE OF FATHER (city or town)

Ind. Res.

(State or country)

Idaho

12 MAIDEN NAME OF MOTHER

Elizabeth Bronche

13 BIRTHPLACE OF MOTHER (city or town)

Ind. Res.

(State or country)

Idaho

14

Informant

(Address)

15

Filed

10/8

1922

Garbett Langer

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

10/8/1922 19

17

I HEREBY CERTIFY, That I attended deceased from

_____, 19____, to _____, 19____,

that I last saw h_____ alive on _____, 19____,

and that death occurred, on the date stated above, at _____m.

The CAUSE OF DEATH* was as follows:

pneumonia

CONTRIBUTORY

(SECONDARY)

(duration) _____ yrs. _____ mos. _____ ds.

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) Garbett Langer, M. D.

_____, 19____ (Address) Lapwai, Idaho

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL

Ind. Cemetery

DATE OF BURIAL

10-9-22 19

20 UNDERTAKER

Wann, Lapwai, Idaho

ADDRESS

MARGIN RESERVED FOR BINDING

8-2004

V. S. No. 98

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1 PLACE OF DEATH
County Nez Perce State Idaho Registered No. 40260 2
Township _____ or Village _____ or
City NezPerce Reservation No. _____ St. _____ Ward _____
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Howard Bronche
(a) Residence. No. Lapwai, Idaho St. _____ Ward _____
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Indian 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single
5a If married, widowed, or divorced HUSBAND of (or) WIFE of _____
6 DATE OF BIRTH (month, day, and year) 1920
7 AGE Years 3 Months _____ Days _____ If LESS than 1 day, --- hrs. or --- min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9 BIRTHPLACE (city or town) NezPerce Res.
(State or country) Idaho

10 NAME OF FATHER Alex Bronche
11 BIRTHPLACE OF FATHER (city or town) Ind. Res.
(State or country) Idaho
12 MAIDEN NAME OF MOTHER Susan Lawyer
13 BIRTHPLACE OF MOTHER (city or town) Ind. Res.
(State or country) Idaho

14 Informant _____
(Address) _____

15 Filed 1920, 19 20 Leaheth Lawyer
REGISTRAR
11-3184

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 18, 1922

17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____,
that I last saw h_____ alive on _____, 19____,
and that death occurred, on the date stated above, at _____ m.
The CAUSE OF DEATH* was as follows:
pneumonia

CONTRIBUTORY (SECONDARY)

(duration) _____ yrs. _____ mos. _____ ds.
18 Where was disease contracted _____
if not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) Leaheth Lawyer, M. D.
, 19 (Address) Lease Clerk

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Ind. Res. Cemetery DATE OF BURIAL 10-18-22
20 UNDERTAKER _____ ADDRESS _____

N one

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

46261

Registered No. 2

1 PLACE OF DEATH

County Nez Perce

State Idaho

Township _____

or Village _____

City Nez Perce Indian Reservation

St. _____ Ward _____

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Rose Bronche

(a) Residence. No. Culdesac, Idaho St. _____ Ward _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Indian

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1845

7 AGE

Years

Months

Days

If LESS than

1 day, --- hrs.

or --- min.

77

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

Ind. Res.

(State or country)

Idaho

PARENTS

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant

(Address)

15

Filed

19

Leah H. Lawyer
REGISTRAR

11-3184

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 18, '22 19

17 I HEREBY CERTIFY, That I attended deceased from

_____, 19____, to _____, 19____,

that I last saw h_____ alive on _____, 19____,

and that death occurred, on the date stated above, at _____m.

The CAUSE OF DEATH* was as follows:

Old age

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) Leah H. Lawyer, M. D.

, 19 (Address)

Lease Clk.

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL

Ind. Cemetery

DATE OF BURIAL

11-19-22 19

20 UNDERTAKER

None

ADDRESS

MARGIN RESERVED FOR BINDING

5-220 d

V. S. No. 98

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

46262
Registered No. 4

1 PLACE OF DEATH

County ~~Idaho~~ Nez Perce State Idaho
Township _____ or Village _____ or
City Nez Perce Reservation No. _____ St. _____ Ward _____
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME George Sapniss

(a) Residence. No. Lapwai, Idaho St. _____ Ward _____
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Indian 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5a If married, widowed, or divorced HUSBAND of Maggie Grant (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1846

7 AGE Years 76 Months Days If LESS than 1 day, --- hrs. or --- min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Invalid

(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Ind. Res. (State or country) Idaho

10 NAME OF FATHER Unknown
11 BIRTHPLACE OF FATHER (city or town) (State or country)
12 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address)

15 Filed 1916 Carbett Lawyer REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 26, 1922

17 I HEREBY CERTIFY, That I attended deceased from

, 19____, to _____, 19____,
that I last saw h_____ alive on _____, 19____,

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

pneumonia - old age

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted If not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) Carbett Lawyer, M. D.

, 19 (Address) Lease Clerk

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Indian Cemetery - DATE OF BURIAL 10-27-'22 19

20 UNDERTAKER Wann-Lapwai, Idaho ADDRESS

MARGIN RESERVED FOR BINDING

N. B.--WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS46263
Registered No. 1

1 PLACE OF DEATH

County Idaho Nez Perce State Idaho
 Township _____ or Village _____ or
 City Nez Perce Reservation No. _____ St. _____ Ward _____
 (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Rose Webb

(a) Residence. No. Sweetwater, Idaho St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Indian 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

5a If married, widowed, or divorced
 HUSBAND of
 (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1895

7 AGE Years Months Days If LESS than 1 day, _____ hrs. or _____ min.
26

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Ind. Res.
 (State or country) Idaho

10 NAME OF FATHER Edward Webb
 11 BIRTHPLACE OF FATHER (city or town) Ind. Res.
 (State or country) Idaho
 12 MAIDEN NAME OF MOTHER E we nun my
 13 BIRTHPLACE OF MOTHER (city or town) Ind. Res.
 (State or country) Idaho

14 Informant _____
 (Address) _____

15 Filed 11/7/22, 19 Carbeth Lawyer
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-6-'22 19

17 I HEREBY CERTIFY, That I attended deceased from

_____, 19_____, to _____, 19_____,

that I last saw h_____ alive on _____, 19_____,

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Influenza

_____, (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
 (SECONDARY)

_____, (duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
 if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) Carbeth Lawyer, M. D.

, 19 (Address) Lease Clerk

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Ind. Cemetery -11-7-22
 DATE OF BURIAL 19

20 UNDERTAKER Vassar - Lewiston, Idaho. ADDRESS

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

46264 3
Registered No. 9

1 PLACE OF DEATH
County Nez Perce State Idaho
Township _____ or Village _____ or
City NezPerce Reservation No. _____ St., _____ Ward _____
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME James Davis,
(a) Residence. No. Kamiah, Idaho St., _____ Ward. _____
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Indian 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5a If married, widowed, or divorced
HUSBAND of Susan Blackeagle
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE Years 61 Months _____ Days _____ IF LESS than 1 day, --- hrs. OR --- min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Ind. Res.
(State or country) Idaho

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant _____
(Address)

15 Filed 1/8, 19 22 Carbett Lawyer
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-27-22 19 22

17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____,

that I last saw h_____ alive on _____, 19____,

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

pneumonia

CONTRIBUTORY
(SECONDARY)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
if not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) Carbett Lawyer, M. D.

, 19 (Address) Lease Clerk

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

Ind. Cemetery

11-28-22

20 UNDERTAKER C.J. Johnson-Kamiah, Idaho

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1 PLACE OF DEATH

County Nez Perce State Idaho Registered No. 402051
 Township _____ or Village _____ or _____
 City Nez Perce Reservation No. _____ St., _____ Ward _____
 (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Julia Teslawood,

(a) Residence. No. Lapwai, Idaho St., _____ Ward _____
 (Usual place of abode)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Indian 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5a If married, widowed, or divorced
 HUSBAND of Isaiah Carter
 (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1905

7 AGE Years Months Days If LESS than 1 day, hrs. or min.
17

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Invalid

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) NezPerce Res.,
 (State or country) Idaho

10 NAME OF FATHER Teslawood

11 BIRTHPLACE OF FATHER (city or town) NezPerce Res.
 (State or country) Idaho

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) _____
 (State or country)

14

Informant _____
 (Address) _____

15

Filed 7/20/22, Carbett Lawyer,
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25, 1922

17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____,

that I last saw h_____ alive on _____, 19____,

and that death occurred, on the date stated above, at _____m.

The CAUSE OF DEATH* was as follows:

Tuberculosis - Throat

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
 (SECONDARY)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
 if not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) Carbett Lawyer Lease Clerk, M. D.
 , 19____ (Address) Lapwai, Idaho

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Indian Cemetery - 7-27-22 DATE OF BURIAL 19

20 UNDERTAKER Wann - Undertaker - Lapwai, Idaho ADDRESS _____

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS1 PLACE OF DEATH
County Nez PerceState Idaho10266 2
Registered No.

Township _____

or Village _____

or

City Nez Perce Reservation No. _____ St. _____ Ward _____

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Angie Amara Wapahili or Weesstarskot(a) Residence. No. Kamiah, Idaho

St. _____ Ward _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Indian5 SINGLE, MARRIED, WIDOWED,
OR DIVORCED (write the word)Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofLeo Weesstarskot

6 DATE OF BIRTH (month, day, and year)

1902

7 AGE

Years

Months

Days

If LESS than
1 day, ---- hrs.
or ---- min.21

8 OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of workHousekeeper(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

Nezperce Res.,

(State or country)

Idaho

PARENTS

10 NAME OF FATHER

Charley Amara

11 BIRTHPLACE OF FATHER (city or town)

Nezperce Res.

(State or country)

Idaho

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

Colville Res.

(State or country)

Washington.

14

Informant

(Address)

15

Filed

7/281922Carbett Lawyer
REGISTRAR

11-3154

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28, 1922

17

I HEREBY CERTIFY, That I attended deceased from

_____, 19____, to _____, 19____,

that I last saw h_____ alive on _____, 19____,

and that death occurred, on the date stated above, at _____m.

The CAUSE OF DEATH* was as follows:

Tuberculosis

CONTRIBUTORY

(SECONDARY)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted

if not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis?

(Signed) Carbett Lawyer Lease Clark_____, 19____ (Address) Kamiah, Idaho* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state
(1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or
HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Ind. Cemetery - 7-29-22

19

20 UNDERTAKER

ADDRESS

C. J. Johnson-Kamiah, Idaho

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

46267

Registered No. /

1 PLACE OF DEATH

County Nez Perce State IdahoTownship Nez Perce Indian Reservation or Village _____City _____ No. _____ St. _____ Ward _____
(If death occurred in a hospital or institution, give its NAME instead of street and number)2 FULL NAME Lucy Rosa Poweke(a) Residence. No. Orofino, Idaho St. _____ Ward. _____

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Indian5 SINGLE, MARRIED, WIDOWED,
OR DIVORCED (write the word)
Single

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1909

7 AGE

Years

Months

Days

If LESS than
1 day, ---- hrs.
or ---- min.13

8 OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of workStudent(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

Nez Perce Ind. Res.

(State or country)

Idaho

10 NAME OF FATHER

Amos Poweke

11 BIRTHPLACE OF FATHER (city or town)

Ind. Res.

(State or country)

Idaho

12 MAIDEN NAME OF MOTHER

Louisa Adams

13 BIRTHPLACE OF MOTHER (city or town)

Nez Perce
Ind. Res., Idaho

(State or country)

14

Informant

(Address)

15

Filed

4/3, 1923Leaseth Lawyer
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3, 1922

17

I HEREBY CERTIFY, That I attended deceased from

_____, 19____, to _____, 19____,

that I last saw h_____ alive on _____, 19____,

and that death occurred, on the date stated above, at _____m.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY

(SECONDARY)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis?

(Signed) Leaseth Lawyer Lease Clerk, M. D., 19 (Address) Lapwai, Idaho

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Indian Cemetery - April 4, 1922

20 UNDERTAKER

Wann - Lapwai, Idaho.

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1 PLACE OF DEATH
County Nez Perce State Idaho
Township Indian Reservation or Village _____ or
City _____ No. _____ St., _____ Ward _____
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Penatalwatsonmy

(a) Residence. No. Culdesac, Idaho. St., _____ Ward. _____
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Indian 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5a If married, widowed, or divorced
HUSBAND of Charley Kowtalikt
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE Years 61 Months _____ Days _____ If LESS than 1 day, --- hrs. or --- min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Indian reservation
(State or country) Idaho

10 NAME OF FATHER unknown
11 BIRTHPLACE OF FATHER (city or town) Ind Res
(State or country) Idaho
12 MAIDEN NAME OF MOTHER unknown
13 BIRTHPLACE OF MOTHER (city or town) Ind Res
(State or country) Idaho

14 Informant Charley Kowtalikt
(Address) Culdesac Idaho.

15 Filed 3/3/22 19 1922 Barlett-Sanger
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-3-22 19

17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____,

that I last saw h_____ alive on _____, 19____,

and that death occurred, on the date stated above, at _____m.

The CAUSE OF DEATH* was as follows:

pneumonia

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(SECONDARY)

(duration) _____ yrs. _____ mos. _____ ds.
18 Where was disease contracted
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) Lease Clk, M. D.
, 19 (Address) Lapwai, Idaho.

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Indian cemetery DATE OF BURIAL 3-4-22

20 UNDERTAKER Wann, Lapwai, I ADDRESS _____

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1 PLACE OF DEATH
County Nez Perce State Idaho
Township Indian Reservation or Village _____ or
City _____ No. _____ St. _____ Ward _____
(If death occurred in a hospital or institution, give its NAME instead of street and number)

46269
Registered No. 2

2 FULL NAME Appostimna
(a) Residence. No. Spalding, Idaho St. _____ Ward _____
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Indian 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1836

7 AGE Years Months Days If LESS than 1 day, --- hrs. or --- min.
85

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Invalid

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Indian reservation
(State or country) Idaho

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14

Informant
(Address)

15

Filed

2/10/22, 19 Carbott Lawyer
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-10- 1922

17 I HEREBY CERTIFY, That I attended deceased from

_____, 19_____, to _____, 19_____,
that I last saw h_____ alive on _____, 19_____,

and that death occurred, on the date stated above, at _____m.

The CAUSE OF DEATH* was as follows:

Old Age

_____ (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(SECONDARY)

_____ (duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis?

(Signed) Carbott Lawyer Lease Clerk D.
_____, 19 (Address) Lapwai, Idaho

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

Indian Cemetery

3-11-1932

20 UNDERTAKER
Wann, Lapwai, Idaho.

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1 PLACE OF DEATH
County Nez Perce State Idaho Registered No. 4
Township Indian Reservation or Village _____ or _____
City _____ No. _____ St. _____ Ward _____
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME John Dog
(a) Residence. No. Juliaetta, Idaho St. _____ Ward _____
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Indian 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1841

7 AGE Years Months Days If LESS than 1 day, --- hrs. or --- min.
81

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Invalid

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Indian Reservation
(State or country)

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant
(Address)

15 Filed 2/17, 19 19 Barrett Lawyer
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14, 1922

17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____,

that I last saw h----- alive on _____, 19____,

and that death occurred, on the date stated above, at _____m.

The CAUSE OF DEATH* was as follows:

pneumonia

----- (duration) ----- yrs. ----- mos. ----- ds.

CONTRIBUTORY
(SECONDARY)

----- (duration) ----- yrs. ----- mos. ----- ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? ----- Date of -----

Was there an autopsy? -----

What test confirmed diagnosis?

(Signed) Barrett Lawyer Lease Clerk D. D.
, 19 (Address) Lapwai, Idaho

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

Indian Cemetery - 3-15-1922 19

20 UNDERTAKER

Wann, Lapwai, Idaho

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1 PLACE OF DEATH

County Nez Perce State Idaho Registered No. 5
 Township Indian Reservation or Village _____ or _____
 City _____ No. _____ St. _____ Ward _____
 (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Peter Slickpoo

(a) Residence. No. Slickpoo, Idaho St. _____ Ward. _____
 (Usual place of abode)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Indian 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widower
 5a If married, widowed, or divorced HUSBAND of (or) WIFE of Julia Slickpoo

6 DATE OF BIRTH (month, day, and year) 1848
 7 AGE Years Months Days If LESS than 1 day, --- hrs. or --- min.
74

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Invalid

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Indian Reservation
 (State or country) Idaho

10 NAME OF FATHER Unknown
 11 BIRTHPLACE OF FATHER (city or town) _____
 (State or country) _____
 12 MAIDEN NAME OF MOTHER E wah wah ha po
 13 BIRTHPLACE OF MOTHER (city or town) Ind. Res.
 (State or country) Idaho

14 Informant _____
 (Address) _____

15 Filed 2/6/27, 19 Carbett Lawyer REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16, 1922

17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____,

that I last saw h_____ alive on _____, 19____,

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

pneumonia

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(SECONDARY)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
 if not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) Carbett Lawyer Lease, Clerk
 , 19 (Address) Lapwai, Idaho

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Indian Cemetery DATE OF BURIAL Wann - March 17, 1922
19
 20 UNDERTAKER Lapwai, Idaho ADDRESS _____

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1 PLACE OF DEATH
County Nez Perce State Idaho Registered No. 6
Township Indian Reservation or Village _____ or
City _____ No. _____ St. _____ Ward _____
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME John Lawyer
(a) Residence. No. Lapwai, Idaho St. _____ Ward. _____
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Indian 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1856
7 AGE Years Months Days If LESS than 1 day, hrs. or min.
66

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Invalid
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Indian Reservation
(State or country) Idaho

10 NAME OF FATHER Unknown
11 BIRTHPLACE OF FATHER (city or town)
(State or country)
12 MAIDEN NAME OF MOTHER Tsim mo
13 BIRTHPLACE OF MOTHER (city or town) Ind. Res.
(State or country) Lapwai, Idaho

14 Informant
(Address)

15 Filed 3/1/22, 19 Carbett Lawyer
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-27-1922 19

17 I HEREBY CERTIFY, That I attended deceased from

_____, 19_____, to _____, 19_____,
that I last saw h. _____ alive on _____, 19_____,

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(SECONDARY)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) Carbett Lawyer Lease Clerk M. D.
, 19 (Address) Lapwai, Idaho

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

Indian Cemetery - March 28, 1922

20 UNDERTAKER ADDRESS

Wann - Lapwai, Idaho

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1 PLACE OF DEATH
County Nez Perce State Idaho Registered No. 1
Township _____ or Village _____ or
City Nez Perce Reservation No. _____ St. _____ Ward _____
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Neoma Moody,
(a) Residence. No. Ferdinand, Idaho St. _____ Ward _____
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Indian 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

Infant

6 DATE OF BIRTH (month, day, and year) 1921

7 AGE Years Months Days If LESS than 1 day, hrs. or min.
1

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Ind. Res.
(State or country) Idaho

10 NAME OF FATHER George Moody

11 BIRTHPLACE OF FATHER (city or town) Ind. Res.
(State or country)

12 MAIDEN NAME OF MOTHER Fannie Parsons

13 BIRTHPLACE OF MOTHER (city or town) Ind. Res.
(State or country) Idaho

14 Informant _____
(Address)

15 Filed 7/2, 19 23 Lease Clerk
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3, 1922

17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____,

that I last saw h_____ alive on _____, 19____,

and that death occurred, on the date stated above, at _____m.

The CAUSE OF DEATH* was as follows:

pnuemonia

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(SECONDARY)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) Lease Clerk Lease Clerk, M. D.
, 19 (Address) Lapwai, Idaho

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Ind. Cemetery DATE OF BURIAL 5-4-1922
19

20 UNDERTAKER None ADDRESS _____

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1 PLACE OF DEATH
County Nez Perce State Idaho
Township Nez Perce Indian Reservation Village _____ or
City _____ No. _____ St. _____ Ward _____
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Harrison Kip
(a) Residence. No. Kamiah, Idaho St. _____ Ward _____
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Indian 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5a If married, widowed, or divorced HUSBAND of Daisy Kipp (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1843
7 AGE Years Months Days If LESS than 1 day, --- hrs. or --- min.
80

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Famer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Ind. Res.
(State or country) Idaho

10 NAME OF FATHER Unknown
11 BIRTHPLACE OF FATHER (city or town) _____
(State or country) _____
12 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (city or town) _____
(State or country) _____

14 Informant _____
(Address) _____
15 Filed 5/5/23 Carbett Lawyer REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4, 1922 19

17 I HEREBY CERTIFY, That I attended deceased from

_____, 19_____, to _____, 19_____,

that I last saw h_____ alive on _____, 19_____,

and that death occurred, on the date stated above, at _____m.

The CAUSE OF DEATH* was as follows:

pneumonia

_____ (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(SECONDARY)

_____ (duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) Carbett Lawyer Lease Clerk M. D.
_____, 19 (Address) Lapwai, Idaho

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Indian Cemetery DATE OF BURIAL May 6, 22 19

20 UNDERTAKER C. J. Johnson, Kamiah, Idaho. ADDRESS _____

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1 PLACE OF DEATH

County Nez Perce State Idaho Registered No. 3Township Nez Perce Indian Reservation Village _____ or _____

City _____ No. _____ St. _____ Ward _____

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Jacob Brown,(a) Residence. No. Kooskia, Idaho St. _____ Ward. _____

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>Indian</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Single</u>
----------------------	----------------------------------	--

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) 1852

7 AGE <u>70</u>	Years	Months	Days	If LESS than 1 day, --- hrs. or --- min.
--------------------	-------	--------	------	--

8 OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work Invalid(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) _____
(State or country)10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) _____
(State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) _____
(State or country)

14

Informant _____
(Address)

15

Filed 5/24, 19 22 Carbett Lawyer
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24, 1922

17 I HEREBY CERTIFY, That I attended deceased from

_____, 19____, to _____, 19____,

that I last saw h_____ alive on _____, 19____,

and that death occurred, on the date stated above, at _____m.

The CAUSE OF DEATH* was as follows:

Old Age

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(SECONDARY)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
if not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) Carbett Lawyer Lease Clerk
, 19 (Address) Lapwai, Idaho* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state
(1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or
HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Indian Cemetery5-25-22 19

20 UNDERTAKER

Geo. W. Trenary - Kooskia, Ida.

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1 PLACE OF DEATH Nez Perce
County Nez Perce State Idaho
Township Nez Perce Reservation or Village _____ or
City _____ No. _____ St., _____ Ward _____
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Gladys Kane Bronche
(a) Residence. No. Lapwai, Idaho St., _____ Ward. _____
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Indian 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 1921

7 AGE Years Months Days If LESS than 1 day, ---- hrs. or ---- min.
1

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Nez Perce Ind. Res.
(State or country) Idaho

10 NAME OF FATHER Hugh Bronche Kane

11 BIRTHPLACE OF FATHER (city or town) Ind. Res.
(State or country) Idaho

12 MAIDEN NAME OF MOTHER Julia White Kane

13 BIRTHPLACE OF MOTHER (city or town) Ind. Res.
(State or country) Idaho

14 Informant _____
(Address) _____

15 Filed 5/23, 19 23 Carbett Langer
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23, 1923

17 I HEREBY CERTIFY, That I attended deceased from

_____, 19_____, to _____, 19_____,

that I last saw h. _____ alive on _____, 19_____,

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Cold or pneumonia

_____, (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(SECONDARY)

_____, (duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) Carbett Langer Lease Clerk M. D.
, 19 (Address) Lapwai, Idaho

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Indian Cemetery DATE OF BURIAL 5-24-23

20 UNDERTAKER none ADDRESS _____

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1 PLACE OF DEATH Nez Perce
County Nez Perce State Idaho
Township _____ or Village _____
City Nez Perce Reservation No. _____ St., _____ Ward _____
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Matthew Ta ma lu sim likt

(a) Residence. No. Slickpo, Idaho St., _____ Ward. _____
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Indian 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

5a If married, widowed, or divorced
HUSBAND of Susan Matthew
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1851

7 AGE Years Months Days If LESS than 1 day, --- hrs. or --- min.
71

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Invalid

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Ind. Res.,
(State or country) Idaho

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) _____
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) _____
(State or country)

14 Informant _____
(Address)

15 Filed 5/26/23, 19 Basbeth Lawyer
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26, 1922

17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____,

that I last saw h. _____ alive on _____, 19____,

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Old age

CONTRIBUTORY _____
(SECONDARY)

(duration) _____ yrs. _____ mos. _____ ds.
18 Where was disease contracted
if not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____
(Signed) Basbeth Lawyer Lease Clerk
_____, 19 (Address) Lapwai, Idaho.

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Indian Cemetery - 5-27-22 DATE OF BURIAL _____ 19____

20 UNDERTAKER Wann - Lapwai, Idaho ADDRESS _____

1. PLACE OF DEATH.

County of Caribou
City of _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Elden Inay Moore

RECEIVED CERTIFICATE OF DEATH.

Registration District No. 82BUREAU Registration District No. 2159

(N.S.A.) _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 46439Registered No. 13

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX. 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male White Single
(Write the word.)

6. DATE OF BIRTH.

Nov. 12 1921
(Month) (Day) (Year)

7. AGE

Yrs. 3 Mos. 15 ds.IF LESS than 1 day
how many _____ hrs. or
_____ min. 2)

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)None
Child

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

A. Frank Moore

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Laura Dwyer

13. BIRTHPLACE OF MOTHER

(State or Country)

Laura

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Moore(Address) Soda Springs, Idh.

15.

Filed July 31 1924 Edwin Kersley
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb. 27 1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Feb. 26, 1922, to Feb. 26, 1922, that I last saw him alive on Feb. 26, 1922, and that death occurred on the date stated above, at 10:4 M.

The CAUSE OF DEATH* was as follows:

Branchio-pneumonia(Duration) _____ Yrs. _____ mos. 7 ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Russell Figue, M. D.7/27/22 (Address) Soda Springs, Idh.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Soda Springs, Idh.

DATE OF BURIAL

Feb. 28 1924

20. UNDERTAKER

None

ADDRESS

See

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A-25M. 1-19.

CERTIFICATE OF DEATH

47163

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Bounded

City of Addie

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 79

Primary Registration District No. 2156

(No. _____ St.)

State File No. 47163

Local Registrar's No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Roy William Hupe

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Male White Married
(Write the word)

6. DATE OF BIRTH

Jan. 10th. 1892
(Month) (Day) (Year)

7. AGE

30 Yrs. 3 Mos. 22 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Lumberman
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Wisconsin

10. NAME OF

Father E. O. Hupe

11. BIRTHPLACE

OF FATHER Germany

12. MAIDEN NAME

OF MOTHER Anna Niebler

13. BIRTHPLACE

OF MOTHER Wis.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Blanche E. Hupe

(Address) Addie, Ida

15.

Filed 5/31 1924 E. E. Fry

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 2nd. 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____ 19____, to _____ 19____,

that I last saw him alive on _____ 19____,

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Killed by powder explosion

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) E. E. Sargello

5/3 1924 (Address) Bonner Ferry, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____

of death _____ yrs. _____ mos. _____ days. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted

if not at place of death? _____

Former or

usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Spokane, Wash.

DATE OF BURIAL

_____ 19____

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 87-

County of Washington

Primary Registration District No.

City of

St.)

File No.

48295

Registered No.

If death occurs away from
usual residence, give facts
called for under special
information.

2. FULL NAME

Oreda E. Adamsen

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

Female White Single

6. DATE OF BIRTH.

Jan 5 1914
(Month) (Day) (Year)

7. AGE

8 Yrs. 1 Mos. 29 ds.

IF LESS than 1 day
how many hrs. or
min. 2)

8. OCCUPATION

(a) Trade, profession or
particular kind of work...
(b) General nature of in-
dustry, business, or estab-
lishment in which employ-
ed (or employer)...

Not Employed

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF
FATHER

Harry F. Adamsen

11. BIRTHPLACE
OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME
OF MOTHER

Corra Wheeler

13. BIRTHPLACE
OF MOTHER

(State or Country)

Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry F. Adamsen

(Address)

New York

15.

Filed 3-20

1912

Feb 22

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

3 10 1912
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
3-7-22 1912 to 3-10-22 1912

that I last saw him alive on 3-10-22 1912

and that death occurred on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) Yrs. 4 mos. 4 ds.

Contributory
(Secondary)

Influenza

(Duration) Yrs. 5 mos. 5 ds.

(Signed)

W. H. K. M. D.

19 (Address)

Cambridge, Mass.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death... yrs... mos... days In the State... yrs... mos... days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

191

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS
should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement
of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE is very important. See instructions on back of certificate.

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

50619

1 PLACE OF DEATH *St. Hall Reservation* State *Idaho* Registered No. *8*
County _____ Township _____ or Village _____
City _____ No. _____ St. _____ Ward _____
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME *Lucille Sawyer*
(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *Ind 4/4* 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of _____

6 DATE OF BIRTH (month, day, and year) *Feb 19 1921*

7 AGE Years Months Days If LESS than 1 day, --- hrs. or --- min.
1 6 6

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *St. Hall Reservation*

10 NAME OF FATHER *Notse Sawyer*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

St. Hall Reservation

12 MAIDEN NAME OF MOTHER *Annie Drink*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

St. Hall Reservation

14

Informant (Address)

*Notse Sawyer
St. Hall, Idaho*

15

Filed

19

11-3184

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug 25 1922*

17 I HEREBY CERTIFY, that I attended deceased from _____, 19____, to _____, 19____,

that I last saw him alive on _____, 19____,

and that death occurred, on the date stated above, at *4 a* m.

The CAUSE OF DEATH* was as follows:

Flu

(duration) --- yrs. --- mos. *7* ds.

CONTRIBUTORY (SECONDARY)

Pneumonia, bronchial

(duration) --- yrs. --- mos. *3* ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *No* Date of _____

Was there an autopsy? *No*

What test confirmed diagnosis? *None*

(Signed) *Henry R. Wheeler*, M. D.

, 19 (Address) *St. Hall, Idaho*

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

St. Hall Reservation

8-28-1922

20 UNDERTAKER

ADDRESS

Notse Sawyer

St. Hall Idaho

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH		2 FULL NAME		3 SEX		4 COLOR OR RACE		5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)		6 DATE OF BIRTH (month, day, and year)		7 AGE		8 OCCUPATION OF DECEASED		9 BIRTHPLACE (city or town) (State or country)		10 NAME OF FATHER		11 BIRTHPLACE OF FATHER (city or town) (State or country)		12 MAIDEN NAME OF MOTHER		13 BIRTHPLACE OF MOTHER (city or town) (State or country)		14 Informant (Address)		15 Filed		16 DATE OF DEATH (month, day, and year)		17 NO DOCTOR ATTENDING		18 WHERE WAS DISEASE CONTRACTED		19 PLACE OF BURIAL, CREMATION, OR REMOVAL		20 DATE OF BURIAL	
St. Hall Reservation		Low Masho		Female		Ind 7/8		Single		1918		4		at home		St. Hall Reservation		David Masho		St. Hall Reservation		Stella Martin		St. Hall Reservation		Stella Masho		St. Hall, Idaho		July 14 1922		No doctor attending		Pneumonia, bronchial		St. Hall Reservation		July 17 1922	
or Village		St., Ward																																					
No.		St., Ward																																					
(If death occurred in a hospital, or institution, give its NAME instead of street and number)																																							
Length of residence in city or town where death occurred		(Usual place of abode)																																					
yrs.		mos.		ds.		How long in U. S., if of foreign birth?		yrs.		mos.		ds.																											
PERSONAL AND STATISTICAL PARTICULARS		MEDICAL CERTIFICATE OF DEATH																																					
5a If married, widowed, or divorced		HUSBAND of (or) WIFE of																																					
1918																																							
4																																							
at home																																							
Pneumonia, bronchial																																							
Stella Masho																																							
St. Hall, Idaho																																							
Brown & Eldredge																																							
Blackfoot, Idaho																																							

FORM V. S. No. 5-25 M-1-19

1. PLACE OF DEATH

County of LemhiCity of Shoup

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No. 41Primary Registration District No. 2116

(No. _____ St.)

Frank AyersSTATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICSState File No. 54929

Local Registrar's No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDMale White Single
(Write the word)

6. DATE OF BIRTH

Not known
(Month) (Day) (Year)

7. AGE

about
55 Yrs. _____ Mos. _____ ds. _____
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Day Laborer
and Trapper.

9. BIRTHPLACE

(State or Country)

United States

10. NAME OF

Father

Not known

11. BIRTHPLACE

OF FATHER

(State or Country)

Not known

12. MAIDEN NAME

OF MOTHER

Not known

13. BIRTHPLACE

OF MOTHER

(State or Country)

Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Aug. Steebler
Solomon Idaho

15.

Filed

9/10

1926

Clis Bellamy

Local Registrar

CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Same 1922
Not known, Missing since 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 19____ to _____ 19____,

that I last saw him _____ alive on _____ 19____,

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Probably
accidentally killed by snow
slide.
Found Aug 19-1926
(Duration) _____ yrs. _____ mos. _____ ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W. E. J. Geller Coroner MD8/19/1926 (Address) Solomon Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ days. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death?

Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Garden Creek Ida.8-19th 1926

20. UNDERTAKER

J. R. Scoble

ADDRESS

Lemhi, Ida

RECEIVED JAN 6 1927

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JAN 6 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
55800
State File No.

County of Ft. Hall Reservation, Idaho.
City of

CERTIFICATE OF DEATH
Registration District No. 121
Primary Registration District No. 2194
(No.)

Local Registrar's No. 207

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Dean Sequint.

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Ind. 4/4 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) 1914

7 AGE Years Months Days
8 --- ---
If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. At home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Ft. Hall Reservation
(State or country)

10 NAME OF FATHER Jimmie Sequint.

11 BIRTHPLACE OF FATHER (city or town) Ft. Hall Reservation
(State or country)

12 MAIDEN NAME OF MOTHER Pemeetsie

13 BIRTHPLACE OF MOTHER (city or town) Ft. Hall Reservation
(State or country)

14 Informant Jimmie Sequint.
(Address) Blackfoot, Idaho

15 Filed Dec. 31 1926 McTear E. J. T.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 3, 1922
(Month) (Day) (Year)

17 No doctor attending
I HEREBY CERTIFY, That I attended deceased from, 19....., to, 19....., that I last saw him alive on, 19....., and that death occurred, on the date stated above, at 11 P m. The CAUSE OF DEATH* was as follows:

Tuberculosis of the lungs.

(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary), (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Henry M. Cochran M. D.
(Address) Ft. Hall, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Ft. Hall Reservation, June 5, 1922 Date of Burial 19

20. Undertaker Brown & Eldredge, Blackfoot, I
Address

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAR 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. **64856**

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Bannock
City of Grange Ida

Registration District No. 84
Primary Registration District No. 2161
(No. _____)

Local Registrar's No. 146

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Alzina Eunice Miles

(a) Residence. No. Niter Idaho St. _____

(Usual place of abode)

(If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single
5a If married, widowed, or divorced HUSBAND of (or) WIFE of _____

6 DATE OF BIRTH (month, day and year) July-8-1922

7 AGE Years 3 Months 23 Days 23 1 If LESS than day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9 BIRTHPLACE (city or town) Niter Idaho
(State or country)

10 NAME OF FATHER Joseph Daniel Miles
11 BIRTHPLACE OF FATHER (city or town) Idaho
(State or country)
12 MAIDEN NAME OF MOTHER Elsie Ann Johnson
13 BIRTHPLACE OF MOTHER (city or town) Idaho
(State or country)

14 Informant Mrs. Joseph Miles
(Address) Grange Ida

15 Filed Feb-28, 1929 Mrs. J. J. Felt
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov-3- 1922
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw h_____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:
Brown - Pneumonia

(duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY (Secondary) _____
(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted if not at place of death? _____
Did an operation precede death? _____ Date of _____
Was there an autopsy? _____
What test confirmed diagnosis? _____
(Signed) John H. Hutton, M. D.
Feb 28, 1929 (Address) Grange Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal _____ Date of Burial _____
20. Undertaker _____ Address _____

RECEIVED SEP 2 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County of TetonCity of Driggs, IdaRegistration District No. 77Primary Registration District No. 9176

DO NOT WRITE IN THIS SPACE

State File No. 71541Local Registrar's No. 4(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)2. FULL NAME Edward Durtzchi Jr.

(a) Residence. No. _____ St. _____

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White5. Single, Married, Widowed,
or Divorced (write the word)Married

5a. If married, widowed, or divorced

HUSBAND of
(or) WIFE ofElizabeth Muetzenberg6. DATE OF BIRTH (month, day and year) 12-3-1890

7. AGE

Years

41

Months

3

Days

13

If LESS than 1 day,

hrs. or

min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of workFarmer(b) General nature of industry,
business, or establishment in
which employed (or employer)Farming

(c) Name of employer

9. BIRTHPLACE (city or town) Wimmis
(State or country) Switzerland

10. NAME OF FATHER

Edward Durtzchi Sr.11. BIRTHPLACE OF FATHER (city or town)
(State or Country)Spiez
Switzerland

12. MAIDEN NAME OF MOTHER

Rosina Katharina Hiltlerand13. BIRTHPLACE OF MOTHER (city or town)
(State or Country)Wimmis
Switzerland

14.

Informant

(Address)

Alfred Durtzchi
Driggs Idaho

15.

Filed

8-28-1930Martha Marker

Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March161932

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____, 19____, to _____, 19____

that I last saw him alive on _____, 19____

and that death occurred, on the date stated above, at 6:00 P.m.

The CAUSE OF DEATH* was as follows:

Pneumonia(duration) _____ yrs. _____ mos. 21 ds.

CONTRIBUTORY

(Secondary)

Flu

(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis?

(Signed)

Dr. Charles J. Martin8-28-, 1930

(Address)

Driggs, Idaho*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT
CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2)
whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Pratt Cemetery 8-19- 1932

20. Undertaker

Address

Lewis Kiser Arbuckle, Idaho

RECEIVED SEP 11 1933

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

85478

State File No.

PLACE OF DEATH

County of Franklin
City of Franklin

CERTIFICATE OF DEATH

Registration District No. 27
Primary Registration District No. 2119
(No.)Local Registrar's No. 11

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary Jane Marshall

(a) Residence. No. St.

(Usual place of abode.)

(If nonresident give city or town and State.)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced

HUSBAND of
(or) WIFE ofGeorge T. Marshall6. DATE OF BIRTH (month, day and year) Aug. 7 18537. AGE Years Months Days If LESS than 1 day,
68 7 7 hrs. or
..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work.H.W.(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Sweet water Wyo.
(State or country)10. NAME OF FATHER George Alder11. BIRTHPLACE OF FATHER (city or town) England
(State or Country)12. MAIDEN NAME OF MOTHER Mary Ann Hamilton13. BIRTHPLACE OF MOTHER (city or town) England
(State or County)14. Informant George T Marshall
(Address) Franklin15. Filed Sept 8, 1933G. W. States
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 15, 1932
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 30, 1921, to Mar 14, 1932that I last saw him alive on March 14, 1932and that death occurred, on the date stated above, at 1:30 p.m.*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT
CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2)
whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:Carcinoma of Stomach(duration) 2 yrs. — mos. — ds.
CONTRIBUTORY General Debility
(Secondary)(duration) 3 yrs. — mos. — ds.18. Where was disease contracted
if not at place of death?Did an operation precede death? no Date of ✓Was there an autopsy? noWhat test confirmed diagnosis? Chirial(Signed) G. W. States M. D.Mar 15, 1932 (Address) Preston Ida

19. Place of Burial, Cremation, or Removal

Franklin Idaho

Date of Burial

Mar 18 1932

20. Undertaker

None

Address

MARGIN RESERVED FOR BINDING
N. B.--WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

PLACE OF DEATH
County of PAYETTE
City of PAYETTE

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 92382

Registration District No. 4

Primary Registration District No. 1008 Local Registrar's No. 13

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number)

2. FULL NAME AUGUST C WA LBRECHT. (AUGUST C. WALBRECHT.)

(a) Residence. No.

(Usual place of abode)

St.

Length of residence in city or town where death occurred, yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and state)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male. 4. Color or Race White 5. Single, Married, Widowed or Divorced (write the word) Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, and year)
Jan. 14, 1893.

7. AGE Years Months Days
29 1 14.
If LESS than 1 day, ... hrs. or ... min.

8. Trade, profession, or particular kind of work done, as spinney, sawyer, bookkeeper, etc. Deputy Sheriff.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (mo. and yr.)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) NEBRASKA.

13. NAME John Walbrecht.

14. BIRTHPLACE (city or town) (State or country) Germany.

15. MAIDEN NAME Ella Opitz

16. BIRTHPLACE (city or town) (State or country) Illinois.

17. INFORMANT E.L. Walbrecht. (Address) Payette, Idaho.

18. BURIAL, CREMATION OR REMOVAL
Place Payette, Id. Date 3/3/22

19. UNDERTAKER I.H. Adair (Address) Payette, Idaho

20. FILED 3/1/22, 193... J. H. Woodward Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day and year) 3/1/22

22. I HEREBY CERTIFY, That I attended deceased from 2/27/22, 193..., to 3/1/22, 193....

I last saw him alive on 3/1/22, 193.... death is said to have occurred on the date stated above, at 12.30pm.
The principal cause of death and related causes of importance were as follows:

Influenza

Pneumonia.

Other contributory causes of importance:

Name of operation..... Date of.....

What test confirmed diagnosis?.... Was there an autopsy?..

23. If death was due to exte'l causes (violence) fill in also the following:
Accident, suicide, or homicide?..... Date of injury.., 193.

Where did injury occur?.....
(Specify city or town, county, and state)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.. No. If so specify.....

(Signed) J. H. Woodward M. D.
(Address) Payette, Idaho

Informant, Funeral Director, Registrar and Medical Attendant, EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215). Address correspondence to State Bureau of Vital Statistics, Boise, Idaho.

United States
Department of Commerce
Bureau of the Census

Certificate Of Death

STATE OF IDAHO

State File No. **152142**
Local Reg. No.
Reg. Dist. No.

1. PLACE OF DEATH:

- (a) County Fremont
(b) City or town St. Anthony
(c) Street Address or R.F.D. No.
(d) Death Occured Inside? X Outside? city or town
(e) Died in a Home... Hospital... Institution... Other place...
(f) Name Hosp. or Inst. Stayed 4 days
(g) Lived in this county years months 4 days

Note. For a person residing in THIS county LESS than 1 year, give FORMER residence under item 2.

2. Usual Residence of Deceased: (Always fill in these)

- (a) State Idaho (b) County Bannock
(c) City or town Lava Hot Springs
(d) Street Address or R.F.D. No.
(e) Deceased lived Inside? Outside? city or town
(f) Citizen of what country?
(g) How long had deceased lived in Idaho? years
(h) Former residence (city, state)

3. (a) FULL NAME SARAH AGUSTA BYINGTON HOFFMAN.

3. (b) If veteran, name war 3. (c) Social Security No.
5. Color or White 6. (a) Single, widowed, married, divorced Widow
4. Sex Female 6. (b) Name of husband or wife 6. (c) Age of husband or wife if alive years
7. Date of Birth (Month, Day, Year) June 23rd, 1857

8. AGE	Years	Months	Days	If less than 1 day
	<u>64</u>	<u>7</u>	<u>1</u>	hrs min.

9. Exact Occupation Housewife Did this work for yrs.
10. Industry or Business Date last worked
11. Birthplace Ogden, Utah (City or town) (State or foreign country)
Mother { 12. Name Joseph Byington
13. Birthplace Vermont (City or town) (State or foreign country)
14. Maiden name Nancy Avery
15. Birthplace Pennsylvania (City or town) (State or foreign country)

16. Informant's OWN Signature Harry Hofman
and Address LaGrande, Oregon

17. (a) Removal (b) Date thereof Jan. 28, 1922
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: Lava Hot Springs, Idaho

18. Funeral Director's OWN Signature William J. Hansen
and Address St. Anthony, Idaho

19. (a) March 1, 1947 (b) W. J. Hansen
(Date received and filed) (Registrar's signature)

MEDICAL CERTIFICATE OF DEATH

20. DATE OF DEATH Jan. 24 19 22
(Month, Day, Year) at o'clock M.
21. I HEREBY CERTIFY, That I attended deceased from 19....., to 19.....

I last saw h..... alive on 19.....; death is said to have occurred on the date and hour stated above.

Immediate Cause of Death: Duration

Brights Disease

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Where was disease contracted?

Name of operation Date PHYSICIAN

Major finding Underline the cause to which death should be charged statistically.

Finding of autopsy

22. If death was due to EXTERNAL CAUSES, also fill in the following: Accident? Suicide? Homicide?
Occurred 19..... City, county, state where violence occurred
Place of Violence: Home Farm Industry
Public Place While at work?

Means of injury

23. Attendant's OWN Signature Dr. W. B. West, M. D.
(M. D. or other) St. Anthony Date 19.....
and Address
(For additional space, use reverse side)

Informant, Funeral Director, Registrar and Medical Attendant, EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215). Address correspondence to State Bureau of Vital Statistics, Boise, Idaho.

United States
Department of Commerce
Bureau of the Census

Certificate Of Death

STATE OF IDAHO

152943

State File No. **152943**
Local Reg. No. **17**
Reg. Dist. No. **511**

1. PLACE OF DEATH:

- (a) County Bernheim
(b) City or town Thatcher
(c) Street Address or R.F.D. No. _____
(d) Death Occured Inside? LESS Outside? _____ city or town
(e) Died in a Home? Hospital Institution? _____ Other place? _____
(f) Name Hosp. or Inst. _____ Stayed _____ days
(g) Lived in this county 24 years 11 months 11 days

Note. For a person residing in THIS county LESS than 1 year, give FORMER residence under item 2.

2. Usual Residence of Deceased: (Always fill in these)

- (a) State Idaho (b) County Bernheim
(c) City or town Thatcher
(d) Street Address or R.F.D. No. _____
(e) Deceased lived Inside? ✓ Outside? _____ city or town
(f) Citizen of what country? U. S. A.
(g) How long had deceased lived in Idaho? 24/11/19 years
(h) Former residence (city, state) Chesterfield, Ida.

3. (a) FULL NAME Nellie Ora Bevins Cahoon

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____
5. Color or _____ 6. (a) Single, widowed, married, divorced married
4. Sex female race white
6. (b) Name of husband or wife Chas. Cahoon 6. (c) Age of husband or wife if alive 31 years
7. Date of Birth (Month, Day, Year) Dec. 10, 1897

8. AGE	Years	Months	Days	If less than 1 day
	<u>24</u>	<u>11</u>	<u>11</u>	hrs min.

9. Exact Occupation housewife Did this work for 52 yrs.
10. Industry or Business _____ Date last worked _____
11. Birthplace Chesterfield, Idaho (City or town) (State or foreign country)

- Mother Father { 12. Name Joseph Hiram Bevins
13. Birthplace Liversoll, Ontario (City or town) (State or foreign country)
14. Maiden name Catherine Ann Pinchett
15. Birthplace Belwood, Minn. (City or town) (State or foreign country)

16. Informant's OWN Signature Alexander R. Bevins
and Address Alexanders Idaho

17. (a) Burial (b) Date thereof approx Nov 14 1947
(Burial, cremation, or removal) (Month, (Day) (Year)
(c) Place: Thatcher Cemetery

18. Funeral Director's OWN Signature George J. Anderson (Bishop)
and Address Thatcher Idaho

19. (a) April 21, 1947 (b) Jessie J. Powell
(Date received and filed) (Registrar's signature)

MEDICAL CERTIFICATE OF DEATH

20. DATE OF DEATH (Month, Day, Year) Nov. 11, 1922
at 1:45 o'clock A.M.

21. I HEREBY CERTIFY, That I attended deceased from Oct. 25, 1922, to Nov. 11, 1922
I last saw her alive on Nov. 11, 1922; death is said to have occurred on the date and hour stated above.

Immediate Cause of Death: Influenza after child birth Duration _____

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Where was disease contracted? _____

Name of operation none Date _____

Major finding _____

Finding of autopsy _____

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to EXTERNAL CAUSES, also fill in the following: Accident? _____ Suicide? _____ Homicide? _____
Occurred _____ 19 _____ City, county, state

where violence occurred _____

Place of Violence: Home _____ Farm _____ Industry _____

Public Place _____ While at work? _____

Means of injury _____

23. Attendant's OWN Signature Oliver Spatt

and Address Soda Springs (M. D. or other) Date April 1947
(For additional space, use reverse side)

MARK X IN COLUMN AT RIGHT IF CHILD
TRANSFERRED TO ANOTHER WARD OR MARRIED

AP 5-100

Printed in U. S. A.

Ira H. Hagan
 General Agent

James J. [Signature]

(MARK X) DEAD ☐ DIVORCED ☐

PLACE OF MARRIAGE

DATE OF DEATH	Nov. 11 1922	PLACE OF DEATH	Thatcher Idaho
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Nov. 11 1922

Thatcher Idaho

Influenza.

INTERNATIONAL CODE